March 8, 2024

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

I'm Matthew Agren of Lewiston Maine. I have been involved the foster care system, in a kinship case for almost 6 years now. Our child doesn't call us Mom or Dad, but I am Uncle Matt, which honestly carries more weight in this world than can be imagined. We were due to get our Permanent Guardian Status on the day the courts shut down for Covid, so we ended up staying under State authority for longer than necessary.

Forgive me, as this is my first time coming to Augusta to testify before a committee about a subject matter, so if I stumble or ramble a bit, please understand and bear with me.

It was encouraging to hear that Governor Mills' new budget has added both CPS Case Aide positions and as well as Legal Administrative Professionals to 5 districts currently. This is something that is direly needed to support the CPS caseworkers in doing their jobs. It is also imperative that we do something about the extremely high level of turnover of caseworkers and make sure those we have are being trained properly. By doing so, we will be able to end the ongoing problem of constant new caseworkers, who give families, both biological and resource, different answers to the same questions, which often makes it appear that no one has the "correct" answer.

These and other problems in CPS are not new; they are unfortunately the result of long term, deeply entrenched institutional problems within DHHS that no one is willing to take on because they are too big and there are so many divisions under their umbrella that they cannot all be managed effectively.

It is time to do away with "fiefdoms" within DHHS. These fiefdoms have served to further jeopardize vulnerable children by keeping direct oversight of their cases unnecessarily complicated and weak. This is noticeable when someone's case crosses more than one area in the state. DHHS is supposed to be one cohesive organization working for the whole state of Maine. Staff focus should be mostly be in their local area of employment. No longer should case management working from the Bangor office, for example, be trying to work with a family who has moved to Old Orchard Beach. If they do not know the area, they will have a hard time helping to provide the immediate services that the family or children need. Instead, long-distance cases should be handed off to local offices. In the example above, the Biddeford office would be better positioned to handle the children and family needs.

I will tell you when the State was doing visits with my son and his mother in South Portland, they hard the hardest time with transportation. One time my wife and I were out when her cellphone rang. The caseworker who had handled the supervised visit was calling to say that there was no return ride for him to Lewiston, as planned. This was not the only time that pre-planned transportation failed him getting to or from see his mother in a supervised situation. We ended up filling in for preplanned state transport more often then we were planning on.

It is imperative that we improve our record ensuring the well-being and welfare of our most vulnerable children. Children in State Care and Custody must receive the best possible care and services that we can provide. To quote a recent Maine Maine Supreme Court Justice's ruling: "Inadequate resources do not excuse a state's obligation to provide benefits under Medicaid that the child was legally required."

Except for legitimate safety concerns, standards for foster parents should not be any different than those for biological parents. This should be especially true for those Kinship resource families who are taking in relatives. After all, they are taking in relatives, and the State says that family connections and relationships can be maintained to help provide stability to children.

As far as reunification, I understand that the courts have ruled that the first choice is to try to reunify the families in question. If there is to be reunification, there must be strict follow-through on the reunification and safety plans so everyone is always aware that conditions will be enforced by the State in order to keep the child(ren) safe. This should include random unannounced home visits, and if required, random substance testing. All of this is with the goal of keeping children safe, which is the reason the State has a Child Protection Service in the first place.

We need to have a fully independent investigator look into child protection operations and practices. This is essential for Kinship and foster as well as biological Families who currently have no outside support or authority to turn to when there is a problem. Let's be totally honest: many families are afraid or reluctant to speak up because of fear of retaliation against them by DHHS/CPS if they report case workers and/or contractors who are acting inappropriately, recklessly or who attempt to intentionally intimidate the child , parent or caregiver. This is applicable to concerns of either the biological or the resource parents of the children in State care. There is lack of accountability from DHHS/CPS because they are not required to follow their own rules and if they step away from them, there is no one to hold them accountable. Lets us all be honest: do any of us truly believe that bureaucratic systems truly want to examine themselves when and if there is a mission failure?

If you have questions based on my comments, please feel free to ask, as I am happy to provide answers to the best of my ability.

I also have with me from a resource family who wishes to remain anonymous Testimony. Based on the their longterm personal experience with the Child Protection Service. They reached out to me, after my piece in the Portland Press Herald and told me their story. I'm sure they would like to be here in person, but fear CPS retaliation against them for speaking out the failures they had to deal with.

