Government Oversight Committee

and

Child Protective Services

For Discussion
Expected May 9, 2025

The 131st GOC's report, "Frontline Perspectives in Child Protection as Catalysts for Reform", may be found at the following link: getDocument.aspx

References to "OPEGA" indicate work performed by that office for the Committee.
The full OPEGA reports may be found at: OPEGA Reports | Maine State Legislature

2018: Marissa Kennedy and Kendall Chick

- Guidance and training for mandated reporters
- Timeliness of answering phone calls
- Assessment of risk and reassessment of risk
- Caseload
- Supervision
- Compliance with policy and procedures
- Compliance with contractual obligations
- Factors impacting decision-making
- Monitoring family participation in services
- Verification of information provided by a child's parents
- Identification of and response to immediate safety risk, but also regarding neglect, truancy, and emotional maltreatment
- Information sharing among schools, law enforcement, health care providers, counselors and therapists, community service providers, and child protective services

2019: Frontline Worker Perspectives

The Nature of the Job

- Off-hours demands
- Work/life balance
- Secondary trauma and health effects
- Worker safety
- Training & preparedness
- Additional work components such as documentation, MACWIS court preparation, travel, and administrative tasks

State of Workload for Intake and the Districts

- External factors related to increased workload

- Internal factors related to increased workload
  - Reports previously assigned to alternative response program
  - Automatic assessments after three inappropriate reports
  - Add-on reports
  - Structured Decision-Making (SDM) tools

- Changes in practice
  - Out-of-home safety planning no longer permitted
  - Team decision-making
  - Changes in the family plan/child plan
  - Recently implemented supervisory tool Kit
  - Supervisors in the field requirement

- Implementation of changes by the organization

Systemic Barriers

- Lack of placements for children
- Lack of services
- The role of the courts

Impacts on the Quality of Work

- Impact of high caseloads
- Ability to do the work
- Places for children in care (including “Hoteling”)
- Policy and practice changes
- Confidence in decision-making

Impacts on Frontline Workers

- Workers seeking outside employment
- Worker-described period of high turnover in 2018
- What could help
- What workers want legislators to know

2022: Oversight of Child Protective Services

- Child protective services as administered by DHHS/OCFS are subject to in-depth regulatory oversight by the federal government as well as advisory oversight from a network of state-level entities.

- Federal oversight is comprehensive and outcomes-oriented with financial penalties for nonconformity.

- State-level advisory oversight engages all three branches of government and both public and private sector stakeholders.

- The roles and responsibilities of the different entities address both macro-level oversight of the system and micro-level review and oversight of specific CPS cases, including cases of death and serious injury.

- The four State-Level panels and the Ombudsman have distinct missions, but there is a degree of overlap as well as nuanced differences in the scope of their activities.

- Information was routinely and regularly shared among the state-oversight entities and DHHS/OCFS. This routine information sharing among the panels was often the result of individual panel members and DHHS/OCFS staff being members of more than one oversight entity.

- Work was being done by several of the state oversight entities to formalize and institutionalize information sharing practices to ensure continuity in information sharing over time.

- The state-oversight entities, including the four panels and the Ombudsman, were structured in a manner, and were practicing in a manner, that generally conformed to published best practices for entities overseeing child protective services.

- Several of the entities had recently made or were in the process of implementing changes to improve alignment with published best practices.

- The oversight structure included many opportunities for DHHS/OCFS to obtain multiple points of view and draw on the expertise of several professional disciplines engaged in child protection across the private sector and multiple levels and branches of government.

2022: Child Protective Services Investigations

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

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

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

- There was wide agreement that the training offered to new caseworkers had been insufficient to prepare them for investigations work. Over the past two years, OCFS had collaborated with the Cutler Institute of the Muskie School of Public Service to restructure the training, and a new course of training took effect in January 2022.

- Supervisors had significant involvement in the training of new caseworkers, and they supported a relatively inexperienced staff of caseworkers in the midst of relatively high turnover.

- Supervisors were key to the investigations process. Supervisors assigned investigations to caseworkers and monitored the whereabouts of caseworkers for safety purposes. They were involved in critical safety decisions at various points, and they provided support, mentoring, and oversight of investigations caseworkers throughout the investigations process.

- While infrequent, OPEGA observed several practice issues in the conduct of investigations that did not appear to be a function of workload challenges, but rather departures from expected practice.

- OCFS's Quality Assurance Program performed ongoing case reviews. The reviews were conducted based on the federal Child and Family Services Review (CFSR) protocol. OCFS used case reviews both during the federal CFSR period and on an ongoing basis as a tool for understanding and monitoring the quality of investigations of reported and alleged child abuse or neglect. The standards and expectations of the case review system were very high and meeting them required exceptionally thorough and comprehensive work to evaluate risks.

