STATE OF MAINE

Department of Human Services

ANNUAL PROGRESS REVIEW

June 2003

Bureau of Child & Family Services

STATE PLAN

ANNUAL PROGRESS REVIEW AND STATE PLAN

State of Maine
Department of Human Services
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ADMINISTRATION OF THE PLAN

The Bureau of Child and Family Services, Department of Human Services, through its Commissioner, is charged with responsibility for administering Title IV-B of the Social Security Act and performing its obligations under the Child and Family Services Plan.

The Department of Human Services directs a system of programs including family independence, public health, social and medical services; and it provides services established by State and federal laws to protect and preserve the health and welfare of Maine citizens. There are six bureaus within the Department that cover a range of human needs, from prevention to highly specialized services.

The Bureau of Child and Family Services, within the Department of Human Services, is responsible for ensuring the safety, permanency, and well-being of children and families throughout the State. The Bureau is authorized to protect children from abuse and neglect, to take reasonable steps to prevent removal of children from their home by providing family support services, to seek court intervention when reasonable efforts to prevent removing children from their home are unsuccessful, to act expeditiously to develop a permanent plan for all children it serves, and to help prepare children and youth in State custody for productive adulthood by promoting their life skills and abilities. The Bureau fulfills this mandate through its Child Welfare Services, which include: Child Protective Services; Children's Services; Adoption Services; Independent Living Services; and Foster Care recruitment, training and licensing. The Bureau enhances these efforts by collaborating with other State agencies and with community-based programs. To ensure quality services and care for the children and families served, the Bureau provides ongoing trainings to staff, foster parents and adopting parents. In addition, the Bureau constantly explores new initiatives to improve and enhance current practice and procedure.

Daycare and residential programs for children in the custody of the Department of Human Services are licensed by the Community Services Center. The Bureau of Child and Family Services licenses all foster homes in the State. The mission of licensing is to promote quality out-of-home care for Maine children through equitable licensing practice, through effective resource and policy development, and through advocacy for providers and children.

The Bureau participates in many diverse community partnerships, both to contribute to its State Plan and to offer regular feedback about initiatives of mutual effort or interest. These groups and individuals provide their insight through regular meetings and occasional focus groups and surveys tied to the State Plan or specific policy initiatives.

- Child Welfare Advisory Committee
- Adoptive and Foster Families of Maine
- Child Protective Advisory Committee of the Courts (Court Improvement Project)

- Child Abuse Action Network
- Wabenaki Child Welfare Coalition
- Residential Treatment Center Group
- School-Based Mental Health Committee
- Cross-Disciplinary Training Teams
- Multidisciplinary Child Death and Serious Injury Review Team
- Foster Family-Based Treatment Association
- The Adoption Forum
- Treatment Network Team
- Youth Leadership Advisory Team
- Foster and Adoptive Parent Advisory Committee

SUMMARY ANNUAL PROGRESS AND SERVICES REPORT

SUMMARY ANNUAL PROGRESS AND SERVICES REPORT

Maine's Bureau of Child and Family Services (BCFS) has made significant progress toward the goals established in the FY2000-2004 State Plan. Since the pilot Child and Family Services Review in 1999, BCFS has developed goals and measures to improve practice and strengthen its response to the needs of children and families.

Prior to 2002, the Plan Updates submitted by the Bureau outlined a wide-ranging work agenda driven largely by the Program Improvement Plan that the Bureau developed in response to the 1999 pilot federal Child and Family Services Review. During FFY 2002, two major developments helped the Bureau more clearly define and articulate its goals to improve child welfare practice.

First, the Bureau's work was thoroughly examined by the Joint Standing Committee on Health and Human Services (HHS) and by the Joint Standing Committee on Judiciary of the Maine Legislature. Both committees generated a series of particularly significant findings and the Bureau agreed to several specific goals and also committed to report other additional information to the Legislature regularly.

Second, the Annie E. Casey Foundation Strategic Consulting Group worked intensively with the Bureau on a *pro bono* basis to develop a beliefs-based performance management system to better support its work. Their first step was to help BCFS staff clarify their beliefs about what their work should be and what it should accomplish. The result of that effort was a set of five general beliefs:

Child Safety is Paramount

- We have the responsibility to intervene to protect children.
- Effectively intervening to keep kids safe depends on a thorough and timely assessment.

Parents Have the Right and Responsibility to Raise Their Own Children

- Parents have the right and responsibility to correct issues of abuse and neglect.
- Parents have the right and responsibility to develop a plan for the safety and care of their children.
- BCFS has the responsibility to support family in the care and protection of their children.

Children Deserve to Live in a Safe and Nurturing Family

- Children have the right to be placed in the least restrictive setting.
- Placements need to support family and community connections.
- Siblings belong together.

All Children Deserve a Permanent Family

- Foster care is a temporary arrangement for children.
- Permanency for children begins from day one.
- Timeliness of case decisions will be made consistent with the urgency of the child's needs for permanency.

Principles of Public Service Will Guide Us in Our Work

- Our work with families is objective, unbiased, and based on good practice.
- Everyone deserves to be treated with courtesy and respect.
- Our staff is our most important asset.
- We have the responsibility to use our professional knowledge and skills to promote changes.

Beyond the beliefs clarification work, the consultants focused on four inter-related operational elements to help the Bureau develop a baseline related to overall practice.

1. Analysis of daily practice in selected Bureau offices, pinpointing areas where that practice can be improved.
2. A fiscal analysis of the Bureau's budget which provides a tool for future fiscal tracking.
3. A strategic planning component incorporates all Bureau mandates from the state legislature and federal government to provide a checklist to ensure that the Bureau is in full compliance.
4. Establishment of a system for retrieving more meaningful and timely management information from the Maine Automated Child Welfare Information System (MACWIS), the SACWIS system that BCFS uses for its work. This analysis was done by the Chapin Hall Center for Children and will help produce data to improve Bureau decision-making and accountability.

Since submission of the 2002 Annual Progress Review of the State Plan, the Bureau has continued its work with the Legislature and the Annie E. Casey Foundation's Casey Strategic Consulting Group to develop a Strategic Plan with goals based on the values and beliefs which are the foundation of the Bureau's work. The goals are:

Goal 1: Improve the quality and timeliness of receiving and responding to reports of child abuse and neglect.

Goal 2: Broaden family involvement from report to the best outcome for child and family.

Goal 3: Improve community connections and collaboration; develop and realign resources as needed to create better outcomes for children and their families.

Goal 4: Improve the experience of children in care while achieving better and faster permanency outcomes.

Goal 5: Assert the leadership role of child welfare professionals by providing supports that enhance the professionalism, skills and cultural competency that result in positive outcomes for children and families.

Goal 6: The Bureau will pursue an implementation strategy for all of the above goals via a comprehensive statewide effort in each district, while simultaneously identifying lead districts for more intensive and accelerated efforts.

The summary progress reports within the State Plan Updates have continued to be presented in much the same format as set forth in the original FY2000-2004 State Plan. However, because the Bureau is now pursuing an implementation strategy for the goals set for the in the Strategic Plan, it is imperative that progress be measured in terms of those goals. Earlier this year, the Bureau completed its Statewide Assessment in preparation for the July 2003 Child and Family Services Review. Those findings were very much in line with the goals identified in the Strategic Plan. Any Program Improvement Plan that results from the July CFSR will be tied to those goals and the Bureau's current work on implementation of the Strategic Plan. Therefore, the format of the 2003 progress report reflects those changes to the planning document submitted for 2000-2004. Following each Beliefs Statement will be the Strategic Goal related to that value. The outcomes from the FY2002-2004 State Plan will be listed under the appropriate Strategic Goal in order to show continuity. The Action Steps (measures) for each Strategic Goal will be followed by the progress to date and the upcoming activities for 2003-2004.

CHILD SAFETY IS PARAMOUNT

GOAL 1. IMPROVE THE QUALITY AND TIMELINESS OF RECEIVING AND RESPONDING TO REPORTS OF CHILD ABUSE AND NEGLECT

Goal 1 includes three outcomes presented in the 2000-2004 Plan:

1. *BSFS Staff implement and manage an intake process that is standardized, efficient and responsive.*
2. *District BCFS staff make an initial assessment on all reports to determine whether the case is inappropriate for assignment, referred to a community intervention program or assigned to Bureau staff.*
3. *BCFS staff assess and make appropriate intervention decisions on all reports within established time frames.*

Action Steps:

- **All child abuse reports will be appropriately triaged for follow-up**
- **Complete safety and child and family assessments within appropriate time frames**
- **Improve Child Protective Services ability to identify repeat maltreatment**
- **Decrease the Use of Voice Mail at Intake**

Progress to Date:

- An internal team was established to review Community Intervention Program funding and practice. (1999-2000)
- Practice expectations and protocols were clarified with Community Intervention Programs (including, e.g., the types of cases referred by BCFS, and how refusals of service are handled). (1999-2000)
- The new Safety Assessment policy, protocol, and training were completed. (1999-2000)
- MACWIS reports provide baseline data on the abuse/neglect reports received through centralized Intake. This information is supplemented by a database operated for the time being within the Intake Unit. (1999-2000)
- The policy and standardized criteria for receiving abuse/neglect reports is complete. (1999-2000)
- QA staff reviewed all abuse/neglect reports assigned to Community Intervention Programs to examine how the cases were handled. (1999-2001)
- Close consultation between Bureau staff and the Community Intervention Programs on service expectations, practice protocols, ASFA requirements, and the

respective roles of the Programs and District staff have clarified roles and responsibilities and resulted in smoother interaction. (1999-2001)

- The Intake Unit/ACES was moved to the Division of District Operations to provide opportunity for improved coordination and more clearly defined roles and responsibilities for District offices, Intake and the Community Intervention Programs. (1999-2001)
- Follow-up focus groups were conducted in all districts to identify additional training needs around the new Safety Assessment tool. (2000-2001)
- QA staff reviewed abuse/neglect reports assigned to Community Intervention Programs to help assure that reports sent to those agencies were appropriate in level of severity. (2000-2001)
- Performance measures for Community Intervention Programs were revised in collaboration with the agencies. The new measures were incorporated in agency contracts effective January 2001. (2000-2001)
- Quarterly Statistical Reports for Community Intervention Programs were revised to provide more complete information on program impact. The new reports were used effective January 2001. (2000-2001)
- Staff developed a new Child and Family Assessment form and protocol, to build on the new Risk Assessment tool. (2000-2001)
- The new Safety Assessment was incorporated into MACWIS. Follow-up reviews were completed in all districts to identify additional training needs around the new Safety Assessment tool. (2000-2001)
- Data are periodically generated from MACWIS on whether Safety Assessments are completed and documented within stipulated time frames. Data indicates that there is need for more improvement in this area. (2000-2001)
- Work continued on establishing baseline data for future measurement and standards for improvement. (2000-2001)
- Intake staff were trained on the new Safety Assessment tool. (2000-2001)
- Performance measures for Community Intervention Programs were re-examined and data collection requirements simplified. (2001-2002)
- BCFS invited Community Intervention Programs' staff to join Bureau staff for training on issues relating to their work. (2001-2002)
- Finalized changes in the Risk (now Child and Family) Assessment, built it into MACWIS, provided needed training on the new tool to staff, and implemented its use. (2001-2002)
- BCFS took the following steps to increase consistency, responsiveness and efficiency of the Intake Unit's work: conducted a time study to assess staff efficiency and to help the Unit in developing schedules that will meet need and performance expectations, added a staff line, installed individual work stations, and systematized job classifications to improve performance and enhance ability of staff to cover cases for each other. (2001-2002)
- Gathered data on the number of mandated reporters who are unable to reach Intake workers in person. (2001-2002)
- QA continued to review abuse/neglect reports referred to Community Intervention Programs (including whether referrals are appropriate, whether agencies return

inappropriate referrals to the Bureau, and how Community Intervention Programs work with referrals) (2002-2003)

- The Community Intervention Programs' data collection and reporting efforts were reviewed and new outcome measures were added to the contracts. (2002-2003)
- Training was help for Community Intervention Program staff on Child and Family Assessment. The assessment tool was modified for CIP use and further training will occur. (2002-2003)
- Piloted the automation of the interface between the Community Intervention Programs and the Bureau in two district offices, to improve communication and to expedite service delivery to families. This interface will standardize how the Programs receive reports and interact with BCFS Intake.
- Functionality added to MACWIS to match practice related to the safety assessment process.
- Increased the percentage of Safety Assessments completed and documented within accepted time frames. Regularly use MACWIS data to monitor progress on this. (2002-2003)
- Continued District based implementation training, consultation and technical assistance in the Department's Safety Assessment and Child and Family Assessment. (2002-2003)
- Provided staff training in motivational interviewing. By engaging clients in the assessment process, more focused and effective case planning can take place.
- Continued QA review of cases referred to Community Intervention Programs to assure appropriate outcomes. (2002-2003)
- Provided ongoing support to staff to assure that case plans and planned service interventions directly address risk factors that led to abuse/neglect. (2002-2003)
- Completed review of policy and all policy is now posted on the BCFS web site. (2002-2003)
- Changes in practice and scheduling has resulted in a significant reduction in the number of calls going to voice mail at Intake (2002-2003)

Activities for 2003-2004

- The Intake Program will, by the end of the summer, have upgraded its telephone system to a Call Center, thereby enhancing its ability to avoid the use of voice mail (2002-2003)
- Assure that all repeat reports of abuse/neglect are documented as official reports and that decisions on cases with two or more reports are critically reviewed. This work includes: clarifying definitions of "new report," "substantiated report," and "repeat substantiation;" enhancing MACWIS' ability to flag repeat reports and determine how many substantiated reports are repeat substantiations; training staff on how repeat reports should be documented/recorded; developing policy and practice expectations to assure that all current or new cases with a history of two or more reports are reviewed to see that they are handled appropriately; and developing a process for implementing the policy (e.g., including training for supervisors, creating a checklist that supervisors can use to review such cases).
- Establish policy, practice expectations and a process for critical QA and supervisory review of intake reports and decisions to assure quality and consistency.