Over 15 years with 1 mother and 4 children.

Total of 5 official removals for jeopardy plus 3 unofficial removals to relatives.
14 months residential treatment (child)
3 months psychiatric treatment for safety (child)
Two diagnosis for severe PTSD (children)
One accidental overdose requiring narcan (child)
No less than 25 clinical professionals (children)
14 years of DHHS involvement with 3 failed reunifications
No less than 10 permanency workers, No less that 10 supervisors Involvement of senior management at the department for more than 13 years
Currently 1 failed TPR trial. No less than 5 criminal charges. Most recent case with CPS has been open for 34 months And they're STILL pushing reunification.

And why is CPS pushing reunification, because the State screwed up royally the TPR for the current child. Here are some of the plans from original jeopardy order for example:

Clean urine for 1 year before unsupervised visits, not met,
Psychiatric evaluation required for her, not met

Post TPR plan was for her to attend ALL visits and medical appointments no excuses, yet the She's missed at least 15 visits since for various reasons and she's NEVER been to a single medical appointments the child has had.

And when they ask why is CPS setting standards, that they are not don't enforce CPS come up with excuses for it:

The Child's schedule is too complex, His needs are too high,
Biological Mother needs to work, She doesn't drive

March 22, 2024

Senator Hickman, Representative Faye, and The Honorable members of the Government Oversight Committee, I would like to thank you for the opportunity to testify and share with you experiences.

My name is Debora DeJulio. I have been a foster / adoptive parent for 26 years in District 7. We have adopted a sibling group of 4 and a sibling group of 3 and currently have 1 foster child. We have had many children come through our home throughout this very long journey. I would like to give you some things that we as a family and more specifically the children in foster care have experienced. I will specifically talk about our sibling group of 3. These kids came into our care on Feb 9th, 2018. They were 3.5 weeks, 2 years, & 3 years old at that time. They were brought into state custody because of severe neglect. I picked these kids up from the Emergency Room after being there 8 hours on a Friday night and only knew their names. Just to give a little background, I was asked by the caseworker before even seeing the kids, "we have dealt with this family before, this will be a quick easy case. Would you adopt them?" I will say that it definitely was not quick and absolutely not easy. All three kids were very sick, and I ended up back in the ER on Sunday with them all. I got them into a pediatrician on Monday and of course was asked "do you have any information on the family or medical information?" Of course, I had nothing but their names. The baby was only 4.5lbs so I was asked if she was premature, about her birth, or even if I knew where she was born. Of course, I knew nothing. We were going to be there a while because the appointment was for all 3 kids. So, the nurse says, let me see what I can find. She came back in later and said "you need to sit down. There is another child that has already been adopted. So, with the kids being so young I assumed the child was older. She said nope she is 18 months old. I just could not figure out how that could happen, I had one younger and 2 older than her. She said the 18-month-old child had been born at 24 weeks and weighed 1.2 pounds and her lowest weight was 10 ounces. She was abandoned in the NICU by her parents. They just walked away. So, she was put in foster care and adopted by another family. She also said there is more. This baby and the adopted child had the same name. (just added that to show type of case we were dealing with), DHS got involved with the next three because when the baby was born, Mom was transferred to another hospital for medical reasons, but because of concerns the hospital had about Mom, they left the baby at the hospital where she was born, and contacted the department. The parents never went back to the hospital to pick up the baby. She was abandoned there for 9 days. DHS finally got the grandmother to go to the hospital and pick the baby up and she took custody of the other 2 as well. Mom was living with the grandmother at the time. They stayed there for 3 weeks before the grandmother told the Department they needed to take custody. She worked and could not be there every day. Her quote to DHS was "they need to be moved before I come home to something that I don't want to see." Reunification was started and it was very clear from the beginning it should not happen. Bio Parents were not interested in the baby at all and did voluntarily terminate their rights on her and she was adopted by us in October of 2000. I just could not understand how it was ok in anyone's eyes that these bio parents could abandon 2 children and were able to continue to try and fight for reunification of the other two. How was it ok to pick and choose which kids you wanted?