- The QA case review results indicated a lack of overall thoroughness and completeness in investigations. However, we observed that caseworkers did generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns, and the most critical and relevant individuals, with respect to the reported allegations. We attributed the lack of thorough and complete investigations to issues related to workload.

- OCFS staff reported that their workloads were unreasonable and that they did not have adequate time to understand risks to the child or the needs of the family.

- Caseworkers reported that families were usually willing to engage with CPS during investigations, though they were sometimes unwilling to participate in services offered.

- The sharing of medical and treatment information with OCFS appeared to be a barrier to completing thorough and timely investigations.

- Parents and children may experience a variety of reactions during a CPS investigation, including fear and confusion. Organizations that advocated for parents indicated that support for parents to assist in understanding and navigating a CPS investigation would be beneficial.

- Access, availability, and engagement in services for families were concerns that emerged through interviews with OCFS management and other stakeholders, as well as in our surveys of caseworkers and supervisors, and in the results of the federal oversight of OCFS.

OPEGA Recommendations Re: Child Protective Services Investigations (2022)

1. Take steps to address the workload issue to ensure that caseworkers and supervisors have the time necessary to conduct thorough investigations and more effectively assess the safety risks to children and the needs of families;

2. Evaluate the nature and extent of after-hours work requirements and expectations placed on caseworkers, and the risks to caseworker effectiveness and burnout; design and implement policy and program changes to address identified issues and risks; and consider restructuring the delivery of Children's Emergency Services to decreases or even eliminate required overnight shifts for caseworkers and supervisors; and

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

OPEGA Recommendations Re: Child Protective Services Investigations (2022) (Continued)

For OCFS and the GOC (as appropriate) concerning additional areas noted, but not fully evaluated by OPEGA:

- Training of new caseworkers and their transition into the field.

- Caseworker access to medical records and treatment information. Reluctance of parents' substance use and mental health providers to speak with caseworkers or share medical records could be a barrier to investigations.

- Services for children and families in the CPS system. Mental health, substance use disorder treatment, in-home behavioral health services, and case management services appeared to be inadequate in comparison to their need.

- Prevention of child abuse and neglect. Child welfare practitioners described three levels of prevention: (1) primary prevention, which is directed to the whole population, (2) secondary prevention, which is targeted to families experiencing risk factors, and (3) tertiary prevention, for families in which child abuse or neglect has already occurred. OCFS is primarily engaged at the level of tertiary prevention. Federal and state child welfare experts recommend that states invest in and coordinate efforts at all three levels of prevention. According to the U.S. Centers for Disease Control, the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (for example, public health, education, social services, and the judicial system).

2023: Hailey Goding

OPEGA did not conclude that any OCFS safety decisions regarding Hailey Goding were unsound within the framework of the records we reviewed, interviews we conducted, agency policy and practice, and legal authority. **Nevertheless:**

Potential Opportunities for Improvement

- Establish a Central Resource for Substance-related Questions

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

- Improve Service Availability and Enhance OCFS's Ability to Ensure Recommended Services Are Provided

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

2023: Maddox Williams

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

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

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

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

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

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

Resource Issue: Staff Vacancies May Impact Casework

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

- Continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated;
- Examine the fundamental structure of caseworker and supervisor jobs, and assess whether any restructuring would promote staff retention;
- Explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity (The Department notes that the work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.);
- Examine the Department's current requirement that caseworkers be licensed social workers;
- Work with the State Board of Social Worker Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed; and
- Report back to the Legislature on the status of these efforts and the current number of vacancies.

Potential Opportunities for Improvement:

- Continue OCFS research into identifying risk factors related to targeted children; and
- Increase availability of court-ordered diagnostic evaluation (CODE) resources

Public Policy Consideration:

- Persistent disconnect between public expectations for the CPS System and the current legal and policy framework and capabilities of OCFS.

2023: Jaden Harding

Two unsound safety decisions in which we concluded that the facts of the case—as known at the time—warranted additional Departmental intervention to ensure the safety of the children in the home prior to Jaden's birth;

Unsound Safety Decision 1: No Additional Interventions or Safety Planning to Ensure the Safety of Children (Prior to Jaden's Birth) from the Man Living in Ms. Hartley's (Jaden's Mother's) Home

Unsound Safety Decision 2: No Additional Interventions or Safety Planning when Ms. Hartley's Out-of-State Relatives Leave Her Home

Two overarching practice issues that spanned multiple investigations and ultimately prevented the Department from making other necessary and appropriate safety decisions and taking related actions to ensure the safety of the children in the home prior to Jaden's birth;

Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations Regarding the Risks Posed by Ms. Hartley's Relative (And Alleged Abuser of Her Children)

Recommendation: OCFS should develop a process and standard for identifying which families' CPS histories should be subject to a more comprehensive review. Additionally, OCFS should ensure that any staff assigned this work have the time and resources needed to conduct them.