- Discuss risk and safety issues, and the impact of repeat maltreatment on children with the courts and Assistant Attorneys General. This includes: clarifying practice guidelines and standards for handling neglect and maltreatment, and training BCFS and court workers on those standards; working with the Court Improvement Project to establish minimum standards for appropriate court involvement in neglect cases; working with the Child Welfare Symposium planning committee to incorporate training about the impact of repeat maltreatment, especially physical neglect and emotional maltreatment; working with Assistant Attorneys General on how Bureau staff can build stronger cases in these areas; and re-evaluating the appropriate threshold for petitioning for a court order to protect children.
- Continue to work with staff to improve the quality of assessments and individualized case plans, tailoring child welfare process and services to meet the needs of the child and family.
- Develop mechanisms to ensure consistent implementation of policy and practice by DHS and contract agency staff.
- Continue to meet monthly with the Community Intervention Program statewide coalition to address procedure, policy and practice issues.
- Continue to monitor reports sent to the Community Intervention Programs to assure compliance with policies.
- Improve the Bureau's ability to identify repeat allegations of child abuse and neglect, flagging them for close review with the goal of reducing the extent of repeat maltreatment.
- Develop a plan for incorporating the Intake database into the main MACWIS system.

PARENTS HAVE THE RIGHT AND RESPONSIBILITY TO RAISE THEIR OWN CHILDREN

GOAL 2: BROADEN FAMILY INVOLVEMENT FROM REPORT TO THE BEST OUTCOME FOR CHILD AND FAMILY

Action Steps:

- **Safely and responsibly increase reunifications**
- **Increase in safe and responsible relative placements**
- **Establish baseline and performance target for increasing siblings placed together**
- **Establish baseline and performance target for increasing sibling contact**
- **Increase the documented cases in which birth families participated in case planning and decision-making, measured by Quality Assurance**

Progress to Date:

- The Bureau's Quality Assurance staff completed an annual review of all child-placing agencies. Annual reviews have been expanded to include a case review component which will provide opportunity for discussion of specific case plans and activities by staff from the Department, the child placing agencies, foster parents, and others involved in case/treatment planning. (1999-2001)
- Policy and protocol for relative placement and kinship care were developed. (2000-2001)
- MACWIS capacity was enhanced to better identify kinship placements. (2000-2001)
- A review of cases was completed in one district which experiences a higher than average rate of relative placements to learn about practices that can be shared with other offices. (2002-2003)
- Kinship support groups have been developed statewide. (2001-2003)
- Kinship care was a primary focus of the Statewide Adoption Conference.
- Two district offices have designated staff to specifically focus enhancing efforts to support kinship care. (2002-2003)
- Requirements related to grandparent visitation and placements were added to policy.
- Efforts to locate relatives to care for children in custody are documented on every case. (2002-2003 and on-going)
- A survey was completed to gather baseline data on sibling placements and contacts. District office staff are re-visiting those cases where siblings are not placed together or do not have contact with one another with determine what changes might be appropriate and in the best interest of the children. (2002-2003)

- There have been several successful initiatives to increase sibling contact and these are on-going.
- A Youth Summit focused on siblings and the importance of sibling contact (2002-2003)
- Training provided regarding kinship care (2002-2003)
- A Family Team Meeting initiative which includes training, coaching on preparation of potential team members and coaching/follow-upon facilitation of the Family Team Meeting. Training is underway in two district offices, as a part of the Bureau's Reform Initiative. Training will be held in all offices starting in the fall of 2003.
- QA continued to monitor cases for documentation of family involvement in case planning (2002-2003)
- Policy regarding relative and kinship care is available to the public, as is all policy, on the Bureau's web site (2002-2003)
- Regional forums were held to learn more about guardianship and to identify areas for further exploration. (2002-2003)
- BCFS has actively supported participation of "A Camp tp Belong" to be held in Maine in the summer of 2004.
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Activities for 2003-2004

- Continue to emphasize that intervention and services must specifically address risk factors leading to abuse/neglect while moving to a more strengths based approach to practice. Take steps to assure that case plans are developed with the family and that their issues directly address identified risk factors.
- Continue to strengthen efforts to search for relatives who might provide kinship care. This includes greater supervisor efforts to assure that caseworkers search for relatives beginning in the assessment phase and document that search in the case record, and supporting and expanding current projects related to kinship care.
- Continue to explore ways to effectively provide guardianship as a permanency option.
- Expand training curricula for Department staff regarding issues unique to kinship care, so that they can more effectively identify potential resources and increase awareness of the special benefits to children who can live with family members.
- Take steps to expand services for families after reunification
- Provide ongoing support to staff to move to a more inclusive practice and ensure that staff are able to work from a strengths base while still holding safety as paramount.

CHILDREN DESERVE TO LIVE IN A SAFE AND NURTURING FAMILY

GOAL 3: IMPROVE COMMUNITY CONNECTIONS AND COLLABORATION: DEVELOP AND REALIGN RESOURCES AS NEEDED TO CREATE BETTER OUTCOMES FOR CHILDREN AND THEIR FAMILIES.

Goal 3 includes the following outcomes form the 2002-2004 State Plan:

1. Placement Resources Meet the Needs of Children
2. BCFS Staff Assure that Children in the Care and Custody of the Department Have Their Physical, Developmental, Emotional and Behavioral Health Needs and Their Educational Needs Met.

Action Steps:

- **Complete a statewide, district by district needs assessment for services followed by realignment of services and resources**
- **Increase the number of family foster homes in the communities/school districts children come from.**
- **Increase the number of children served in their home communities/.school districts**
- **Broaden representation on statewide Child Welfare Advisory Committee**
- **Adolescents leaving the care of the Department by plan, will have adequate life skills and/or critical community connections**
- **Number of children placed with extended family as preferred in ICWA will be increased.**

Progress to Date:

- Concerted efforts have developed in-state resources allowing children to return from residential facilities outside of Maine. In particular, the Department worked closely with several agencies to increase supervised living services for teens, homes for children needing integrated mental health and substance abuse treatment, sex offender treatment services, homes for children with developmental disabilities, bridge homes, staff secure treatment homes, and residential treatment. (1999-2000)
- An independent living needs assessment policy was developed for children in treatment foster care, group care, and residential treatment. The Independent Living program continued efforts to bring more consistency to life skills assessment and instructional practice statewide, including training for staff from all treatment foster care and group care contractors in use of an assessment/

instructional tool. The Department also collaborated with the Child Welfare Training Institute to develop training for care providers and adolescent casework staff on how to use "best practices" in life skills assessment and instruction. (1999-2001)

- Reviewed Life Skills training provided to youth in out-of-home care, and implemented standards for that work. (2000-2001)
- The Levels of Care Committee (composed of representatives from the Legislature, the mental health community, foster and adoptive parents, the Child Welfare Training Institute, private providers, BCFS and group homes) continued to work on developing criteria for determining the most appropriate placement for children entering care. (2000-2001)
- Bureau and Child Welfare Training Institute staff received specialized training in permanency assessment from the National Resource Center for Special Needs Adoption. (2000-2001)
- Through a partnership with International Adoption Services Center, Inc., and collaboration with Adoptive and Foster Families of Maine, the Bureau developed a statewide recruitment and retention plan for foster and adoptive parents. Through agreements with private agencies, a concerted effort is underway to heighten public awareness of the need for placement resources. (2000-2001)
- The Commissioner of the Department has given higher priority to diversity in the agency's recruitment efforts. This includes greater emphasis on hiring staff that reflect the racial/ethnic/cultural composition of those the Department serves, which should increase the sensitivity of agency services. The new statewide recruitment plan for foster and adoptive parents also is based in part on a realization that the pool of available families should reflect the diversity of children in the State who need adoptive and foster homes. (2000-2001)
- Treatment foster care and group care contractors received training in use of an assessment/instructional tool to bring more consistency to life skills assessment and instructional practice statewide. (2000-2001)
- Collaborating with the Child Welfare Training Institute and the Muskie School, The Bureau developed training for care providers and adolescent casework staff on how to use "best practices" in life skills assessment and instruction. (2001-2002)
- Developed an 11 session training in conjunction with the Child Abuse Action Network to be provided to a number of clinicians throughout the state to expand the pool of providers prepared to work with the special issues related to child abuse and neglect.
- A work group reviewed the status of older youth on a V-9 agreement with respect to policy and practice. (2002-2003)
- Three tribal groups and two bands of Native Americans received start-up funds to provide life skills services for their youth. (2002-2003)
- Detail about activities related to Independent Living can be found in Addendum A.
- Membership on the Child Welfare Advisory Committee was expanded to include representation from mental health services and older youth in care.

- Developed a Foster and Adoptive Family Advisory Committee to partner with foster and adoptive parents to address issues of importance to families and the Bureau and to enhance systems to better deal with those issues. Writing of By-laws is in process. (2002-2003)
- The Cross Agency Collaborative developed recruitment and retention strategies for foster and adoptive homes and policies to support permanence for children. (2003-2003

Activities for 2003-2004

- Conduct a needs assessment to identify gaps in services statewide, for each district, and for various client groups. Analysis should include possible gaps mentioned in the last federal review and the more recent Statewide Assessment: psychiatric evaluations; post-adoption support; placements for adolescents, especially juvenile sex offenders; visitation centers with trained monitors; substance abuse treatment services; services for persons with mental retardation; sex offender treatment; placements for pregnant or parenting teens; psychological evaluations/infant mental health assessments; intensive in-home services; child psychiatrists; dentists who accept Medicaid; specialized treatment for sexual abuse victims; and transportation to services.
- Actively develop additional services for children and families (for example, substance abuse and domestic abuse treatment services). Explore use of additional providers for child welfare purposes (i.e., licensed professional counselors, licensed marriage and family therapists). Adopt standards for service providers to help increase the pool of providers. Better integrate provision of services to children and families, including services from schools, human service providers, and different agencies and state departments (including mental health, substance abuse, domestic violence treatment and child abuse services).
- Continue outreach to the Native American tribes and continue to work on State/tribal agreements and improved implementation of ICWA.
- Continue planning, training development and conflict resolution meetings with the Tribes to improve compliance with ICWA.
- Continue to work with staff to ensure a focus on strengths based practice while holding safety as paramount. Make necessary adjustments to the safety assessment and child and family assessment to include a strengths based approach.
- Take steps to ensure that service providers are clear on the expectations and desired outcomes of their work with families. This includes: developing clear practice standards governing how and when referrals are made to service providers; training caseworkers, supervisors and service providers how to implement those standards; clearly communicating Department expectations to providers; educating providers about ASFA and its related safety, permanency and case planning expectations; and assuring that service providers submit written reports on the progress of clients, including direct reference to the risk factors that led to abuse/neglect. Assure that BCFS staff remains active in cases even when a case management agency is involved.

- Continue the work of the Cross Agency Collaborative in coordinating statewide foster care recruitment and retention efforts and in supporting adoption and post-adoption services.

ALL CHILDREN DESERVE A PERMANENT FAMILY

GOAL 4: IMPROVE THE EXPERIENCE OF CHILDREN IN CARE WHILE ACHIEVING BETTER AND FASTER PERMANENCY OUTCOMES

Goal 4 addresses the following outcomes from the 2000-2004 State Plan:

1. BCFS Staff Facilitate Permanency For Children in the Bare and Custody of the Department in Time Frames Calculated to Meet Their Needs
2. BCFS Staff Assure that Children in the Care and Custody of the Department Have Their Physical, Developmental, Emotional and Behavioral Health Needs and their Education Needs Met.

Action Steps:

- **Reduce the median length of stay in foster care**
- **Fewer children in residential and group care**
- **Safely and responsibly reduce the overall number of children in care**
- **Safety and well-being reviews completed according to policy**
- **Licensed foster homes receive license renewal within regulatory time frames**
- **Establish baseline data and set performance improvement goal on reducing the number of moves for children**
- **Improve coordination and integration of services with other human services agencies**

Progress to date:

- Safety Assessment and Family Standards trainings were completed for staff. (1999-2000)
- QA staff reviewed cases of children whose parents' rights had been terminated, in order to identify barriers to achieving permanency. (1999-2000)
- The Department continued to monitor timely provision of physical, developmental, emotional and behavioral assessments. Staff understands the need to complete this work in a timely manner, and the assessments are usually performed in a timely manner when resources are available. (1999-2001)
- Availability of mental health services to meet the needs of children and families varies geographically, with more resources in populous areas of the State. Agreements like the one between the Department of Human Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services are addressing development of a comprehensive mental health infrastructure for children with mental health needs (ref. CFSP FY2000-2004, p. 46). (1999-2001
- Policies were reviewed to assure that changes in federal and state laws concerning permanency planning have been incorporated. (1999-2001)

- The standards and process for a single study licensing both foster and adoptive homes (known as Family Standards) was completed, and training was done for Department staff. (1999-2000). Training on Family Standards was provided for appropriate private agencies. (2000-2001)
- The Department's Staff Education and Training Unit and the Child Welfare Training Institute continued to develop the scope and depth of their training for foster and adoptive parents. The Department also helped to plan and deliver training for Group Care providers, and it cosponsored specialized training for private practitioners, private agency staff and staff of other departments. (1999-2001)
- The Treatment Network Team (composed of representatives from child placing agencies, foster/adoptive parents, and Bureau staff) reviewed and revised the "Program Standards for Treatment Foster Care in Maine" to more clearly reflect the goals and expectations of the Department and to assure that the Standards address critical elements of practice related to safety, well-being and permanency planning for children. (1999-2001)
- QA staff routinely review several cases each month to assure ASFA compliance and to identify barriers to early permanency. (2000-2001)
- Policy has been clarified requiring in-person review of the well-being and safety of children in out-of-home placement by their caseworkers at least once every three months. (2000-2001)
- The new Child and Family Assessment tool and the new Well-being/Safety Review tool were incorporated into MACWIS and implemented statewide. (2001-2002)
- Staff analyzed data on the frequency of caseworker contact with children on their caseload, showing that about 80% of cases were seen as required by policy and practice expectations. The importance of regular contact between caseworkers and children was emphasized, and the percentage of cases seen as required by policy and practice expectations subsequently improved to over 90%. (2000-2001)
- BCFS began to develop policy, practice expectations and infrastructure to implement concurrent planning, so that permanency is addressed earlier in all cases. Information was gathered on how concurrent planning has been developed and implemented elsewhere, and technical assistance was obtained from the National Resource Center for Foster Care and Permanency Planning. (2001-2002)
- National Resource Center for Special Needs Adoption has provided training on recruitment through the use of the website and internet. The most recent training was on AdoptUSKids.
- Clarified policy and improve practice and documentation around sibling visitation. Continued to assure that QA reviews examined whether the case planning process has been used to address visitation issues. (2003-2003)
- Increased staff and provider awareness of available post-adoption services, and continue to increase families' use of post-adoption support services. Continued to provide training for therapists on post-adoption services and on the unique needs

of adoptive families so they can help to avoid adoption disruptions and strengthen adoptive families. (2002-2003)