Visits were set up with the bio family and they were absolutely crazy from day one. The first visit was on Tuesday and there were literally 15 people at the first visit. Parents, grandparents, great

grandparents, cousins, and who knows who else. When I went back to pick them up a lady asked me if she could talk to me in the parking lot. I said sure. She introduced herself as being the grandmother on the mother's side. She asked if there was any way we could work out visits between us as they were going to be scheduled during the day and she worked for DOT and could not make them. So, I said that would not be a problem. She was the only one that was decent to me at all. On the first visits the grandparents and great grandparents made comments about me trying to take the kids from them. It just got worse as time went on. I had death threats, I was being stalked by them, stalking my older kids at their workplaces, accused of everything imaginable, and many other not so pleasant things that went on for the whole time the case was open for 1848 days, just over 5 years. And it continues today with them.

The timeline for this case was so ridiculous. The kids came into care on February 9th, 2018, we never had a jeopardy hearing until May of 2019, the kids were sent home on a trial home placement on December 21, 2018, that ended after 3 days with a domestic violence incident. TPR was filed in July of 2019, we never got a TPR hearing until January 2022. We got a decision of TPR in May of 2022, then of course an appeal was filed right away and then we never got a decision on that until late November 2022. Appeal was not granted, and the kids were adopted by us in March of 2023. Visits were stopped with both bio parents in Jan of 2019, so no contact from Jan 2019 until the TPR hearing in Jan of 2022.

These kids had 1848 days in foster care, 6 caseworkers, 2 GAL's, and 2 judges. At every visit the kids were given toys and candy, told how awful I was, when they came home, they would not have to go to daycare or school, they would not have to listen to me, and life would be so great by the bio family. What kid would not want that at 4 to 5 years old? Visits were stopped at the request of the supervising agency because they were so bad. These kids were given false hope of what they were told life would be and to this day it has created lots of behavioral issues. My oldest wants to be with his bio family and will struggle with the fact that he cannot lifelong. The older two were told that their youngest sister "does not have a Mom or Dad, she was bought at the baby store." My middle daughter who is Autistic believes that to this day. These kids have so many different diagnoses, ADHD, ODD, Mood Disorder, Anxiety, Autism, RAD, Trauma Related Stressor Disorder, and the list goes on and on. A lot of these were caused by what they experienced after coming into care, by the state of Maine. My Autistic daughter who is now 8 struggled so bad that she had the police called on her at 6 years old in First Grade because of an incident on the bus. It was totally handled so wrong and caused so much more trauma. She can no longer ride the bus to school and her behavior escalated so bad in school that she destroyed a classroom, a lot of self-harm, and was cut down to 1 hour a day in a self-contained classroom at school. She is a tiny little thing but when she is mad, she could take down a football team in about 3 seconds flat. She and her brother were adopted on March 3rd, 2023. Her behaviors decreased dramatically since that day. She now knows where she will be, she is in her forever home, she is loved, and all her needs will be met. I am happy to say that since September she has been in school full time, not one meltdown. She is in the Special Ed program still and probably will always be but is being introduced to the mainstream classroom slowly.

I could go on forever about what these kids have been through. But will finish up with my suggestions. One being that sometimes it is not safe to place these kids back with bio families, the kids needs should be paramount, timelines as far as hearings should be followed to the letter. Not

one of the cases I have ever had has ever had a Jeopardy hearing in 120 days and as a matter of fact some have been well over a year before one is held. I truly believe there should be a timeline as far as TPR. It seems like after it is filed it is sometimes years before getting a trial date. In the meantime, these kids are subjected to so much more unneeded trauma. Permanency should happen as soon as possible not 5 to 6 years later. Foster parents should be listened to, as we are the ones that are with these kids 24/7. I have had cases where reunification should never have happened and then these kids are returned to care and sometimes sent home over and over. I hope that this does not come off as not supporting reunification as I have fought the department for reunify many kids and if it is a safe place for them to be then that is where they should be. But the fact is that there are these cases where reunification should not happen, and innocent children are being hurt or killed unnecessarily.

Thank you for your time.

Debora DeJulio

The Failures of Reunification; TPR Filings, Safe and Timely Permanency is tragically affecting the safety and wellbeing of children in Maine.