Overarching Practice Issue 2: No Comprehensive Review of the Family's Prior CPS Involvement That Would Have Shown a Pattern of Ms. Hartley Allowing Unsafe Individuals Around Her Children

Eight Practice Issues that occurred during specific investigations that were both prior to and following the announcement of Ms. Hartley's pregnancy with Jaden;

Practice Issue 1: Extremely Overdue Investigation with Periods of No Investigative Activity

> Recommendation: Although we did not review data that would enable us to quantify the impact of 2018 policy changes on workloads, we would still recommend that the Department take a thoughtful, measured approach to future policy changes with a focus on potential workload impacts to avoid similar risks—especially as the Department experiences difficulties in the recruitment and retention of caseworkers

Practice Issue 2: Inadequate Efforts to Locate the Family

Recommendation: As the Department continues to update its investigations policy and any related documents, we recommend that the "Activities to Locate" tool continue to be used and caseworkers continue to be trained in its application.

Practice Issue 3: Incorrect Identification of Alleged Abuser by Intake

Recommendation: While we do not know the extent to which intake screening errors such as this occur, we do recommend that OCFS consider implementing a mechanism into their existing process to denote instances in which intake—and not the referent—has identified a critical case member. In denoting these individuals, caseworkers may be more cognizant of the need to verify the accuracy of the identities provided solely by intake.

Practice Issue 4: Reported Allegations and Safety Threats Unexplored by Caseworkers

Recommendation: OCFS should clarify and communicate its expectations for what caseworkers should do when an "FYI report" that would otherwise be screened out is added to an open investigation. For other screened-in reports containing multiple allegations, supervisors should ensure that caseworkers, at a minimum, discuss all allegations with the parents/caregivers.

Practice Issue 5: Inconsistent and Sometimes False Information Unexplored by Caseworker

Recommendation: OCFS should make efforts to communicate and reinforce its expectation that caseworkers identify and challenge inconsistencies in the information provided to them by families.

Practice Issue 6: Status of Bangor Police Department Investigation Unexplored by Caseworker

Recommendation: Although we are unsure of the extent to which a scenario like this occurs, we believe that following up on the results and status of earlier criminal investigations can provide valuable information to caseworkers. As such, OCFS should consider developing guidance for closing summaries specifying how caseworkers are to document that there are ongoing criminal investigations at the time the investigation closes, and, also, establish expectations for what subsequent caseworkers are to do when they review that documentation in the future.

Practice Issue 7: Installation of Child Safety Locks Not Verified by Caseworker

Recommendation: OCFS should consider the development of a process to ensure that any tasks identified as next steps to complete the investigation as part of the preliminary safety decision are revisited by the caseworker and supervisor prior to the closure of the investigation. Any steps that are determined to still be relevant, but not yet performed should be performed before the investigation is closed.

Practice Issue 8: Mr. Harding's (Jaden's Father) Safety Never Assessed

Recommendation: OCFS should consider revising its investigations process and related checklists to require caseworkers to confirm a family's living arrangements and all household members have been identified when nearing the end of an investigation to ensure that the safety of all individuals residing in the home with access to the family's children is assessed before the investigation is closed. This is particularly relevant as it appears the living arrangements and household compositions of the families that the Department works with can change often and sporadically.

Systems Issue 1: Multiple Profiles for the Same Individual

Recommendation: Even with the improvements offered through the use of Katahdin, OCFS should establish appropriate search guidance to be used by caseworkers to mitigate the risks associated with multiple profiles. This guidance could include more thorough search criteria, such as adding a date of birth or social security number.

The Department should also review its current guidance related to screening people into the Department's various systems to ensure that guidance outlines a process that appropriately addresses the risks associated with entering multiple profiles for a single individual

Three Potential Opportunities For Improvement:

- Identify and Provide Appropriate Levels of Services for Families
- Improve Information Sharing Between OCFS, Law Enforcement, and the Courts
- Improve Feedback and Management Expectations

2024: Sylus Melvin

With regard to the casework performed from the time of Sylus' birth on July 28, 2021, to his death on August 29, 2021, OPEGA concluded that it was sound within the parameters we have applied in our four case file reviews.