- Addressed issues causing delay in the legal clearance process. (2002-2003)
- Offices are engaging adoption staff earlier in the case to address adoptive placement needs of children. (2002-2003)
- Reviewed all cases with the goal of Long Term Foster Care and corrected those in which the goal was being incorrectly identified. QA continued to review requests for Long Term Foster Care Agreements. (2002-2003)
- Supervised Visitation Services were contracted to community based agencies and consistent expectations for reporting on visits established. (2002-2003)
- Quality Assurance routinely reviews cases in each district office and gathers data to provide information to the Legislative Committee on Health and Human Services. They report on 19 quality assurance indicators that include cases in compliance with safety/well-being visits, number of relative placements, family contacts, number of children with multiple placements, compliance with timeframes, compliance with ICWA and others.
- Reviewed cases of all children in care, ages 6-12 to assess the reasons for extended time in care and to assure review of each case in terms of permanency goal. (2002-2003)
- Achieved more listings for adoption and more timely response through continued work with Adopt US Kids.
- The Department of Human Service and the Department of Behavioral and Developmental Services developed a Transition Protocol that sets forth expectation and agreements that help youth transition to adult services; and developed protocol for joint involvement on cases in which both agencies are involved in decision making and service provision. (2002-2003)
- The Department of Human Services and the Department of Corrections developed protocol for service provision to youth in voluntary care. (2002-2003)
- An agreement was signed between the State of Maine and the Houston Band of Maliseets establishes protocol for the Maliseets and the state to work together in matters related to child welfare. (2002-2003)
- An Office of Substance Abuse work group developed uniform screening and assessment tools for use with adults with possible substance abuse problems. There is a substance abuse professional located in one DHS office to pilot the screening tool. (2002-2003)

Activities for 2003-2004

- Continue to take active steps to assure that there is meaningful contact between caseworkers and the children on their caseloads according to policy.
- District supervisors will continue to monitor case practice to assure that interventions and activities occur in a timely manner.
- Continue to develop BCFS policy, practice expectations and infrastructure to implement concurrent planning, so that permanency is addressed earlier in all cases. This will occur statewide.
- Continue to work with staff on meeting practice expectations designed to limit the use of long-term foster care as a goal for children in care. Identify long-term

foster care cases, and assure that QA examines "compelling reasons" for those cases on a regular basis. Educate courts regarding the ASFA requirements on "compelling reasons" and how to balance those with concerns about attachment and placement stability.

- Expand options for visitation that are child friendly and family oriented. When a court issues a preliminary protection order, assure that a child has scheduled visitation with his/her parents and siblings within days of the order, unless there is a compelling reason not to schedule such visitation.
- Expedite permanent placement of a child, including kinship care, when reunification is not possible.
- Continue to emphasize stability and continuity in home placements, including placements with the extended family and foster families, as appropriate for the child.
- Re-examine Bureau policy requiring caseworker safety/well-being visits with children every 3 months. Assure that frequency of visits is part of each case plan, that training and supervision emphasize the need for workers to have individual conversations or visits with children, and that QA staff monitor frequency of visitation.
- Increase staff focus on gathering pertinent medical and genetic histories (this is important to the adoption process for adoptive parents' and children's understanding of their medical/health backgrounds, and it helps the Bureau to meet the children's medical needs while in custody).
- BCFS and the Courts will pilot an enhanced effort to decrease the length of time between termination of parental rights and adoption. The lessons learned will guide activities in other offices.
- The Child Welfare Conference will address issues related to delays to adoption.

PRINCIPLES OF PUBLIC SERVICE WILL GUIDE US IN OUR WORK

GOAL 5: ASSERT THE LEADERSHIP ROLE OF CHILD WELFARE PROFESSIONAL BY PROVIDING SUPPORTS THAT ENHAVE THE PROFESSIONALISM, SKILLS AND CULTURAL COMPETENCY THAT RESULT IN POSITIVE OUTCOMES FOR CHILDREN AND FAMILIES

Goal 5 includes the following outcome from the 2000-2004 State Plan:

1. *Develop an operations management plan to improve communication, identify barriers to effective service delivery, manage daily operations and establish a common set of management standards.*
2. *Develop enhancements to MACWIS to measure and document baseline date and performance changes based on critical systems outcomes.*
3. *BCFS offers supports and incentives to retain staff and to enhance recruitment efforts.*

Action Steps:

- **Design and implement leadership training for all staff**
- **Build upon existing initiatives, design and implement a comprehensive strategy for enhancing the cultural competency of all staff**
- **All supervisors will be trained and show demonstrated competency in analytic model of supervision**
- **All supervisors will be trained and show demonstrated competency in safety assessments, child and family assessments and child and family reviews**
- **Convene workload analysis workgroup to develop strategies to make workload manageable**
- **Develop a customer service performance measurement baseline and performance improvement target**
- **Research and develop a comprehensive strategy for increasing staff retention**
- **Increase capacity for data utilization and continuous quality improvement**
- **Convene caseworker advisory group to provide direct feedback loop to management on the above goals and objectives**

Progress on Activities to Date:

- Staff have effective input into training, and the Department makes many workshops and seminars available to staff. (1999-2000)

- Work has continued on establishing accurate baseline data on current workload (1999-2001)
- MACWIS has continued to be integrated into operations at all levels. (1999-2001)
- Time frames for activities have been established, and a tracking tool is in place in MACWIS for child protective services. (1999-2001)
- The case assignment process was continuously monitored to assure that it supported sound case management. (1999-2001)
- Most District offices are using case aides or other designated staff for various functions. (1999-2000)
- The Department has improved opportunities for staff to attend national conferences and specialized instate training. (1999-2000)
- The Department has continued to offer on-site MSW classes and has made it easier for staff to conduct field placement activities through block field placements. (1999-2001)
- The Department has stepped up recruitment through job fairs, targeted newspaper advertisements, and the Internet. (1999-2001)
- MACWIS training/updates and other technology training is offered on a regular basis. Because MACWIS is so central to performing the Department's case work, need for additional MACWIS training is continuously assessed (1999-2001)
- ASFA training is provided to new staff during Pre-Service Training (1999-2001)
- Staff have input regarding training needs and serve on committees to review and revise the Pre-Service curriculum. (1999-2001)
- Caseload standards for child protective services (15 to 20 cases), children's services (18 to 22 children) and adoption (15 to 18 children) were established. (2000-2001)
- Management helped to develop performance standards as part of the State of Maine's implementation of performance budgeting. (2000-2001)
- The Bureau successfully worked with Personnel and Human Resources to expedite response and hiring time for applicants, in addition to enhancing the advertising and search process. (2000-2001)
- There is greater emphasis on hiring staff that reflect the racial, ethnic and cultural composition of those the Department serves. (2002-2001)
- The Bureau has worked to better recognize and appreciate the efforts of veteran staff (e.g., by providing an incentive raise for staff completing their third year of employment, and recognition at the fall conference). (2000-2001)
- Provided training on ASFA implementation (e.g., ASFA requirements and its related safety, permanency and case planning expectations) to Bureau staff, staff of service providers and other appropriate stakeholders. A consultant from the National Resource Center for Foster Care and Permanency Planning did three ASFA trainings around the State. The consultant also did a train-the-trainers

session; the teams trained there will continue to offer sessions on ASFA in the future. (2001-2002)

- The Bureau integrated the operations management plan, State performance measures, ASFA outcome measures, and the program improvement plan developed from the federal pilot review into a comprehensive Bureau plan. (2000-2002)
- BCFS incorporated tracking tools for adoption, foster home licensing and children's services into MACWIS, and implemented their use. (2001-2002)
- The Bureau initiated a Foster Parent Advisory Group to assure input from foster parents to the Department of Human Services. (2001-2002)
- Supervisory tools were developed to assist in assessment work (2002-2003)
- Increased focus on supervisory trainings (2002-2003)
- Work continued with Chapin Hall to further enhance the Bureau's ability to create reports to guide management in decision making. (2002-2003)
- A Draft Communications Plan has been developed as part of the Bureau's overall reform initiative. The goals are linked to the Bureau's Belief Statement that is outlines at the beginning of this Report. (2002-2003)
- The Bureau has developed a recruitment and retention plan for child welfare caseworkers and will continue to seek ways to strengthen the workforce. (2002-2003)

Activities for 2003-2004:

- Continue to enhance the Bureau's ability to provide accountability information to the legislature and the public.
- Continue to train staff to be appropriately sensitive to all cultures.
- Develop strategies to better incorporate a customer service focus into practice.
- Continue to improve on utilization of quality assurance reports by strengthening communication between QA and district staff.
- Continue outreach to the Native American tribes, and continue to work on State/tribal agreements and improved implementation of ICWA. Consult more closely with tribal representatives, consumers, service providers, foster care providers, the juvenile court and other public and private child and family serving agencies (e.g., through the Child Welfare Advisory Committee), and include their major concerns in the goals and objectives of the CFSP.
- In collaboration with Chapin Hall, continue to expand capacity for data analysis/management.
- Plan how to address additional training needs identified in the findings/ recommendations from the Child and Family Services Review (July, 2003) (e.g., through the Child Welfare Symposium and the Child Protective Advisory Committee of the Court (Court Improvement Project), additional information sessions for judicial staff on safety issues and the impact of repeat maltreatment on children; training for BCFS staff on how to limit use of long-term foster care as a goal; training for BCFS staff emphasizing the importance of sharing children's medical records with foster parents).

- Work with the Child Welfare Training Institute to add outside stakeholders to its advisory board.
- Work with District management to identify ways to provide incentives to staff.
- Develop opportunities for meaningful field placement and supervision for caseworkers pursuing higher education.
- Provide information and technical support to the Governor's Advisory Council on the Reorganization and Unification of the Department of Human Services and the Department of Behavioral and Developmental Services in support of improved services for children and families.

GOAL 6: THE BUREAU WILL PURSUE AN IMPLEMENTATION STRATEGY FOR ALL OF THE ABOVE GOALS VIA A COMPREHENSIVE STATEWIDE EFFORT IN EACH DISTRCIT, WHICH SIMULTANWOUSLY IDENTIFYING LEAD DISTRICTS FOR MORE INTENSICE AND ACELERATED EFFORTS.

Action Steps:

- **Statewide implementation plan developed and adopted by 9/2002**
- **Lead Districts identified September 2002**
- **Lead District reform plans and accelerated targets developed October 2002**
- **Non-lead districts phase in more intensive planning and implementation efforts as lessons are learned from lead districts – ongoing, beginning October, 2002**
- **Lead District implementation to begin no later than January 2003**

Progress to Date:

- The implementation Plan had been completed.
- Other districts have also restructured to move the reform agenda forward and are trying new approaches to practice.
- Key staff in districts other than lead districts are being exposed to opportunities for change to build momentum to accomplish the goals of the Strategic Plan.
- Work has begun with the Lead Districts particularly with restructuring, Family Team Meeting training, and foster parent recruitment.

Activities for 2003-2004

- Continue to move toward a systems approach to child welfare that focuses on child, family and community.
- Bring agencies and individuals beyond BCFS into the loop to help move the Strategic Plan to improve child welfare practice. This will include the Attorney Generals Office, the defense attorneys, the Guardian ad-litem, the courts and providers of service,

CHILD WELFARE COMPONENT PROGRAM NARRATIVES

CHILD WELFARE SERVICES

Services available to children and families who come to the attention of the Department include preventive and support services, protective services, family preservation, time-limited family reunification services, adoption promotion and support services, foster care maintenance, and programs designed to assist older youth in the transition to independent living.

CHILD PROTECTIVE SERVICES

A key Bureau of Child and Family Services' function is to receive all allegations of child abuse and neglect in the state, examine those allegations, determine the degree of harm or threatened harm to the child(ren), and assure as far as possible the child(ren)'s future safety. The Department's Intake Unit receives and does initial assessment of reports. The Child Protective Services caseworker follows up when a report alleges risk to a child posed by a parent or fulltime caregiver. Their work is child-centered and family-focused social service. When a report is received from the Intake Unit, there are two options. CPS staff can refer the report to a community intervention agency, private agencies contracted to Child and Family Services. These agencies offer services or coordinate services designed to reduce the risk of child abuse or neglect – such as counseling, substance abuse treatment or parenting education. Or when risk is severe, supervisors assign a child protective caseworker to do a safety assessment, looking specifically at whether each child in the home is safe and, if not, what must be done to keep each child safe. Before this work begins, caseworkers provide a Handbook for Parents, explaining the rights of parents and children and key points about safety assessment.

The safety assessment and other follow-up assessments identify parental behaviors and family factors that influence the likelihood of a child being abused. Research shows that understanding these factors produces the most accurate decisions about child safety and potential for future maltreatment.

A District Court petition is required before a child can be removed from parental care. A preliminary order by the court can be sought in situations where harm to a child or children is considered imminent and a hearing on such an order must be scheduled within 10 days. It is important to recognize that Child and Family Services seeks court intervention in the minority of situations – about 15 percent of reports annually. Most child protective work involves work with families to voluntarily reduce risk to children.

Child Protective Services uses two assessment models to get a full and uniform evaluation of suspected child abuse and neglect. Safety Assessment determines if abuse and neglect has occurred or is threatened to occur, the level of safety for each child, and the changes or interventions needed to make or keep a child safe. If it is determined that

a child's safety is compromised, the caseworker assists the parent/caregiver in developing a safety plan focused on actions that will make the child safe. If this plan is likely to provide safety, Child and Family Services may determine that continued involvement with the family is unwarranted.

A Child & Family Assessment is completed when the safety plan is unlikely to provide for the safety of the child beyond two weeks without the continued involvement of child protective. The Child & Family Assessment determines how likely it is that a child will be abused or neglected in the foreseeable future and the parent's capacity and willingness to change. The focus is information about the underlying causes of the abuse and neglect and the impact on the abuse of the neglect on the child. This assessment process must be completed within three weeks of completing the safety assessment.

Child and Family Services makes an official determination about whether allegations of child abuse and/or neglect are substantiated or unsubstantiated after the appropriate assessments are done. The decision is based on whether a preponderance of the evidence establishes that abuse or neglect occurred or is threatened to occur. If abuse or neglect has not occurred and is not threatened to occur, the report is unsubstantiated and the involvement of Child and Family Services ends. The record of unsubstantiated reports is expunged after 18 months, by law.