Senator Hickman, Representative Faye, and the honorable members of the Government Oversight Committee, my name is Melanie Blair. Thank you for the opportunity to offer testimony in response to the OPEGA report on Reunification.

As stated in the report, *Both federal and state statute require OCFS to seek termination of parental rights when the child has been in foster care for 15 of the most recent 22 months. In OPEGA's analysis of the cases rated Area Needing Improvement, found that in the majority of cases reviewed (62% or 91 of 146 cases), reunification remained the goal too long, and about one-half of the cases reviewed (51% or 74 of 146 cases identified) had delays in TPR filing.*

In a survey I conducted with 44 foster parents, 38 out of 44 (86%) reported TPR's were not filed within the timelines specified in statute. Some reasons they were given were; couldn't find the parents, parents are trying now, not enough time to complete the paperwork, not prepared in court, we waited too long and ran out of time, don't think they have enough evidence to file, caseworker doesn't know how to complete the paperwork. 25 out of 44 (57%) of respondents asked to remain anonymous because of fear of retaliation, they still have the placement, don't want to lose their placement, and don't want the drama.

Also stated in the report, *Continual assessment and subsequent decision-making during the reunification process rely upon the caseworker's ability to conduct thorough and comprehensive casework. However, high workloads driven by caseworker vacancies, a lack of support staff, and a lack of visitation supervisors and transportation for families, all place additional burdens on caseworkers which can adversely impact all parts of this practice.*

The inadequate assessment of parents' substance use, caseworker inability to engage with the parents, addressing domestic violence and mental health concerns are all serious concerns in practice challenges are further impacted by high workloads, vacancies, lack of support, visitation and transportation staff, amongst other challenges.

These deficiencies are sending Maines Children to unsafe homes, some who will now be subject to more abuse, neglect, or worse. As well, many languish in care living for years

with the uncertainty of where their forever home will be. There are consequences to this that will have lifelong effects on children.

None of these problems have immediate solutions. The drug and mental health crisis, the lack of service providers, and the staffing crises do not have a fix that will improve the safety of children in any immediate manner. Significant changes need to happen now while we are waiting for these crises to improve. The lives of children continue to be lost while we talk about all of the issues without putting forward immediate policy, practice and/or legislative action. We must initiate outside monitoring IN THE MOMENT, rather than waiting for another death to occur. I have advocated through two legislative sessions and am still waiting to see the safety of children really be the first and foremost priority. This needs to include the reunification policies. Children deserve safe, timely (12-15 mos) permanency regardless of whether this is by returning home or being adopted by kinship or foster parents. Regular oversight of reunification needs to occur to prevent further trauma or abuse. Leaving kids in or returning them to unsafe homes has resulted in the death of far too many children.

I would like to close my testimony with an example of a tragically failed reunification example that I have been asked to share from a former foster parent of 10 years that also has experience as a department service provider:

We had a case with two siblings for three years. After a failed trial home placement, the children came back into care to us, now with an additional infant sibling. Despite ours and other professionals pleading, they returned home after 4 months. Three days later, the infant died from suffocation. This became a quieted incident, with the other two children remaining in the parents care for a year until they were found homeless, hungry, and shoeless in a stolen car with their parents using hard drugs. The two children left finally came back into care but were so traumatized by additional abuse and neglect that they needed therapeutic care and still have no permanency. This, like Maddox and many other cases did not need to happen but did because of a failed reunification priority and process, hiding mistakes, and safety plans not followed. The focus was on the parents rather than the children's safety and it cost all of those children, as well as many others, more than you will ever know.

Gmail

Fwd: Testimony on OPEGA reunification

Betsey Grant <betseygrant1@icloud.com> Thu, Mar 7, 2024 at 4:47 PM
To: rderaps23@gmail.com

Marissa Kennedy
9 calls from caseworker
(teachers police counselor caseworker)

Sent from my iPhone

Begin forwarded message:

From: Betsey Grant <betseygrant1@icloud.com>
Date: March 7, 2024 at 3:57:30PM EST
To: goc@legislature.maine.gov
Cc: Sabrina Carey <sabrina.carey@legislature.maine.gov>
Subject: Testimony on OPEGA reunification

Chair
Good Afternoon Senator Hickman
Representative Fay Co Chair
and Honorable Members of the
Government Oversight Committee

My name is Betsey Grant and I am blessed to be able to provide childcare for my community for 24 years. In that time I have been able to observe The practices of OCFS/DHHS/CPS in many categories from Investigators, Case Workers, Supervisors, Central Office, sub contracted Child Abuse Doctors, transportation volunteers and paid transportation workers. Billing specialist, foster parents, biological parents, children and most importantly Adults who lived in State Care who explain some of the same Chronic Issues that continue to plague our ability To Keep Children Safe today.