OPEGA also reviewed Department interactions with the family that preceded Sylus' birth. Overall, OPEGA identified one instance in which we concluded that an unsound safety decision was made regarding the safety of Sylus' older full sibling.

Additionally, OPEGA identified an overarching practice issue which continued throughout the family's involvement with the Department, as well as a practice issue that was specific to one investigation. Three potential opportunities for improvement, and a practice observation, are also discussed in OPEGA's conclusions.

Unsound Safety Decision: Placing a Child (Sylus' Older Full Sibling) in a Home Without Assessing the Safety of that Home and Caregivers.

Overarching Practice Issue: Out-of-Home Child (Sylus' Older Half Sibling) Not Located.

Recommendation: The identified issue occurred in 2018, and, since that time, the Department has made policy changes and implemented a new child welfare information system, Katahdin—both of which appear to have addressed this issue. Current OCFS policy outlines that all critical case members are to be included in all reports, investigations, and cases, and added to the relationships screen in Katahdin. Within Katahdin, there are additional instructions explaining how caseworkers are to enter this information.

Specific Practice Issue: Safety Plan was not Documented.

Recommendation: While safety planning practice at OCFS has changed significantly from 2018, we understand that safety plans remain an area of uncertainty for some caseworkers today. OCFS' Safety Planning Workgroup should continue to clarify what constitutes a safety plan and encourage standardized practice.

Potential Opportunity for Improvement: Involve Caseworkers and Supervisors in the Development of the Department's Public Memorandum.

As this may be the only public accounting of what occurred in the case (other than related prosecution), it is vitally important that the information in those memos is accurate. In subsequent discussions with the Department regarding this potential opportunity for improvement, the Department reported that the inclusion of caseworkers and supervisors in the development or review of the public memo is now standard practice.

Potential Opportunity for Improvement: Obtain Relevant Call Logs When a Child Fatality Occurs.

As this information could be useful to the Department in the future for assessing whether and how communication breakdowns occurred, the inability to obtain these records long after the events allegedly took place points to another potential opportunity for improvement: as a matter of practice, the collection of all relevant call logs (for both landlines and cell phones, including text messages) for involved caseworkers and supervisors when there is both an open case (investigation, service, or permanency) and a child fatality.

Potential Opportunity for Improvement: Information Sharing Between Law Enforcement and CPS.

We believe that had the officer known of the active CPS investigation and informed the Department the caseworker would have had the opportunity to follow up on this inconsistency and explore Ms. Newbert's mother's concerns with her—possibly leading to better understanding the current conditions in the home. As this is not the first time we have observed a scenario in which law enforcement had information that would not otherwise be reported to CPS (see Information Brief: Maine's Child Protection System – A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home), but appeared relevant to an open investigation, we believe this illustrates a potential opportunity for improvement: better coordination between law enforcement and CPS in terms of information sharing when there is an active CPS investigation underway.

<u>Practice Consideration</u>: Apparent Incongruity Between the Terms of the PR&R and the Department's Discussions with Ms. Newbert Regarding Visitation.

This record reveals the apparent incongruity of a victim of domestic violence left to decide for themselves whether to insist on third-party visitation services of a child by their domestic abuser or to supervise the visits themself. In discussing this observation with the Department and the OAG, OPEGA was advised that challenges in obtaining third-party visitation could be encountered, including availability and cost. Also, the language of a PR&R like in the case at hand is the product of negotiation among parties and overseen and approved by the presiding judge. Given the complexities, OPEGA is not able to offer a formal recommendation, but wishes to acknowledge this apparent incongruity for potential future consideration.

2024: Reunification

OPEGA identified **Four Cross-Cutting Challenges** that are prevalent in reunification casework.

Caseworker Practices Concerns

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

High Workloads Impacting Safety, Permanency, and Well-Being Outcomes

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

Waitlists for Evaluations and Treatment

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

Timeliness of Termination of Parental Filings and Other Legal Concerns

Case reviews identified challenges with timeliness of filing termination of parental rights, leading to delays in permanency for children. Several factors may contribute to delays, including caseworker workload and the backlog of cases in the judicial system delaying hearings necessary for timely reunification.