When substantiation of child abuse occurs, the caseworker and supervisor determine how to proceed. The options considered are:
Close the case – Safety is compromised, however, the parents/caregivers clearly understand and recognize the safety issues and are actively engaged in services and the caseworker and supervisor believe the likelihood of future abuse and/or neglect is low to moderated. Of, safety is compromised and the parents/caregivers refuse to engage in developing a family plan to address the identified behaviors or conditions that compromise the child's safety.

Close the case and refer the family to the local community intervention agency. Safety is compromised and the parents/caregivers are engaged in services or are willing to engage in services. The caseworker and supervisor believe the likelihood of future abuse and/or neglect is low to moderate, however, they also believe the family will need additional support to address identified concerns.

Develop a safety plan with the family. The plan must address any identified behavior or conditions that are making a child unsafe and changes that will allow the child to remain in the family home.

Voluntary care – Voluntary care is available to families who find themselves in temporary crisis. It is intended to be a short-term option no longer than 180 days based on a reasonable expectation that the child can be safely returned to his/her family at the end of the time period.

File a Child Protection Order with the Court – The child is unsafe because of serious harm and/or threats of serious harm that cannot be influenced or managed by parental or caregiver protective capacities. The district court, in making its determination, must find by a preponderance of the evidence that the child is in circumstances of jeopardy, that remaining in the home is contrary to the welfare of the child and that Child and Family Services has made reasonable efforts to prevent the removal of the child from the home. The child remains with the parents/caregivers until the court hears the evidence and makes a finding.

File a Preliminary Protection Order with the Court – The child is very unsafe when serious harm and/or threats of harm are both present and imminent and cannot be immediately influenced or managed by the parent or caregiver's protective capacities in order to quickly and significantly improve upon that child's safety. A child is at immediate risk of serious harm. Child and Family Services may request an Order of Preliminary Protection under these circumstances. This request may be made on an exparte basis. A summary hearing on this matter must be scheduled within fourteen, but not less than seven days, to allow the parents to be heard.

Relative Placement and Kinship Care - Child and Family Services policy regarding Relative Placement and Kinship Care directs that relatives be given priority consideration as a resources when children are ordered into temporary care. Child and Family Services is required to inform the court at the time of the summary preliminary hearing about the availability of relatives to care temporarily for the child. Kinship Care refers to the placement of a child with a relative on a permanent basis when district court or the family have determined that the child will not be returning to the home and care of the parent(s).

Collaborative Efforts:

Community Intervention Program

The Community Intervention Agencies have become a major part of the child protective system in Maine. Unlike several years ago, virtually all abuse/neglect reports judged appropriate for investigation by the Intake Unit are now assigned to either Bureau or agency staff. Strengthening the communication between the Bureau and the Community Intervention Agencies as well as addressing training needs has continued throughout the last year. There are regular meetings between the agencies and increasingly, practice had become more standardized. The Quality Assurance Unit continues to review the work of the Community Intervention Agencies as well as looking at the appropriateness of the reports sent to them by BCFS staff.

Child Abuse and Neglect Councils

The Department of Human Services provides funds to these community-based councils located in each county of the State. The Councils initiate and coordinate child abuse prevention activities at the local level. Funded activities include: prevention education programs; public education on child abuse issues; collaborative efforts with other

agencies to develop needed resources for children and their families; trainings in the area of mandatory reporting; and development of a resource directory.

Maine State Police/CPS Protocol

The Maine State Police and Child Protective Services have joint responsibility to investigate child death cases where the cause of death may be homicide. To assure that effective collaboration occurs on these difficult and often complex cases, the two agencies developed a protocol to cover investigation/assessment procedures, release and sharing of information, communication lines, decision-making and conflict resolution. In practice, this protocol has worked well and been used to resolve some critical conflicts, resulting in better investigative outcomes. This is a dynamic protocol that is changed to accommodate new laws and new circumstances.

Children's Emergency Response Program

BCFS entered into contracts in 1992 with the Lewiston and Portland police departments. Under the contracts, the Bureau agreed to fund an officer whose primary purpose is early intervention with families in order to identify and ameliorate problems early on, thereby preventing or reducing risk of child abuse and neglect. Working closely with the Bureau, the officers conduct an initial assessment and make referrals as appropriate. The officers also work with Bureau caseworkers in investigation of sexual abuse cases, emergency interventions, and court-ordered removal of children from their homes as necessary.

Children's Services

Overview

There are more than 500,000 children nationwide living outside of their homes because of child welfare concerns. In Maine, the number of children in care declined in 2002, from 3,174 to 3,080 most recently. Either because of a court order or a voluntary care agreement, these children live in family foster homes, group homes, residential treatment homes, with relatives, or other placements.

Children's Services (CS) supervisors and caseworkers work toward specific goals for each child. In some instances, this involves dual planning – working to reunify a child with family and exploring other permanent options if reunification is not possible. At all times, it is work that requires great coordination and professionalism. Children in care have experienced both loss and the trauma of abuse and neglect. The challenge is in meeting each child's needs with as much continuity of care as possible and focus on permanency goals.

The strategic plan of Child and Family Services, developed with consulting support from the Annie E. Casey Foundation, has brought renewed focus to the permanency goals of Children's Services. Among the strategic plan's goals:

- A 25 percent increase in child placements with relatives.
- Safely and responsibly decreasing the number of children in care by 5 percent.

Maine also benefits from a sound foundation in children's services. The state is considered a national leader in its work with older youth in care. In 2002, more than 80 older youth in care were taking part in post-secondary education. Foster children were represented on virtually every campus of the University of Maine and Maine Technical College Systems, as well as Maine Maritime Academy, St. Joseph's College, Worcester Polytechnic Institute, and many other private colleges.

Court Findings

Before transferring custody of a child to Child and Family Services, a District Court must find by a preponderance of the evidence that the child is in circumstances of jeopardy or in immediate risk of serious harm. The law also requires a finding that Child and Family Services made reasonable efforts to prevent the petition for removal.

When filing a petition with the District Court, or shortly after, Child and Family Services must give the court a case plan that describes a reunification plan or a decision not to reunify, efforts made to prevent the removal of the child from the home, and information about the availability and appropriateness of a relative placement. This plan is reviewed by the court and must be provided to the family and all parties.
When the custody of a child is granted to Child and Family Services, the law and established policies guide continued work with the child and family. For example, Child

and Family Services must provide a stable living situation for the child, and in most instances provide rehabilitation and reunification services to the family, or develop an alternative if rehabilitation and reunification is not possible. In order to ensure the child's need for permanent home is met in a timely manner, casework staff may concurrently develop an alternative while also vigorously pursuing reunification.

Reunification and Rehabilitation Efforts
Plans for reunification are intended to be a cooperative effort between professional casework staff and the parents. The District Court oversees these efforts. The rehabilitation and reunification plan must include among other provisions, the reasons for removal, changes that must occur for the child to return home, services that must be completed, visitation schedules and timeframes. Parents are responsible for resolving problems that prevent the return of a child to the home and must take part in the rehabilitation and reunification plan, maintain meaningful contact with the child, cooperate with the agency in developing and pursuing the plan and engage in appropriate services such as:

-Counseling for Parent and Children
-Psychological Evaluation and Parental Capacity Evaluations
-Substance Abuse Treatment
-Family Violence Treatment Programs
-Parent Education

Child and Family Services reviews this plan with the child's parents every three months to assess progress and make appropriate modifications. The court and all involved parties will review this plan every six months or sooner.

Commencing of Ceasing Reunification Efforts
The court may order that Child and Family Services not start or cease reunification efforts if it finds that specific requirements in the child protection statute are met. The reasons for this action include the existence of an aggravating factor or that continuation of reunification efforts is inconsistent with the permanency plan for the child.

Judicial Review
The court that has found jeopardy (issued a Jeopardy Order) must review the matter at least every six months or sooner if requested by a party. All parties must receive notice of this Judicial Review. At the review, the court hears evidence and considers the original reason for the adjudication and disposition, the events that have occurred since, the efforts of the parties, and the effect of a change in custody on the child. Foster parents, relatives providing care and any pre-adoptive parents are entitled to notice and the right to be heard at all Judicial Reviews and Permanency Hearings.

Guardian *ad Litem*
The court appoints a Guardian *ad litem* for the child in every child protection proceeding. The Guardian *ad litem* must meet qualifications established by the Supreme Judicial Court. A Guardian is charged with acting in the best interest of the child. They are a party to the child protection proceeding and have access to all reports and records. The

Guardian must see the child within seven days of their appointment and every three months thereafter. Guardians must independently investigate the circumstances of the child and family and report to the court and the parties on a regular basis.

Permanency-Planning Hearings
Recognizing that children need permanency in their life, the court conducts a legally required Permanency Planning hearing to determine a permanency plan for the child within 12 months of the time a child is considered to have entered foster care and every 12 months thereafter. If the court's jeopardy ruling includes a finding of an aggravating factor, the court may order that Child and Family Services cease reunification, in which case a Permanency Planning Hearing commences within 30 days. The Permanency Plan must have determinations about whether and when a child will be returned to the parent, placed for adoption, referred for legal guardianship or placed in another permanent living arrangement. The wishes of a child 12 years or older shall be considered by the court.

State law requires all child protective proceedings to be closed to the public, unless ordered otherwise by the judge. This provision reflects federal requirements and serves to protect the privacy of children and families.

The Child

The Child's Plan
Child and Family Service's policy requires that a "Child Plan" be developed to address the specific needs of the child. This plan must be updated every six months. This plan, among other things, identifies conditions that must be addressed for the child to be safe in returning home. The plan may include:

-Special Placement Issues
-Medical/Dental/Medication Needs
-Mental Health Needs
-Education Placement/Needs
-Independent Living (if appropriate)
-Peer Relationships
-Child's Permanency Wishes

Apart from the requirements of the plan, every child in Child and Family Services care must have a medical exam within ten days. In those cases when children are not expected to be returned home within ten days, mental health counseling maybe deemed appropriate.

Placement Options for Children
When a child must be removed from his/her own home, Child and Family Service's policy requires that the child live in the least restrictive and most family-like setting available in close proximity to the parents' home and consistent with the best interests and special needs of the child. Child and Family Services policy regarding Relative Placement and Kinship Care mandates that relatives be given priority consideration as a

resource for care. When relatives are not available or appropriate, the child will be placed in a licensed foster home or other facility. In the case of out-of-state relatives, Child and Family Services must request that the other state's child welfare agency assess the family to determine the appropriateness of the child's placement in that home. This evaluation can take from two to six months, depending on the state and circumstances.

Child and Family Services will not send a child out of state without a recommendation from the state where the child would live and, in most instances, without an agreement by that state to supervise the child in their new living situation. These home studies and evaluations are coordinated through the Interstate Compact on the Placement of Children (ICPC). The ICPC is an agreement between among states that describes the home studies and support for a child in state care who is being considered for an out-of-state home.

Safety/Well-Being Interviews

It is expected Child and Family Services caseworkers will meet with all children in custody alone at their placement at least once every three months. The worker is required to interview the child to determine his/her experience in the placement and assess the child's safety. For children in out-of-state placement, this expectation can be met by having the Maine caseworker interview multiple children at the facility where they are present. However, the caseworker assigned to the child must personally see the child every six months. It is expected that caseworkers, when visiting a child in his/her placement, will observe the physical environment, including the child's sleeping area. When a report is received of alleged child abuse and or neglect of a child in state care, the report is directed to the Institutional Abuse Unit and the child's caseworker. The Institutional Abuse Unit is responsible for investigating the report. The Children's Service's caseworker, as legal guardian, needs to respond immediately to assess the child's safety.

When Reunification is Not an Option

When the court orders rehabilitation and reunification efforts to cease, Child and Family Services must immediately develop a permanent plan for the child. The first determination is whether to file a petition to terminate the parental rights. At the same time, caseworkers and supervisors must continue to consider permanency options for the child, such as adoption, court-ordered custody to a relative, and other planned permanent living arrangement.

Termination of Parental Rights

Maine Law mandates that Child and Family Services file a termination of parental rights petition with the court if a child has been in foster care for 15 of the most recent 22 months or a court order includes the finding of an aggravated factor and an order of cease reunification. Exceptions include:

- Child and Family Services has not provided services necessary for the child's safe return to the home consistent with the time period in the case plan
- Child and Family Services has chosen to have the child cared for by a relative, or

- Child and Family Services has documented to the court a compelling reason for determining that filing such a petition would not be in the best interest of the child

The court may order the termination of parental rights if it finds, by clear and convincing evidence, that the statutory requirements for a termination have been met.

Adoption
When a return of a child to his/her parents is not possible, adoption is considered the best alternative for the child. Adoption creates a permanent and stable legal relationship. Child and Family Services works diligently to find adoptive homes for children with relatives and others.

Long-Term Foster Care
Child and Family Services may consider long-term foster care when, among other considerations, it is determined that the child is not likely to return to his/her parents and it is not likely that the child can be adopted. The prospective foster parents must meet the standards established for long term foster care. There also must be a signed agreement between Child and Family Services and the foster family that outlines responsibilities and authorizations. Long-term foster care does not necessarily require the termination of parental rights.

Transition Programs

ndependent Living Program
The Chafee Foster Care Independent Living Program offers older youth in care both formal and informal life skills learning experiences tailored to their individual needs. The program challenges them to develop their talents and pursue their educational aspirations in preparation for adulthood. These services are viewed as an expansion of Child and Family Service's permanency planning initiatives. The Chafee Foster Care Independence Act, enacted in 1999, requires that a written independent living case plan be developed with each youth in care, at least by the age of 16. This case plan describes the services that will help the youth prepare for transition from foster care to the community.

All of the Child and Family Service's contracted foster care agencies, as well as group and residential care agencies are required to use a standard life skills assessment and case planning format with respect to work with foster youth in their programs. There is also a quality assurance oversight with respect to the provision of these specific services. Life Skills Educators work with older youth in care to develop networks of both adults and peers to support youth in care as they near the time of leaving care so that they will not live in isolation as young adults. A primary focus of life skills work with older youth is planning for and pursuing post-secondary education career aspirations.

The Foster Care Youth Leadership Advisory Team is an important component of the Chafee Foster Care Independence Program. This team is comprised of more 50 older youth in care statewide who advocate for the needs of all children in foster care. They

make public presentations to a variety of groups, including local and national conferences, State Legislative Committees, to foster care providers, child welfare staff, child welfare staff in training and other groups. They have helped draft policies that affect children in foster care. Maine's Youth Leadership Advisory Team is recognized as being one of the best in the country.