Psychology of Abuse: We must understand the psychology of Abuse before we try to "solve the situation" or else we could be causing more abuse and Re - victimization to the children we are tasked to protect.

Marissa Kennedy

We Empower the Abuser, by doing vague and shallow visits as seen in Maddox Williams' case. We must understand what Abusers do when they have been triggered by a surprise visit from CPS. We must understand that some abusers enjoy lying to CPS and experience what called "dupers delight".
Abusers triangulate and some dominate their entire family but most abusers are a team. As disturbing as it is for Us to think that a parent could hurt their own child we must awaken our brains to that Disturbing Reality.

Investigations must be Honest and Accurate so Decisions can be made Safely. I've seen Investigators Intimidate, Insult, Interrupt and Insert words while gathering Information. Intentionally supplying Inaccurate Information and/or Omitting Obvious information is Obstruction.

OCFS /DHHS/CPS is a giant agency allowed to police itself which leads to the ability for misconduct, misrepresentation, mishandling of federal funding and retaliation to take place.
Mandated Reporters are often ignored (such as myself) and then retaliated upon.
I have called in numerous concerns of child endangerment, and the mental anguish of not knowing

TINY TIKES DAYCARE

if it was followed up on is too much. So I learned to follow up. Apparently I've been labeled internally as a nuisance and I am disregarded as a reliable information source. Commissioner Lambrew will be supplied Information to look over this week that is Inaccurate regarding my complaints and dealings with OCFS, but this is what she will review from her own staff and it resembles the same Investigation Tactics that's are misleading. that were used in OPEGA + ombudsman Report.

Herein lies the problem.....no agency, industry, entity, business or organization can be optimally productive and meet its mission if CHECKS & BALANCES do not exist.

Employee Retention and Vacancies are the constant theme along with lack of training and lack of services and safe places for children to stay during their family crisis. This is seen in the ombudsman report as well .....also page 10 of her report says that "In order to make safety decisions correctly during an investigation , Enough facts & Evidence must be collected, and the facts and evidence must be interpreted correctly.

This is an easy situation for sleight of hand to take place to cover up misconduct or failure to protect by OCFS /DHHS/CPS.

If We are to attract Good, Strong, Ethical people to work in Child Protective Services We need to make sure their work environment is clear of the **Internal Intimidation and Intentional Covering Up that exists across the Divisions within OCFS.**

If we are to retain them we must Support them with a deeper understanding of What Abuse is and we must protect them by using Better Strategies to help them document safety issues that they see.

1. Child Safety Commissioner (Independent from OCFS/DHHS/CPS)

2. Due Process for Complaints

3. Revolutionize the Childcare Industry

Briefly .....1. We need a Child Safety Commissioner to educate, advocate and connect the general public to **ALL SAFETY ISSUES** facing our children.

2. Due process must exist so a casework could raise a concern about a supervisor for example without **Fear.**

3. Revolutionize how we See Childcare. I have never been Short staffed....Why?

Because I pay them well, offer free childcare , hire people with BHPs, nursing or Psychology backgrounds, As well as I have a mental health professional for all staff. I bring this up because I saw how retention is excellent for my childcare and when employees get done it's because they were fired. It only takes one employee to ruin productivity and a positive work environment. It takes a team to accomplish the mission.

** of Note .... The rate of child maltreatment is higher in families who lack employment, people can't work without childcare **

There are 509 things to be done at the same time and We are from Maine which means we **Lead,**
I pray we can Collectively save more children from the generational trauma of Child Abuse & Neglect.

Sincerely,
Betsey Grant & Tiny Tikes Daycare Family
Sent from my iPhone

- Bring Spread Sheet

- HOME SCHOOLING (Responsible Education)

Proof of Life

Checked on While Sleeping

March 22, 2024

ReUnification

Without Reliable Information we cannot make Intelligent Safety Decisions regarding the Well-Being of Our Children.