2024: Direct Engagement by the GOC: “Frontline Perspectives”

Report of the Government Oversight Committee

131st Maine State Legislature

Second Regular Session

Frontline Perspectives in Child Protection

as Catalysts for Reform

February 2024

https://legislature.maine.gov/doc/11463

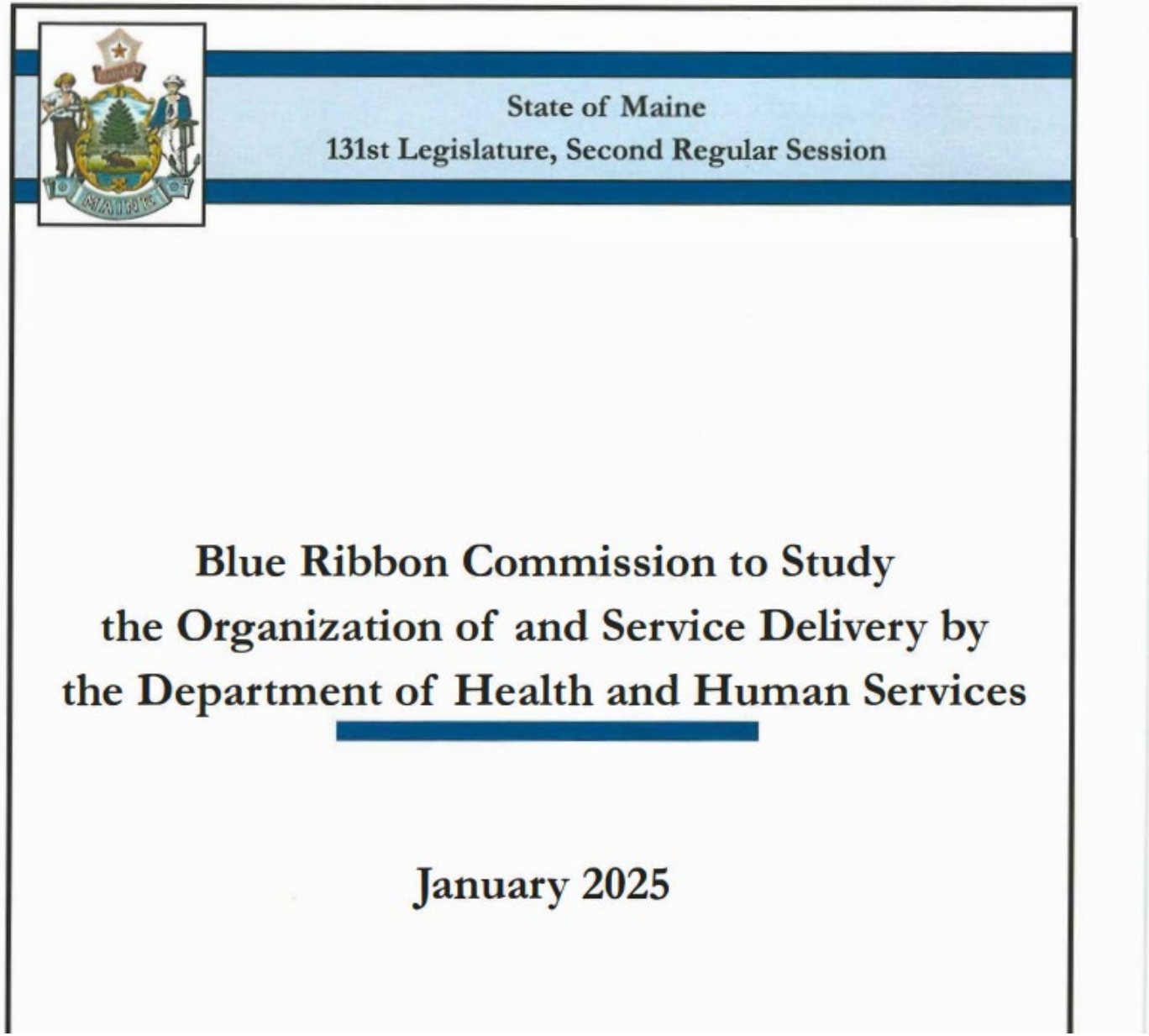
(Hard Copy in Committee Member Binders)

Federal Audit:

Maine Did Not Comply With Screening, Assessment, and Investigation Requirements for Responding to Reports of Child Abuse and Neglect | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

(Hard Copy in Member Binders)

January 2025: Blue Ribbon Commission



https://legislature.maine.gov/doc/11463

(Hard Copy in Member Binders)

January 2025, Blue Ribbon Commission Report, at p. iv:

Child Welfare and Child Protective Services

1. The Legislature should support the 30 recommendations of the Government Oversight Committee's investigation of the perspective of persons involved on the front-line of Maine's child protection system.

2. The Department should determine how better to communicate with persons who report suspected child abuse or neglect so that the reporter understands the process that will occur based on the report.

3. The Department should implement security standards for licensed child care facilities through rulemaking taking into consideration the costs provider will incur from new security standards.

End