Extended Care Agreement

When a foster child reaches age 18 and there is mutual agreement with Child and Family Services that ongoing care is needed, state law authorizes care until the youth reaches 21 years of age. Child and Family Service's policy allows a youth and their caseworker to negotiate and enter into a written agreement outlining expectations about education, employment, living arrangement, medical and mental health needs. This policy was revised in 2001 with the assistance of the Youth Leadership Advisory Team and professional casework staff and supervisors.

Education Beyond High School

Child and Family Services provides financial assistance for post-secondary education to youth in state care, or the extended care program. This assistance supplements available federal student grant and scholarship assistance. There is also a foster care tuition waiver for those youth who plan to attend one of the University of Maine system colleges, one of the state's Vocational Technical colleges, or Maine Maritime Academy. These youth submit an application for the tuition waiver to the Finance Authority of Maine along with other required documentation. The Foster Care Tuition Waiver Law was enacted by the State Legislature in 1999, was amended in 2000, and went into effect in the fall of 2000. Child and Family Service's provision of post-secondary financial assistance is subject to the department's policy and procedures criteria and the availability of both federal and state funds. In the 2001-2002 academic year, the department provided varying levels of post-secondary financial assistance to 82 youth. This represents an increase of nearly 20 youth over the previous year. This may be due to youth in care taking advantage of the foster care tuition waiver and the work of this agency's Life Skills Educators who work directly with youth around their college planning.

New Initiatives

Levels of Care System

Child and Family Services are working with the foster care community to develop a new Levels of Care structure. The focus of this work is offering a continuum of care and an initial assessment so children coming will have the most appropriate, least restrictive option. A Levels of Care Committee is establishing the assessment matched with new levels of care structure. The intent of this work is to improve permanency by increasing the likelihood that an initial placement will be the most appropriate and least restrictive available. The Levels of Care Committee is comprised of both Child and Family Services professional staff and key stakeholders including, foster parent representatives, a representative from both foster/adoptive parent support agencies, a representative from the Foster Family Treatment Association and a representative from the Maine State Legislature's Health and Human Services Committee.

Sibling Initiative

The Youth Leadership Advisory Team approached its Child and Family Services liaison about developing a sibling policy to specifically address the needs of siblings in the foster care system. Our agency embraced this idea, based on the organization's belief that all attempts to place siblings together, when it is safe and in their best interest, should be made. The Youth Leadership Advisory Team helped draft a policy that encourages placement of siblings together whenever possible and more frequent visitation when siblings cannot live together. In addition to a new policy, an initiative is under way to bring Camp-To-Belong to Maine. Camp-To-Belong is a summer camp experience that reunites siblings separated in foster care for a week at camp.

Foster Care

Overview

Every child has the right to be with his or her biological family provided that the child is safe in their home. When a child is removed from their home because the family situation meets legal standard describing serious harm or a threat of serious harm to the child, Child and Family Services is normally mandated to provide rehabilitation and reunification services to the family. CFS also provides a temporary home for the child – a foster home.

Foster care is not generally viewed as a permanent plan for a child. For those children who cannot be returned to their biological parents or relatives, adoption is the preferred plan. Foster care plays an essential role in both providing a temporary home and care for children and assisting in a child's transition to permanency. The emphasis is meeting each child's individual needs and providing permanency plans through rehabilitation and reunification services to families.

Foster parents play a critical role in the child welfare. They provide stability, a home and a sense of community for the child in their care. Foster parents are expected to assist and support reunification efforts between the child and their parents. Foster parents often provide important information about the child to the court and the parties involved in a child protection proceeding. They have the right to notice of these proceedings and the right to attend and present testimony.

Caseworkers attempt to find the most appropriate foster care match for each child and develop a case plan outlining a process to achieve the child's needs. This careful matching of foster home and child is not always possible when more children need foster homes than the community, region or state can supply. A major emphasis in the CFS strategic plan is developing more family foster homes. This is an especially challenging goal in many regions.

Family Standards

Child and Family Services works to assure that each child in care has a family that meets his or her needs for safety, permanency and well-being. Prospective foster/adoptive parents must possess the skills to meet these needs. To achieve this goal, the CFS has established standards that require finding a family for each child, rather than finding a child for each family. Through the use of this one set of family standards for both foster and adoptive families, the agency strives to provide an adequate number of foster/adoptive families that reflect the diverse racial, ethnic and minority status of the children in care. All applicants applying to become a foster and/or adoptive resource go through an initial application and screening process to ascertain whether they meet

eligibility requirements of the family standards. Then, an in-depth home study gathers information on family history, background, relationships and values. Applicants must be able to meet the following core standards of foster/adoptive care:

- Commitment
- Acceptance of and respect for child's prior/current relationships
- Constructive relationships
- Established lifestyle
- Understanding of child development and needs
- Capacity to meet the intensive needs of a child
- Positive approach to discipline

Applicants must also complete pre-service training, offered by the Child Welfare Training Institute (CWTI), a collaborative effort between Child and Family Services and the University of Southern Maine's Muskie School.

Foster Parent Training

CFS contracts with CWTI to offer Introductory and In-service training to foster and adoptive parents. A 24-hour, competency-based Introductory training offers prospective foster and adoptive parents the necessary foundation to work effectively with children, children's birth families and other professionals with whom they will interact as caregivers. This training fulfills the Family Standards training requirement. Introductory training encourages participants to explore their motivations for fostering and/or adopting and provides information on the system, the impact of abuse and neglect on children, and the importance of the birth family.

In-service training provides training and support to experienced foster and adoptive parents, assisting them in their professional development, providing respite and recognition and contributing to the retention of trained and effective caregivers. CWTI, in conjunction with Maine Caring Families—the Child and Family Service's statewide therapeutic foster care program—works to design training to meet core requirement needs and develop curricula responsive to the changing needs of caregivers. Training is offered on 17 topics, including Enhancing Self-Esteem in the Foster/Adoptive Family, Alternative Discipline for Foster and Adoptive Parents, and Promoting Healthy Sexual Development. A variety of training formats and delivery methods encourage increased access/participation in training. CWTI is currently working towards offering web-based In-Service training.

Curricula from Introductory and In-Service training are reviewed to ensure continued effectiveness and the training process is evaluated to gather feedback and ensure sufficient transfer of knowledge.

Foster Care Licensing

Federal law requires that all foster homes be licensed in order for a state to be eligible for Federal funding. The authority for licensure is left to the state. CFS has adopted licensing rules and strives to promote quality out-of-home foster care for Maine's children through equitable licensing practice.

Applicants must meet licensing requirements, for which they undergo Child Protective screenings, screenings for fire and safety violations, criminal history and checks through the Bureau of Motor Vehicles. A full license is issued for two years. A temporary license may be issued when a foster family affiliated with a Child Placing Agency moves to allow the continuation of services to the child(ren) currently placed with the family. A temporary license shall not exceed 120 days. A conditional license may be issued when an individual fails to comply with applicable laws and DHS specifies in writing the corrections that must be made. The law provides that a license may be revoked at any time the licensee fails to comply with the law or with rules and regulations. Licenses may be renewed, subsequent to an updated assessment of the family and their ability to meet licensing rules and regulations, a site visit, an updated DMV check and an updated criminal history search.

There are two categories of foster home licenses: Family Foster Homes for Children and Specialized Children's Foster Homes. To become a specialized foster home, the primary caregiver must have verifiable experience working with moderately to severely handicapped children and at least one course dealing with the special needs of moderately to severely handicapped children. Specialized licenses are only used for foster homes providing therapeutic foster care either through Maine Caring Families or independent child-placing agencies.

Foster Parent Recruitment

CFS makes diligent efforts to recruit potential foster and adoptive parents, who reflect the ethnic and racial diversity of the children in custody. The recruitment design includes providing potential foster and adoptive families throughout Maine information about the characteristics and needs of the available children, the nature of the foster care and adoption process, and the supports available to foster and adoptive families.

The agency is aware, however, of the need for more foster homes, particularly for children not requiring high-level therapeutic foster care. The lack of sufficient numbers of local foster homes results in children being moved away from their schools and communities. CFS aims to increase the number of family foster homes through collaboration, and in some cases, contracts with A Family For ME, Adoptive and Foster Families of Maine, local communities and Maine media. In addition, Family Standards outlines specific principles, goals and objectives for recruitment, including:

- Establishing a statewide foster and adoptive care committee of key stakeholders to serve as a resource

- Implementing a statewide plan for foster and adoptive care promotion, advertising and public relations
- Developing quality assurance mechanisms to measure recruitment outcomes
- Providing culturally competent services at inquiry, intake and informational meetings

Retention is believed to be responsible for 90 % of recruitment. As experienced foster and adoptive families are responded to and supported, they share their positive experiences. Parents need to be rewarded, respected and most of all, their opinions need to be heard and valued. Defined activities for increased retention are:

- Conducting exit interviews with foster and adoptive parents
- Providing increased support to all members of foster/adoptive families
- Improving matching of children and parents
- Involving foster and adoptive parents directly in activities

Federal Review Findings

The federal Administration for Children and Families conducted a pilot Child and Family Services Review in 1999. They found that too many children—especially young children—had long-term foster care as a goal. Reviewers' findings included:

- Approximately one-third of children in placement were in therapeutic homes, often because regular foster homes are not available.
- Maine did not have consistent criteria for referral to therapeutic care.
- Maine lacked a mechanism to monitor progress of children in therapeutic care and thereby to assess whether the therapeutic care continued to be warranted.

As a result of the pilot review, CFS developed both a program improvement plan and later a strategic plan that incorporated the full range of strategic issues. These plans targeted desired outcomes. Steps to improve foster care included:

- Work toward institutionalizing a process to ensure permanency earlier in all cases through concurrent planning.
- Developed statewide criteria for when children should be placed in a therapeutic home.
- Established clear goals for children's therapeutic care.
- Completed policy on long-term foster care to limit its use and train staff to implement policy and practice expectations related to "compelling reasons."

In addition, the collaborative Therapeutic Network Team (TNT) meets regularly to address issues concerning therapeutic care.

Therapeutic Network Team

This collaborative group is made up of one representative (staff member or foster parent) from each treatment foster care agency and representatives from Child and Family Services. In 1996, when the TNT was formed, the team developed the Program

Standards for Treatment Foster Care in Maine as well as policy for exceptions to the two-child limit in treatment-level foster homes. In January 2000, CFS instituted changes for standardization and clarification, which necessitated the revision of the Program Standards. The TNT formed subcommittees, which included foster parents, addressed specific issues and established Program Standards, effective January 1, 2001. The team continues to meet monthly and upcoming projects include resolving day care payment issues and maintaining consistency between programs.

New Initiatives

Foster Care Licensing Rules

CFS completed its implementation of new foster care licensing rules in 2002. These rules, which regulate the licensing of Specialized Children's Foster Homes and Family Foster Homes for Children, are designed to ensure the safety and well being of children placed in foster homes. The changes in the rules included adding on going training requirements for family foster, increasing the ongoing training requirements for specialized foster homes, limited the number of children placed in specialized foster homes, updating the rules to come into compliance with the Program Standards for Treatment Foster Care in Maine and including new federal guidelines regarding applicants with certain criminal histories. The proposed rules were distributed for comment to the Child Placing Agencies to be shared with their staff and foster parents. They were also sent to both Foster/Adoptive Parent agencies, the Youth Leadership Advisory Team and other parties who had expressed and interest. The comments received as well as comments received from those attending the Public Hearings and those who responded during the written comment period were reviewed. Changes were made based upon these comments.

Recruitment/Retention

CFS has begun a new recruiting and retention campaign called A Family For ME. This campaign is designed to recruit and retain foster, adoptive and kinship families who reflect the racial, ethnic, national origin and cultural composition of the children in our care. A Family For ME has built a solid first year foundation of efforts that include a standard packet of information for adoptive and foster families, Thursday's Child bi-weekly TV recruitment, radio and newspaper ads and high visibility in all 8 DHS Districts in Maine. Retention activities have included recognition efforts as well as exit interviews of families leaving the foster/adoptive care system.

Foster/Adoptive Parent Advisory Council

CFS has developed a foster/adoptive parent advisory council. The agency recognizes and values input from key stakeholders and this committee is another avenue to increase stakeholder participation child welfare functions and decisions. The role of this committee will be twofold:

1) to provide an avenue for foster/adoptive parents to express concerns and opinions to CFS staff directly involved in policy and practice decisions, and
2) to provide CFS with direct access and a "feedback loop" to the foster/adoptive parent community. Major issues and policy changes will be discussed with this

group. The composition will consists of one foster and one adoptive parent, chosen by the foster/adoptive parent community, from each of the eight DHS Districts.

Adoption

Overview

Child and Family Services primary permanence goal is reunifying families when possible. When the District Court finds that children cannot be returned to their birth parents, adoption is the next preferred permanency plan.

Child and Family Services is required to actively promote the adoption of children into stable families. The agency provides a range of adoption services to children who are legally freed for adoption and to those children's birth, foster and adoptive families. The number of children who required adoption-related services declined slightly from 735 in 2001 to 677 in 2002. Child and Family Services saw a corresponding decline in the number of legally adopted children from 423 in year 2000 to 302 in year 2001 and 294 in 2002.

The adoption staff assigned to work toward the adoption permanence goal includes 45 caseworkers, 8 supervisors, and 1 adoption program specialist statewide. Primary services include:

- Assessing and preparing the child for adoptive placement
- Assessing and educating foster parents transitioning to adoption
- Recruiting and educating new adoptive families
- Matching and placing children with families
- Supporting and stabilizing the adoptive family system and post-legalization support services

Adoption Services works with children who live in a range of setting including: family foster care homes (with relatives and non-relatives), therapeutic foster care homes, residential care facilities and group homes, as well as relative adoptive care, foster parent adoptive care, legal risk and traditional adoptive placements.

Family Standards

Child and Family Services recruitment plan for foster and adoptive families has combined foster and adoptive care standards into one set of guidelines covering the initial inquiry to approval and licensing. This redesigned family standards approach was implemented June 1, 2000.