We gather "Information" through the Investigation Process.

This is an Area within OCFS that is severly deficient.

I have had 57 foster children in the last 3 years and I have seen Trauma. I've seen FEAR and felt FEAR.

Reunification means Trauma has already been happening for a family. Removals are Traumatizing

What I have seen and documented throughout the last few years of direct experience with our Child Welfare System is Traumatizing.

1. Investigation Issues

2. Mandated Reporters Disregarded + then Retaliated on by OCFS.

3. Ignored by specific high level leaders with in the OCFS.
   Disinterested by stander is my Best Description. Disconnected to the Obvious Safety Threat.

4. The Inability to Understand how to Support a Family.

Perhaps Commissioner Lambrew does not realize or didn't mean to intimidate,

Perhaps the complex PTSD I have from being a mandated reporter and still not being able to save some children from death makes me too emotional .....

But the statement from April 8, 2022 " that does not question the motives of our employees" .....

This sent a shockwave through me as a reminder of the Risk people take when CPS gets involved in your life.

Back to reunification.

Theres levels..... How many removals
How many placements
How many years.

Next: How early in the transition what about aftercare for when reunification is complete.

Do the Foster/Resource Family + Bio Family have a Bonded relationship?

I've seen success and I've seen Death.

Reunification should not = ~~Revictimization~~ Revictimization.

Resiliently,
Betsey Grant + Tiny Tikes Daycare Family

Investigation Tactics

- Incomplete Questioning
- Intimidation
- Impartiality (Lack of)
- Incompetence
- Indifference (Lack of concern to actual danger)
- Ignoring Evidence
- Information Misrepresentation
- Inadequate Documentation (DHHS does not document every time they contact the subject of investigation)
- Intentional Interrupting while Interviewing the Subject
- Inappropriate/Immature Behavior Standards
- Invalid Information Supply
- Insertion of Words the are Misleading
- Inaccurate Information Reporting

Investigators/CPS can use position of power to gain self-serving advantages over their "clients"

Testimony of Melissa Hackett
To the Government Oversight Committee
March 8, 2024
Public Hearing on the Child Protective Services Reunification - Information Brief

Senator Hickman, Representative Fay, and esteemed members of the Government Oversight Committee. My name is Melissa Hackett. I am a policy associate with the Maine Children's Alliance, which serves as the backbone organization for the Maine Child Welfare Action Network. I am here today to provide testimony on behalf of the Network.

First, we want to express our gratitude and respect for the thoughtful work that OPEGA staff put into gathering and sharing out the information provided in this report. In particular, we appreciate the consideration given to gathering perspectives not only from frontline child protective staff, but also to parents and caregivers and others working with children and families involved in reunification. This quantitative and qualitative approach mirrors the work of this committee in its overall work to review and consider challenges to child safety in our current child welfare system. This kind of reporting provides a more accurate picture of the nuanced and complex issues impacting families and caseworkers, that present challenges to ensuring desired outcomes for child safety and stability. This understanding is essential if we are to develop effective policy solutions to address challenges and improve effectiveness.

Most of what was evident in the key findings of the report was not necessarily new information to members of this committee or to those who have been involved in the review of child protective services in the last two years. Yet, it does serve to highlight, and provide more detail, to some of the challenges that have been raised previously. These include:

- Caseworker practice concerns, particularly related to the ability to conduct accurate assessments of parental substance use issues, and inadequate engagement with parents
- High workloads for caseworkers, and a lack of support staff and capacity for visitation and transportation
- Waitlists for parents to receive evaluations and access to needed supportive services, particularly for substance use and mental health issues, and
- Concerns with the legal system, including a lack of parent attorneys and case backlogs creating delays in cases

Strong and effective reunification policy and practice is critical to ensuring parents have the opportunity to address identified challenges to child safety, in order to work to bring their children safely home. It is also a complex process with many components of policy and practice that all need to be adequately resourced and working effectively for the best outcomes to be achieved. Given the important role of reunification as a process for ensuring child safety and permanency, we recommend this committee, and the Legislature more broadly, take the following actions:

- Support the provisions in the proposed supplemental budget related to increasing support staff (including legal aides) and coaching and training positions, to reduce child protective caseworker workloads and ensure they have the ongoing support and skill building to work most effectively with families
- Consider investments in the supplemental budget, on the table, and for consideration this session, that would increase access to critical supportive services statewide for parents experiencing challenges, including substance use, mental health, and domestic abuse and violence
- Consider ways to alleviate the strain on the legal system, especially to ensure there are more parent attorneys who have the time, expertise, and desire to help families navigate the reunification process

We recognize that none of these recommendations is simple to fully implement, and that it will take time to see the results of those changes. But, with intentionality and shared purpose, we can work together to strengthen child protective practice, support parents to address challenges, and give children the best chances to experience safety and stability with their families.

Thank you.

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Thank you.

Letter from Parents Involved with
the Center for Parent Leadership and Advocacy in Child Welfare,
an initiative of the Maine Child Welfare Action Network
to the Government Oversight Committee
Friday, March 8, 2024

Senator Hickman, Representative Fay, and esteemed members of the Government Oversight Committee, we respectfully submit this testimony to you from the Center for Parent Leadership and Advocacy in Child Welfare (CPLA). We are a group of parents who have successfully navigated the child welfare system and reunified our families. Our experiences with reunification range from 20 years ago to as recently as just one year ago. As we have shared previously with this committee, with the right support, many parents who are involved with child protection are able to make the changes needed to safely raise our own children. We appreciate the Committee's commitment to understanding more about the reunification process and the thorough review of the OPEGA report.

Caseworker practice concerns that were outlined in the report were consistent with many of our own experiences. The report noted that engagement with parents was inadequate in most of the cases reviewed, with 67% showing inadequate conversations, and 63% showing a lack of case planning with parents. 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. Parents need transparency and to know what is going to happen, and it's important to help them understand the process and their responsibilities. It is not kind or helpful to avoid telling parents the truth, and it is also less effective; everyone, including the parents, should understand exactly what needs to be done. We appreciated when our caseworkers were able to have hard conversations and share all the information they had with us, even when they expected we might have a strong reaction. Caseworkers need ongoing training and coaching to develop the skills to have difficult conversations with parents that effectively balance messages of support and accountability, and to clearly communicate the steps they need to take to safely reunify the family. Family Team Meetings are an important place where clear and productive conversations between parents, caseworkers, and others working with the family, should happen. We recommend strengthening training for caseworkers to facilitate – or have outside facilitation support – for these important sessions and their impact on reunification cases. Caseworkers also need ongoing training on how to ask good questions, and on best practices to follow in situations where there is domestic abuse and violence, so parents are able to fully- and safely- participate in their own case planning process.

We recognize that inadequate support for caseworkers has a negative impact on families, especially the lack of visitation and transportation support. The state should focus on reducing the amount of time caseworkers and case aids spend on these activities. One solution could be allowing contracted visit supervisors to transport parents when appropriate. Many parents who have children removed are living in poverty and have limited or no access to transportation. Parents can receive reimbursement for traveling to appointments and visits with their child, but the state reimbursement rate paid to parents is currently $.22 per mile while resource parents are reimbursed $.46 per mile. In comparison, resource families receive nearly twice the rate for transportation reimbursement, as well as monthly stipends, and allowances for clothes, diapers, and household items.

Far too often, what parents need is not accessible. In 70% of the cases reviewed in the report, standards were not being met for providing adequate services for reunification, largely due to waitlists for evaluations and treatment. Maine's Supreme Court recently overturned a termination of parental rights due to the state's failure to provide adequate supportive services for the family.[1] Access to mental health and recovery services are essential both during a crisis, and in order to maintain health over a lifetime. We recommend investing in more SUD and mental health recovery and treatment resources, including more peer support services, and 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. Peer support for parents can also ease the burden on caseworkers and increase parents' active participation in their case, by matching parents with those who have lived expertise of the system to provide support and education.[2]

Parent attorney shortages were also raised as a concern in the report. Parent attorneys were not available to answer parents' questions and to prepare them for any legal proceedings. We believe this is because there aren't enough of them to represent the number of parents. This had led to inadequately advising parents. We have heard from parents that they were encouraged to waive their right to a hearing on preliminary petition, jeopardy, and