After an initial application, education and screening process to determine eligibility standards, an in-depth home study gathers information on family history, background, relationships and values. Applicants must be able to meet the following core standards of foster/adoptive care:

- Commitment
- Acceptance of and respect for a child's prior/current relationships
- Constructive relationships
- Established lifestyle
- Understanding of a child's developmental and individual needs
- Capacity to meet a child's intensive needs
- Positive approach to discipline

Applicants also complete pre-service training, offered by the Child Welfare Training Institute (CWTI), a collaborative effort between Child and Family Services and the University of Southern Maine's Muskie School.

Implications of the Adoption and Safe Families Act

The federal Adoption and Safe Families Act (ASFA) was enacted in 1997 to promote permanency planning for children and to prevent children from languishing in foster or other temporary care settings. Maine's work to comply has included changes in MRSA Title 22 to meet the Adoption and Safe Families Act requirements and required a focused effort to meet both the technical aspects and the spirit of the law. Child and Family Services continued efforts in this area include:

- Building into our child welfare informational system the capacity to document the efforts to locate, place and legalize a permanent family for children in our custody.
- Providing educational sessions regarding ASFA to groups of adoptive and foster parents, therapeutic agencies and social work groups.
- Implementing an adoption-tracking tool that aids in managing the flow of a child through the adoption process.
- Funding child specific as well as general recruitment services. Our electronic photo listing/web page, done in partnership with the National Adoption Exchange, has been in place since October 1999. Child and Family Services has placed more than 30 children and received numerous general inquiries through this tool.
- Reduce inter-jurisdictional and geographic barriers by contracting services with the private sector. This also allows the CFS professional staff to be more responsive to the needs of children and families managing adoptions across county and state lines.

Changes and Challenges

A significant agency focus and philosophy is the timeliness of adoption services to children and families. Child and Family Services has implemented a management plan to set time frames for the movement of children/families in the adoption process. Management expects the foster parent adoption process to be completed nine months from the time the child is legally cleared for adoption and enters the adoption unit. This will help professional casework staff meet the National Standard time frame of 24

months [to move from entry into foster care to legalize adoption] for children whose goal is adoption.

Studies of the adoptive families, by CFS staff or the private sector contractors, must be complete in four months and with all required documents in the case record. Each caseworker is expected to meet a minimum goal of eight legalized adoptions per year. Child and Family Services believes that good practice is timely practice. The increased movement and number of adoptions already show positive initial results. The adoption-tracking tool will help the management group in holding staff accountable for their results.

Short-term goals are:

- To increase the rate of permanency through increased adoption legalizations
- To increase the rate of relative adoptions
- To increase the rate of foster parent adoptions from 75% to 80% of total legalizations
- To decrease time in foster care before adoption
- To increase placement stability [including legalized adoptive families]
- To increase the pool of adoptive families to reflect the racial, ethnic, national origin and cultural composition of children in our care

Long-term goals are:

- To emphasize permanency planning for older and disabled children and teens
- To expand support services for adoptive families post-legalization
- To strengthen and build our capacity through partnerships with private adoption agencies

Public and Private Partnerships

Maine Adoption Guides

Beginning in 1998, the Child Welfare Demonstration Project has allowed Child and Family Services to expend funds in the area of post-legalization adoption services, not normally covered by Title IV-E funding. This is a partnership of the Maine DHS, Casey Family Services and the University of Southern Maine. Maine's project, named the Maine Adoption Guides Project, is now in its fourth year and is in full statewide implementation. Project goals are to:

- Increase the number of special needs adoptions
- Decrease the average length in foster care
- Decrease the rate of adoption disruptions
- Increase family functioning

Outcomes were fully met in the first three years of the project. The first and second year included training 260 providers serving adoptive families on adoption competencies.

This is having significant impact on the provision of services to all adopting families in Maine as measured by the research on this phase of the demonstration project.

The second phase of the project is delivery of post-legalization adoption services, which started with a pilot run in York and Cumberland Counties on October 1, 1999 and will conclude March 31, 2004.

The core principle of this program is that adoption is different. The dynamics of a family created by adoption are different from the dynamics of a family created by birth. Adoption is life-long and its impact creates unique opportunities and challenges for families and communities. Adoption is mutually beneficial to parent, child and society. Society is responsible for supporting and aiding integration and preservation of adoptive families.

Participants are recruited from the overall population of families adopting children with special needs from the Maine Department of Human Services (DHS) foster care system managed by CFS. Every year for four years, 140 children and their families are recruited into the project. At the time that families meet with adoption caseworkers to plan for federal Title IV-E subsidy arrangements, about three months prior to legalization, families are invited to participate in the project. Families are then randomly assigned to either the Standard Services (control) group or Guided Services (experimental) group.

Standard Services families receive the normal sets of supports and subsidy from Maine's adoption casework staff. Guided Services families receive the normal supports and subsidies and have access to a Maine Adoption Guide social worker from Casey Family Services. All families who participate in the project commit to a set of interviews once every six months. Families in the Guided Services group commit to being contacted by their assigned social worker at least once every six months. This case-management type of service delivery model is delivered statewide and is provided through a partnership of DHS and Casey Family Services.

The Guided Services intervention is a community-based delivery of service program designed to be family driven. The adoptive parent or parents are viewed as the expert on their child. The social worker assigned to the family functions as a guide who consults with the family through the expected and normal crisis in the life of an adoptive family. The long-term plan, based on the positive outcomes of this study, is that these same guided services could be expanded to the general population of adoptive families.

The research design is a longitudinal control group design with random assignment and observations both before the intervention and then conducted every six months for the duration of the study. There will be four cohorts observed in the study. The outcome evaluation assesses to what extent the children/families who received the Guided Services Model (experimental group) and the children/families who received Standard Services (control group) differ in regard to a number of outcome measures. The outcome measures include:

- Rates of adoption dissolutions
- Number of days child in the home/displacement rates
- Assessment of family functioning
- Assessment of child functioning/well being
- Assessment of access to and utilization of services

Contracted Services

Child and Family Services and the Department of Human Services have offered the opportunity of a public/private partnership with all of the non-profit private adoption agencies in Maine. Child and Family Services operates with a lead contractor, International Adoption Services Centre, Inc. This arrangement provides oversight of the sub-contracted agencies and keeps the standards of services consistent. These private sector resources allow CFS to expand its capacity in the provision of timely services to children and their families. The agency began contracting for home study services in 1996. Through contracting, adoption caseworkers are more able to concentrate their efforts on securing permanent adoptive placements and preparing children for the transition.

Maine DHS contract for the following services:

- Study/Assessment of Foster and Adoption Families
- Statewide Post Legalization Adoption Services: This continuum of services includes advocacy, family education, information and referral, community supports, medical/genetic research and other search issues, mediation and problem solving, recommendations and referrals.
- Purchased Services from private [not for profit] adoption agencies that have developed and approved adoptive parents who wish to adopt children from the DHS foster care program.
- Recruitment and Retention of foster and adoptive families: An effort to develop foster/adoptive and kinship families who reflect the racial, ethnic, national origin and cultural composition of the children in our care. This project is called "A Family for ME" and has built a solid first year foundation of efforts that include a standard packet of information for adoptive and foster families, Thursday's Child bi-weekly TV recruitment, radio and newspaper ads and visibility in all regional districts.

New Initiatives

The federal Adoption 2002 Initiative challenged States to double the amount of legally adopted children between 1998 and 2002. Maine has increased the number of adoption legalizations from a baseline of 112 children in FFY 1998 to 361 children in federal fiscal year 2001—more than a 200 percent increase. Maine won a U.S. Department of Health and Human Services Adoption Excellence Award in December, 2000.

Child and Family Services adoption assistance program currently supports 1600 children and their families through financial subsidies, Medicaid and non-reoccurring adoption

expenses. As part of an ongoing effort to educate and support adoptive families about the adoption assistance program and post legalization adoption services, CFS created a revised Adoption Assistance Handbook and a new Maine Post-Adoption Resource Guide. Completed in 2002, the guide is expected to be used by CFS caseworkers and all private adoption agency staff and families. This resource guide is also located on the web at www.adopt.org/me and on www.cwti.org . This Guide identifies services that are provided to families who have adopted both through DHS as well as through a licensed private agency, along with the eligibility requirements. Adoption Support Groups are listed in the Guide – some of these are specific to families who have adopted from outside of the country.

Maine has the capacity to document the efforts to locate, place and legalize a permanent family for children in DHS custody through the SACWIS system. An adoption-tracking tool has developed to aid in managing the flow of he adoption process. BCFS has reduced Inter-jurisdictional and geographic barriers by contracting services with the private sector. This also allows BCFS to be more responsive to the needs of children and families crossing county and state lines. A Family For ME has compiled a list of all available adoption resources in Maine as well as out of state families who have expressed an interest in adopting children from Maine.

The number of children in care, who had been previously adopted is available through MACWIS'AFCARS Plus section. Currently, Non-recurring Adoption Assistance payments have been made to only 3 children (2 families) who were adopted through a private agency.

Adoption Services actively solicits feedback from our adoptive families to support continuous improvement. In 2001, Adoption Services directed researchers at the University of Southern Maine to undertake a survey of parents who have children receiving adoption subsidy payments. All of these families were contacted through a one-time mail out questionnaire. Parents were not asked to provide their name and there was no identifying information provided to the researcher; the sample was anonymous. A total of 382 surveys were returned for a 44% response rate.

The survey provides detailed information about the status and needs of the adoptive child, the families' needs, pre-legalization experiences with adoption agencies, and post-legalization service utilization. This report is available to those who are more interested in detailed descriptions. A quick summary of one core result: 86 percent reported being satisfied/very satisfied with the adoption experience. Asked if they would adopt this child again, 71 percent said yes and 15 percent stated they probably would adopt. A total of 77 percent of the respondents stated that they would recommend adoption to others.

Oversight and Accountability

Child and Family Services is responsible for promoting the safety, permanency and well-being of children and families through the provision of social, regulatory and purchased services on a continuum from prevention to protection. CFS is guided in these efforts by federal laws and regulations, the law and the courts of Maine, agency rules and internal agency policies. What follows is a brief outline of the areas of oversight and accountability as applied to CFS in connection with these services.

Child and Family Services Review

The federal government, through the Department of Health and Human Services - Administration for Children and Families, conducts reviews of all State Child Welfare programs. These reviews, which focus on issues relating to the safety, permanency and well-being of children and families, are conducted every three years. CFS participated in a voluntary pilot review in 1999. Maine is scheduled to participate is its first non-voluntary review in 2003. The extensive reviews include a complete review of case records selected at random. The review team conducts interviews of people identified in the case record which may include; CFS staff, biological parents, foster parents, children when appropriate, service providers, guardian ad litems, judges, attorneys, law enforcement and school personnel. In addition to the case reviews, focus groups of critical constituencies are convened to look at how CFS meets the needs of the children and families it serves in both community relations and service delivery. Based on the findings of the review, States are required to develop a Program Improvement Plan to address any needed changes.

Federal IV-E Audit

Title IV-E of the Social Security Act mandates this federal audit. The audit is performed to determine the state's continued eligibility for federal dollars based on a number of very specific criteria designed to ensure the safety, permanency, and well-being of children and families. The audits are conducted every three years. Maine's most recent audit was concluded in March of 2001. The next one is scheduled to begin in 2003. In determining whether a state meets the federal requirements for continued Title IV-E funding, the audit looks at numerous criteria for compliance including: the financial eligibility of a family, the reasonable efforts to prevent the removal of a child from their home, the timeliness of court reviews and the placement of children in licensed facilities. There are significant fiscal sanctions for failing to pass the audit.

Office of the Inspector General

The Office of the Inspector General has the authority to conduct reviews of States receiving federal dollars through the Title IV-E program. Such reviews determine compliance with the specific federal provisions required for Title IV-E funding. Most

recently the Office of the Inspector General reviewed Maine's foster home license renewals.

State Plan

In order to be eligible for payment under Titles IV-B and IV-E of the Social Security Act and the Child Abuse Prevention and Treatment Act (CAPTA), states must submit an annual plan of their child welfare services program. The required plan is very comprehensive. Among the many areas that must be detailed in the plan are an overview of the state's child welfare program in relation to federal requirements and a detailed plan for achieving specified administrative and programmatic goals. The state plan is reviewed to ensure substantial conformity with federal requirements and to help states improve child welfare services and outcomes for families and children who receive services.

The Child Welfare Outcomes Annual Report

The Adoption and Safe Families Act (ASFA) requires that the Department of Health and Human Services collect data from individual States regarding child abuse and neglect and issue an annual report. The report includes national data on child abuse and neglect. In addition, the report reviews the performance of individual states to determine whether a state meets the needs of children and families who come into contact with the child welfare system, focusing specifically on the "outcomes" or results, for these children. The identified outcomes are as follows:

- Reduce the recurrence of child abuse and neglect
- Reduce the incidence of child abuse and neglect in foster care
- Increase permanency for children in foster care
- Reduce time in foster care to adoption
- Increase placement stability
- Reduce placements of young children in group home or institutions

The outcome measures are calculated using two national data collection systems currently in operation: the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS). States are required to submit specific data for these reports. This data is used to determine if a state is in compliance with the provisions of the Titles IV-B and IV-E and with the identified outcomes. Federal funding is tied to successful state performance.

Maine Law and the State Courts and Agency Rules

The Child and Families Services and Child Protection Act, 22 M.R.S.A. 4001 et. seq. sets forth the authorizations and obligations of CFS in relation to its child welfare practice. The Act authorizes CFS to provide services to families at risk and to protect children from abuse and neglect inflicted by persons responsible for their care. The Act is designed to balance the rights of parents to be free from undue government intrusion into their family affairs, against the right of children to be safe in their own homes. There are

important statutory safeguards in the law for both children and parents. District courts throughout the state hear all child protection matters and render their decision based on the application of law, the Maine Rules of Civil Procedure and Maine Rules of Evidence. CFS is held accountable for its action and inaction in relation to the law as applied by the courts. The Supreme Judicial Court sitting as the Law Court hears all appeals from Jeopardy Orders, Termination of Parental Rights Orders and Medical Treatment Orders. In addition, CFS has promulgated Rules pursuant to the Administrative Procedures Act in a number of areas. These Rules are judicially enforceable and describe the agency's procedures or practices in a number of areas.

Quality Assurance

The Case Review and Quality Assurance Unit located within CFS provides ongoing internal assessment, data collection and feedback of the agency's compliance and performance regarding federal law and regulations, state law and agency policy. The Unit is comprised of eight managers located in districts throughout the state. In addition to the reviews outlined below, the unit often responds to specific and special requests for studies and reviews. The managers perform the following functions:

Internal Reviews

The unit managers conduct monthly reviews of randomly selected Child Protective and Children's Services cases, analyzing theses cases to ensure the safety, permanency and well-being of children in the foster care system. Reviews also are conducted in the area of Children's Services for the purpose of reviewing the safety assessment process as well as case progress. Written reports of the findings and recommendations are made available to program administrators, supervisors and caseworkers. In addition, the data is collected on a grid that tracks all state and federal protections required in a case.

Long-Term Foster Care Agreement Recommendations

In all cases where a district is considering long-term foster care as the permanent plan for a child unit, managers conduct a review. The unit managers review the case files, assess the permanency plan and review the appropriateness of the plan for the individual child. The final recommendation is reduced to writing and provided to the district supervisor and program administrator for consideration.

Administrative Case Reviews

The unit managers conduct an annual review for all children who have a long-term foster agreement in place. These reviews consider the continued appropriateness of the placement for the child. In addition to ensuring the continued well-being of the child, these reviews are required by federal regulation.

Therapeutic Foster Care Agency Reviews

In order to insure that children in therapeutic foster care settings are receiving quality care and the most appropriate services, the unit conducts reviews of therapeutic treatment foster care agencies. Fifteen agencies have been reviewed as of June of 2000, representing the total number of child placing agencies. The initial review consists of an interview with agency staff, a selection of 20% of the cases served by the agency for

record review, in-home interviews with foster parents about their experiences with the agency, and interviews with CFS staff who had worked with the agency. The information is summarized in a report that documents the findings regarding the agency's strengths, needs and recommendations. This report is provided to appropriate CFS staff and a letter summarizing the report is sent to the agency. The Unit conducts a follow-up review of these agencies. This review focuses on the individual child's progress in the program in relation to their safety, permanency and well-being, the transition that the agency provided for children who were moved to another placement during the year, and the agency's ability to assist children who are moving to adoption. This review includes the addition of two cases selected by the agency. These cases are assessed through a network meeting which may be comprised of services providers, the caseworker, the child's guardian ad litem, the parents and the foster parents, to ensure that the plan provided by the agency is the most appropriate plan for the child. A written report outlines the findings and includes agency's strengths, needs and recommendations. A summary of the report is provided to the agency. The agency has 30 days to address how it plans to respond to the recommendations.

Community Intervention Program Reviews

Community Intervention Programs provide services to families through a contract with Child and Family Services. CFS makes referrals to these agencies of those families with low to moderate risk reports of abuse and neglect. The review includes: the timeliness of the referral and the appropriateness of the referral, the services provided by the agency and the timeliness of the services provided and the level of the family's cooperation with the agency. A written report is then provided to the agency. In addition to specific case reviews, the unit conducts quarterly reviews of statewide intake reports to consider the appropriateness of the referrals to Community Intervention Programs.

FINANCIAL DETAIL

PROPOSED USE OF IV-B, SUBPART 2 FUNDS
Promoting Safe and Stable Families

The Bureau of Child and Family Services will use funds to promote safe and stable families to help support the initiatives set forth in the Strategic Plan. As detailed earlier in this report, there are several areas of focus for the Bureau as part of its Strategic Plan to improve practice. Much has been accomplished, a number of initiatives are underway and there are still many challenges to be met. Among the reforms to be accomplished are: improve intake and assessment process, understand caseload and improve practice, realign resources, develop an outcome accountability system and assure overall reform initiative coordination.

IV-B, Subpart 2 funds will help in the following areas: provision of in-home services to prevent removal, post-reunification services designed to help families re-build relationships and improve family functioning, increased use of relatives to provide permanency for children, recruitment efforts to expand resources which will assure the least restrictive placement for children and youth, greater coordination of services with other agencies, and training of staff to enhance skills and competencies.

Increasing resources to help preserve and strengthen families continues to be a primary goal for the Bureau. 15% of IV-B funds will continue to support intensive in-home family preservation services. Through existing MaineCare programs in the state, Medicaid eligible clients are able to receive many home-based services. That is the reason for fewer IV-B funds allocated to this service area. Time-limited reunification services and family support services will play a critical role in the Bureau's ability to move ahead with new initiatives and a total of 45% of IV-B funds will be used to access community based services to support reunification and to provide services to strengthen and preserve families. These services will also be available to relatives providing care and adoptive families. 25% will be used for family support services and 20% for reunification services.

The work of the Levels of Care Committee continues and funds will be needed to help assess and realign resources – both placement and service resources. All children in care and entering care will be assessed to assure the most appropriate placement and the services needed to support that placement. Along with this initiative, there will be expanded recruitment efforts statewide for foster and adoptive homes and support services to maintain foster and adoptive homes. The Bureau will use 20% of funds to support the recruitment and retention of foster and adoptive parents and to assure that resources are developed where they are needed and at the level of care that children most need. 10% of available funds will be used for planning activities and training related to this initiative

CFS-101, PART II: ANNUAL SUMMARY OF CHILD AND FAMILY SERVICES

OMB APPROVAL # 0970-0047
Approved through Jun. , 2005

State or IT Maine

For FFY OCTOBER, 2003 TO SEPTEMBER 30, 2004

SERVICES/ACTIVITIES	TITLE IV-B (a) I-CWS	TITLE IV-B (b) II-PSSF	(c) CAPTA*	(d) CFCIP*	(e) TITLE IV-E	(f) TITLE XX (SSBG)	(g) TITLE IV-A (TANF)	(h) Title XIX (Medicaid)	(i) Other Fed Prog	(j) State Local Donated Funds	(k) NUMBER TO BE SERVED [ ] Families [ ] Individuals	(l) POP. TO BE SERVED	(m) GEOG. AREA TO BE SERVED
1) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	310	315				807						Reports of abuse/neglect	Statewide/ Reservation
2) PROTECTIVE SERVICES	55									830			
3) CRISIS INTERVENTION (FAMILY PRESERVATION)		891						2000		4,500			
(A) PREPLACEMENT PREVENTION												All children in foster care	Statewide/ Reservation
(B) REUNIFICATION SERVICES	100	215											
4)TIME-LIMITED FAMILY REUNIFICATION SERVICES	100	225						810		215			
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	10											All egligible children	Statewide/ Reservation
6) FOSTER CARE MAINTENANCE: (A) FOSTER FAMILY & RELATIIVE FOSTER CARE					17,782		3,010		2,650				
(B) GROUP/INST CARE													Statewide/ Reservation
7) ADOPTION SUBSIDY PMTS.					8,876					157			
8) INDEPENDENT LIVING SERVICES	40			690									
9) ADMIN & MGMT	396	25											
10) STAFF TRAINING			66		2,915					264			
11) FOSTER PARENT RECRUITMENT & TRAINING	118									71			
12) ADOPTIVE PARENT RECRUITMENT & TRAINING	150									50			
13) CHILD CARE RELATED TO EMPLOYMENT/TRAINING										82			
14) TOTAL	1,279	1,671	66	690	29,758	807	3,010	2,810	2,650	6,169			

* States Only, Indian Tribes are not required to include information on these programs

CFS-101, Part I: Annual Budget Request For Title IV-B, Subpart 1 & 2 Funds, CAPTA, And Chafee Foster Care Independence Program Fiscal Year 2004, October 1, 2003 through September 30, 2004

1. State or ITO: Maine	2. EIN: 01600000-AC
3. Address: 221 State Street #11 State House Station Augusta, ME 04333-0011	4. Submission: [X] New [ ] Revision
5. Estimated title IV-B, Subpart 1 Funds (25% State match required).	$ 1,357,626
6. Total Estimated title IV-B, Subpart 2 Funds. (This amount should equal the sum of lines a – f.) (25% State match required.)	$ 1,522,755
a) Total Family Preservation Services. 15%	$ 288,413
b) Total Family Support Services. 25%	$ 380,689
c) Total Time-Limited Family Reunification Services. 20%	$ 304,551
d) Total Adoption Promotion and Support Services. 20%	$ 304,551
e) Total for Other Service Related Activities (e.g. planning). 10%	$ 152,275
f) Total Administration (not to exceed 10% of estimated allotment). 10%	$ 152,276

7. Re-allotment of Title IV-B, Subpart 2 funds for State and Indian Tribal Organizations (25% State match required).

a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the Promoting Safe and Stable Families program. $ 0

b) If additional funds become available to States and ITOs, specify the amount of additional funds the State or Tribes is requesting. $ 0

8. Child Abuse Prevention and Treatment Act (CAPTA) Basic State Grant Only (no State match required)

Estimated BSG Amount $ 128,151, plus additional allocation, as available.

9. Estimated Chafee Foster Care Independence Program (CFCIP) funds (20% State match required).	$ 771,149

10. Re-allotment of CFCIP Funds (20% State match required).

a) Indicate the amount of the State's allotment that will not be required to carry out CFCIP $ 0.

b) If additional funds become available to States, specify the amount of additional funds the State is requesting $ 22,000.

11. Certification by State Agency and/or Indian Tribal Organization.

The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA BSG and CFCIP, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the ACF Regional Office, for the Fiscal Year ending September 30.

Signature and Title of State/Tribal Agency Official	Signature and Title of Regional Office Official
Peter E. Walsh	
Date 6/24/03	Date

CFS-101, Part I: Annual Budget Request For Title IV-B, Subpart 1 & 2 Funds, CAPTA, And Chafee Foster Care Independence Program Fiscal Year 2003, October 1, 2002 through September 30, 2003

1. State or ITO: Maine	2. EIN: 01600000-AC
3. Address: 221 State Street #11 State House Station Augusta, ME 04333-0011	4. Submission: [ ] New [x] Revision
5. Estimated title IV-B, Subpart 1 Funds (25% State match required).	$ 1,361,032
6. Total Estimated title IV-B, Subpart 2 Funds. (This amount should equal the sum of lines a – f.) (25% State match required.)	$ 1,587,519
a) Total Family Preservation Services. 10%	$ 158,752
b) Total Family Support Services. 35%	$ 555,632
c) Total Time-Limited Family Reunification Services. 10%	$ 158,752
d) Total Adoption Promotion and Support Services. 20%	$ 317,503
e) Total for Other Service Related Activities (e.g. planning). 15%	$ 238,128
f) Total Administration (not to exceed 10% of estimated allotment). 10%	$ 158,752
7. Re-allotment of Title IV-B, Subpart 2 funds for State and Indian Tribal Organizations (25% State match required). a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the Promoting Safe and Stable Families program. $_____ b) If additional funds become available to States and ITOs, specify the amount of additional funds the State or Tribes is requesting. $ 300,000	
8. Child Abuse Prevention and Treatment Act (CAPTA) Basic State Grant Only (no State match required) Estimated BSG Amount $ 134,305, plus additional allocation, as available.	
9. Estimated Chafee Foster Care Independence Program (CFCIP) funds (20% State match required).	$ 753,542
10. Re-allotment of CFCIP Funds (20% State match required). a) Indicate the amount of the State's allotment that will not be required to carry out CFCIP $ 0. b) If additional funds become available to States, specify the amount of additional funds the State is requesting $ 60,000	
11. Certification by State Agency and/or Indian Tribal Organization. The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA BSG and CFCIP, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the ACF Regional Office, for the Fiscal Year ending September 30.	
Signature and Title of State/Tribal Agency Official Peter S. Walsh	Signature and Title of Regional Office Official
Date 6/24/03	Date

MAINTENANCE OF EFFORT

The Department of Human Services maintains a system of financial reports and audits to assure documentation of spending levels. Contracts with provider agencies are monitored fiscally and programmatically through quarterly reports.

The total budget for the Bureau of Child and Family Services is over $280,000,000 which includes State general funds for services to children and families and Social Services Block Grant funds for services. Other funding sources IV-E, Medicaid and federal grants.

Funds received under this plan are for activities performed in addition to and not in substitution for activities previously carried on without Federal assistance.

CHAFEE FOSTER CARE INDEPENDENCE PROGRAM REPORT

JUNE 30, 2003 PROGRAM REPORT

CHAFEE FOSTER CARE INDEPENDENCE PROGRAM
MAINE DEPARTMENT OF HUMAN SERVICES

This Program Report covers the programs, services, and activities for which Title IV-E, Section 477 and Title I, Improved Independent Living Program, Public Law 106-109, Chafee Foster Care Independence Act of 1999, amending section 477 of the Social Security Act, funds were expended and disbursed between October 1, 2001 and September 30, 2002. There is also some information with regard to activities under Chafee for FFY-2003 starting October 1, 2002 through May 31, 2003.

OVERVIEW OF SOME STRATEGIES USED TO MEET THE NEEDS OF THE ELIGIBLE POPULATION:

All Department of Human Services contracted treatment foster care, group and residential care providers are now using a single life skills assessment, independent living case planning, and instructional tool; the Competency Based Assessment system developed by Dorothy Ansell who is the co-Director of the National Resource Center for Youth Services at the University of Oklahoma. In June of 2000 all Department contracted care providers were trained to use the Ansell Competency Based Assessment System (CBA) in their independent living preparation practice with older youth in care.

Use of the CBA system became a requirement for all contracted treatment foster care and group and residential care service providers in Maine beginning in the fall of 2000. In the summer of 2001, one Quality Assurance Program Specialist was assigned to the Chafee Foster Care Independence Program to begin on site quality assurance reviews with respect to the use of the CBA system at each group and residential care program throughout the state. These on site reviews consist of reviews of individual youth records with respect to the quality of the written life skills assessment and independent living case plan and six month reviews of progress notes on the youth's identified life skills goals. Also included in these on site reviews are observations of group life skills instruction sessions and discussions with individual youth with regard to their independent living case plan. The quality of individual youth's life skills portfolios is also being assessed. Group and residential program staff are provided with specific written feedback with regard to quality of their provision of life skills and independent living preparation services. Many treatment foster care and group and residential care providers use other life skills instructional materials to supplement the use of the CBA system curriculum depending on the needs of the youth in their facility. For example, some programs serve youth with special mental

health, or mental functioning level challenges and need to use life skills materials that are at the level of functioning of the youth in their program.

As of June 2003, nearly all of the contracted group and residential care programs in Maine have been reviewed on site. The overall quality of independent living service provision has been good. Some programs have neglected to send copies of the youth's life skills assessment and independent living case plan, or progress notes with respect to identified life skills goals to the youth's Department of Human Services caseworker. However, they have agreed to begin doing so once this was pointed out to them. Three group and residential care programs have been revisited for review based on some level of concern about the quality of the provision of services. The on site reviews have had the additional benefit of sharing with our group and residential care providers what is happening with the Chafee Foster Care Independence Program in Maine in terms of program priorities.