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[1] https://drme.org/news/2024/press-release-2024-02-01

[2] New Hampshire's Department of Children Youth and Families has successfully integrated peer support into their child welfare system statewide https://granitepathwaysnh.org/strength-to-succeed/

terminations hearings. Attorneys are saying they are unlikely to win and takes more time to prepare and attend then they have available. Parents have reported not being aware of potential long-term impacts such as aggravating factors and the lifelong child protective record. Many people only met their lawyer for the first time at court for the preliminary petition; yet no one would hire a lawyer and expect to meet them for the first time in the courthouse. Maine also doesn't require any specialization in child welfare law, making our state a national exception, and contributing to a lack of expertise available to parents in legal representation in their cases.

Poverty is often mistaken for neglect, and it takes skill to know the difference. We would recommend training for child protective caseworkers to ensure families experiencing conditions of poverty are not caught unnecessarily in the child protection and reunification processes. 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. Many states have updated their definitions of neglect to clarify it as withholding a resource that parents already have, not one that is absent in their household.[3] We recommend updating Maine statute to clarify neglect as willful withholding, not a lack of financial resources.

We collectively had a variety of experiences that supported our successful reunification. Caseworkers and other providers who made the most positive impact regularly told us that they wanted us to succeed in bringing our children back home and were able to have difficult conversations. We received the right help, at the right time, from services and resources that were able to help us address the most pressing issues in our lives and helped us to build a pathway to stability for our families.

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. We thank the committee for their time and attention to reunification policy and practice, as a critical part of the process of working with families to address challenges and work to keep children safe and families together.

Thank you for your time and attention.

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[3] https://www.childtrends.org/blog/in-defining-maltreatment-nearly-half-of-states-do-not-specifically-exempt-families-financial-inability-to-provide

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PROBLEM: Shortage of Mental Health and Substance Use Providers

-DHHS cases are complicated and require specialized training

-DHHS cases require many hours that cannot be billed for under Mainecare causing financial burden on clinicians.

-Cannot bill for Family Team Meetings, DHHS collateral contact with caseworkers, GALS, other service providers, email updates, and court preparations and testimony, all of which are necessary for DHHS cases.

IMPACT:

-Providers across the state are unwilling to take on DHHS cases due excess burdens of cases.

-Providers that do take on DHHS case, lose money, spending time dealing with the case rather than in session.

-Inexperienced providers that can, and have, inadequately assessed and testified on cases.

-Providers that do not have the time to engage the system as needed to fully navigate DHHS cases take cases, but do not engage with DHHS.

SOLUTIONS:

-DHHS partnership/mentorship program where clinicians experienced in DHHS cases mentor new clinicians as they take on DHHS cases. This is a program funded by DHHS/ State of Maine.

-Clinicians are able to bill DHHS for non-Mainecare billable case related services including time in Family Team Meetings, preparation for court and testimony, and contact with caseworkers and GALS.

PROBLEM: Visitation

-Maine continues to attempt to write and fill servicing contracts with visitation agencies through a fee-for-service model. This model was inadequate and dangerously close to collapse prior to COVID, now is fully unsustainable.

-Agencies cannot fill contacts because staff do not want to work for unpredictable income.

-Agencies, with limited staffing, cannot provide increased time or amounts of visits for parents, which is vital to providing parental capacity and moving through reunification. Agencies cannot provide transportation for children, increasing the burden on DHHS case aide and foster families, who are already quitting fostering due to things like increasing pressure to provide transportation.

-Burden is placed back on case aides at DHHS offices, who must set aside admin work and take on the role of visits supervisors, even through they are not trained to provide such

supervision to families. This in turn further stained and burdened caseworkers with admin work and case aides additional stressors, causing greater turnover.

-Agencies are not paid once visits are not supervised fully, so they become unwilling to support check in visits, and community based visits.

SOLUTION:

-DHHS abandon its fee-for-service model its long used for contracting and paying visitation agency.

PROBLEM: Transportation

-DHHS relies on contract agencies with "volunteer" drivers that are only paid milage.

-This, especially in our current economic climate, is not a viable model, causing a chronic shortage of ride providers.

SOLUTION:

-DHHS staff contracts where drivers are paid.

-DHHS reimburse ride service apps such as UBER and LYFT to families that can access them.