The Quality Assurance Program Specialist has also conducted on-site reviews of seven group and residential care programs for older youth that are not in a contracted relationship with the Department. Technical assistance and information was provided to these programs about what other similar programs were doing with respect to life skills service provision. Some of these programs were using parts of the CBA system and other life skills curriculum materials with their residents. We are asking the non-contracted service providers to use materials that are consistent with the core life skills areas that are addressed in the CBA system materials. Quality of services in these programs was found to be generally good. Recommendations were made to these care providers with respect to more specific focus on life skills assessment and independent living case goals.

Treatment foster care agency practice with regard to using the CBA life skills assessment and independent living case plan system in their foster homes is being reviewed on an ongoing basis by other Quality Assurance managers throughout the state. Life skills assessment and case planning practice has been found to be of good quality in these programs as well. The Chafee Independent Living Program Manager has consulted with the Quality Assurance Program Manager with respect to expectations for independent living assessment and independent living case planning in our treatment foster care agency homes. The Chafee Independent Living Program Manager will be presenting information regarding life skills assessment and independent living case planning to a unit meeting of the Quality Assurance Program Specialists before the end of 2003 to make sure that what is being reviewed is in line with expectations.

The use of the CBA system has brought a level of consistency to independent living life skills assessment, independent living case planning, and service provision practice to the foster care provider network. Because our older youth in care often move from one placement to another, this has enabled them to continue to work on identified life skills goals in their new placement using the same systemic model covering the same core life skills needs areas. It avoids the

frustration of feeling like they are repeating the same life skills instruction when they move to a new placement.

A number of treatment foster care agencies and group and residential care agencies have continued to expand their program services to include "congregate" and "scattered site" apartment program services for youth in care between the age of 17 and up to the age of 21. Over the past year to two years, another two or three programs of this type have been established in different areas of the state. The Independent Living Program Manager has been involved in ongoing discussions over the past two years with various programs throughout the state regarding the expansion of their programs to include this particular type of placement option for older youth in care. The Commissioner of the Department of Human Services has had staff from his office working on the development of programs for youth in care in Maine who have had to be placed in out of state residential care facilities for lack of a program in Maine. These programs are geared to assisting youth who have mental health diagnoses and behavior management issues. Congregate living and scattered site apartment programs now exist in the major cities of the state and in some of the more rural areas of the state as well.

Our Chafee Independent Living Program Life Skills Educators continued to provide some consultation and assistance to foster care and group care providers during the past year and a half. The Life Skills Educator's role in this type of situation is mostly limited to consulting with the care provider in the development of the youth's initial life skills assessment and independent living case plan and discussion and planning of post-secondary educational and career options with the youth. The Department's Life Skills Educators have prioritized their work for those youth who are in living situations where they may be receiving minimal life skills and independent living support. Examples of these type of living arrangements are youth who are living with a relative, youth who are living with an unlicensed provider, youth who are living in an apartment under a landlord lease agreement, or youth who are living in another type of living arrangement other than a licensed foster home, group home, or residential care facility. There are only six Chafee Life Skills Educators to serve the needs of our older youth in care in Maine. We feel that it was very important to expect our treatment foster care and group and residential care providers to be providing quality life skills and independent living preparation work with older youth under their care. In this way, we are able to adequately cover the life skills and independent living preparation needs of the entire population of our older youth in care in Maine.

Each Life Skills Educator is assigned to specific Department district offices statewide and works directly with each office's Children's Services casework and supervisory staff in their respective offices. Referrals to Life Skills Educators are received directly from each district's Children's Services caseworkers who consult with the Life Skills Educator with regard to the life skills and independent living preparations needs for the youth. This has proven to be the most effective way to maintain direct communication and consultation between the Life Skills Educators and their district office caseworker and supervisory staff. This also ensures that the appropriate independent living preparation services are being provided to the youth who are referred for

services. Our Life Skills Educators are also very well connected with a broad range of resources and programs in the community to which they refer many of their youth for specific services. They are particularly adept at helping our youth make meaningful connections in the community.

Overall, our Chafee Independent Living Program continues to provide services primarily through the six specialized Life Skills Educators and a contract with the University of Southern Maine's Muskie School. The contract with the USM Muskie School operates and oversees the Community Mentoring program for older youth in care in southern Maine, coordinates and oversees the nationally recognized activities of our Youth Leadership Advisory Team, provides older youth in care with paid positions within the Department offices in the southern part of the state and at the University of Southern Maine, and provides staffing to assist with planning and conducting the annual Teen Conference.

As recommended by Region I Administration for Children and Families Program Specialists, we have made the Chafee 2001-2004 Application and State Plan available on our Bureau of Child and Family Services website under "Independent Living." A member of our Youth Leadership Advisory Team did the work on the on the Independent Living web page on the site. There are a number of other documents on the Independent Living web page as well. There have been ongoing revisions made to the Bureau's website in addition to the Independent Living section of the site. To access the Independent Living web page go to www.state.me.us and under "Government" select "Department of Human Services." From that point select "Bureau of Child and Family Services." Under that page you will find a selection for "Independent Living."

1. DESCRIPTION OF ACTIVITIES CONDUCTED AND SERVICES PROVIDED

Training and Independent Living Program Service Provision Education and Awareness:

As required by the Chafee Foster Care Independent Act, we have made quality training on various independent living topics available to our foster care and group and residential care providers through our state's Child Welfare Training Institute. These trainings were selected after receiving input from foster parents, group care providers, and other individuals who work with older youth in care. One of our Life Skills Educators is a member of our Child Welfare Training Institute's training advisory committee. Training on independent living topics became available in Fall 2001. Training topics have included: "Creating Personal Profiles: Coaching and Teaching Life Skills to Teens in the Foster Care System," "Supporting Youth in Care: Assisting Them in Achieving Their Educational Aspirations and Goals," "Teaching Life Skills for Developmentally Delayed Youth," "A Youth Development Approach to Working with Youth in Foster Care and the Maine Foster Care Youth Leadership Advisory Team," "Promising Practices: How Foster Families Can Best Prepare Youth for Life After Foster Care," and "Developing Career Pathways and Job Readiness Skills for Youth in Care." Members of our Youth Leadership Advisory Team have been co-trainers for some of these trainings such as a

new workshop for child welfare staff and care providers entitled "Working with Gay, Lesbian, Bisexual, Trans-gendered and Questioning Youth."

More specific guidance on conducting quality life skills assessments and developing independent living case plans was provided to our Department's foster care district management and caseworker supervisory staff beginning in November of 2000. This has been an ongoing process since November 2000. Our district's casework supervisors had requested specific guidance for their casework staff with regard to conducting life skills assessments and improving independent living case plans for older youth in care. This request had arisen as a result of recognizing that there were some older youth in care who were not living in a contracted treatment foster care home, or group or residential home who might need some additional support with respect to their life skills and independent living preparation needs. A simple life skills assessment and independent living case plan format was developed with the assistance of three of our Life Skills Educators that includes the same basic "core life skills" needs areas as the Competency Based Assessment system. Our goal was to have a simple, "user friendly" tool available to our adolescent casework staff that was compatible with what our contracted agency programs were using. We believe that we have met this goal using this easy to use format.

Another major training effort that began in the Fall of 2000 was the University of Maine's Muskie School's 3 year grant to develop an adolescent casework competencies based curriculum for caseworkers who work with adolescents. Maine and Connecticut have been identified as primary pilot sites for this project. We are currently in the third year of this grant project. Foster care caseworkers have received training on the casework competencies and "train the trainer" teams that include both adolescent casework staff and older youth in care have been identified. We are using a youth development approach in that we are involving older youth in care in both the design and delivery of the training on the adolescent casework competencies. Youth received training with respect to delivery of the curriculum in August of 2002. Trainings are scheduled at locations in different areas of the state for the spring and summer of 2003. The training is entitled, "Empowering Practices for Working with Youth in Transition from Foster Care." We expect that this curriculum will improve casework practice with our older youth in care and lead to improved transition outcomes.

Progress Made: Chafee Act Provisions With Respect to the Native Americans in Maine:

All three tribal groups and the two bands in Maine submitted proposals for provision of life skills services for their youth during the summer of 2002 and all were approved. Contracts were developed with each tribe and band. Each tribal and band chief, or leader signed contracts beginning on October 1, 2002. Chafee start-up funds of $5,000 per each tribe and band were disbursed. Each contract stipulated that both fiscal and program reports are to be submitted to the Independent Living Program Manager on yearly basis. We are now in the process of gathering the reports and making a collaborative decision with the tribes and bands with respect to the next allotment of Chafee funds. The collective group of the tribes and bands in Maine is

referred to as the Wabanaki Coalition. There are some funds remaining from the first contracts that will be spent down by the Wabanaki Coalition by conducting a joint independent living, life skills event for their youth before the end of the summer of 2003. We anticipate the signing of renewal contracts with each tribe and band beginning in October 1, 2003. It should be noted that the tribes and bands have defined their independent living services population as being youth between the ages of 14 and 21. These are all youth who are under tribal, or band care.

Development of Independent Living Apartment Programs and Collaborative Efforts with Federal and State Agencies:

During the past three years, some agencies have developed new congregate, or scattered site apartment programs. One agency in Maine continued to operate a "scattered site" apartment living program. Another program opened in the fall of 2002 to serve older males between the ages of 17 and 21 who were being discharged from residential treatment programs both in and out of state. Scattered site apartment living sites have been in operation and are located in Waterville, Portland, Rumford, and Lewiston, Maine. Orientation to the program can occur on site so that the youth does not have to leave their school program, or employment situation to become oriented to the program. Youth in care who are living in these apartments are doing very well and very pleased that this living arrangement is available. Youth in these apartments gradually assume more financial responsibility for their living costs and have the option of remaining in the apartment after the age of 21 if they are able to assume the total costs of the apartment. Other new congregate apartment living, or independent living group care programs have been opened within the past two years. Two are located in the northern part of the state and serve older young women in care. Another new program for young women is located in the Saco, Maine area. There are two other new programs serving both young men and women in care located in the greater Portland, Maine area. And finally, there are two new programs in the central part of the state serving the needs of older young men and women in care who have significant mental health needs. There has been considerable growth in the development of programs for older youth in care that focus on independent living preparation and learning life skills. Service providers recognize that this is an important form of service provision for older youth in care.

We feel that some of our older youth in care need to experience "apartment living" through a somewhat structured program with appropriate guidance and support available if needed. In our negotiations with agencies planning to operate apartment living programs, we included the expectation that the youth gradually assume more financial responsibility for their rent and other living expenses. This expectation is built into the per diem rate cost calculations.

We are working more closely with the staff of the Department's Training Resource Center to assist older youth in care with choosing a career path. Our Life Skills workers have been working with the staff in the state's Career Centers during the past few years to refer youth that they are working with for services. Career Centers now house the state's Vocational

Rehabilitation services program that our older youth in care access as well. The Career Centers are now structured as "one stop shopping centers" which has made accessing services more convenient.

An initiative that has representation from state's DOL Career Centers is the partnership collaboration spearheaded by United Parcel Service and Casey Family Services in Maine called the "Maine School to Career Partnership." This is a broad based collaboration that has been in place for nearly two years designed to link older youth in care with job opportunities and help them with career path planning at UPS facilities in South Portland and Lewiston and at five Home Depot sites in cities in southern and central Maine. Maine is one of the UPS sites for a project of this type as is Connecticut and the city of Baltimore in Maryland. Maine's model is what is termed a "rural model." We have youth in care employees located at two UPS sites in Maine, at two or three Home Depot sites, and at offices under the University of Southern Maine.

A very recent initiative that is coming to Maine is the Jim Casey Youth Opportunities Initiative. (JCYOI) A planning grant is being developed by the USM Muskie School and an Advisory Board is being created for this initiative. Members of Maine's Youth Leadership Advisory Team will be part of the board. Maine was selected due to having a strong youth leadership program and for being the only rural model site participating in the initiative. This initiative will allow for older youth in care to develop a matched savings account and linkages with community businesses and programs to develop what are called "door openers." We expect that JCYOI will be in operation before the end of 2003.

Housing Support for Older Youth in Care and Quality Assurance:

With respect to the Chafee Act, the Maine Chafee Independent Living Program has set aside up to 5% of it's annual Chafee funding allocation for use for apartment security deposits, apartment rent, dormitory room and board, and other apartment living expenses for those youth who have reached the age of 18 and remain in the voluntary care of the Department up to the age of 21. We have had minimal need to use Chafee funds for housing support for our older youth in care because we support the room and board costs of older youth in care between age 18 and up to age 21 using our Bureau's budgeted state funds. Maine has been providing this kind of support for many years for it's older youth who continue in voluntary care. The point that housing may become an issue for some of our older youth in care is after the age of 21 when both state and federal funding support cease. About a year ago, a new housing program serving young adults between the ages of 18 and 24 became available in the greater Portland and Bangor areas. This housing program is administered by the Maine State Housing Authority and is called RAC+. Some of our older youth in care have been referred to this new program for housing and services.

Our Department's Life Skills Educators are particularly adept at linking older youth in care with housing support programs offered by federal, state, and non-profit agency programs as well as working directly with local landlords to secure and apartment for some older youth in care who

are between ages 18 and up to the age of 21. We are careful not to create financial hardship, or stress for the youth. However, we do expect that our older youth in care who are living in an apartment gradually assume more of the financial responsibility for their living costs. Over the past three years, more youth between the ages of 18 and up to the age of 21 are living in their own apartment arrangement with a private landlord. More than 60 older youth continuing in care in Maine are currently living in an apartment separate of any agency program. The youth's Children's Services worker, or Life Skills Educator guides the youth with the process of finding the apartment and helps the youth negotiate a per diem payment rate with the landlord. Most youth in apartments are paying at least a portion of their own rent out of their employment earnings. In most cases, the Department pays half of the monthly rent, at least initially. The funds used to support these apartment living arrangements are state funds that are part of the Department's Bureau of Child and Family Services budget. This type of living arrangement is far more cost effective than a placement under an agency program's per diem rate and, more importantly, it allows the older youth to experience the most realistic community living arrangement possible while remaining in voluntary care. Of course, not every older youth in care is ready to manage this kind of living arrangement. We recognize that we need a variety of apartment living program living arrangements available to meet the needs of all our older youth who are continuing in care after the age of 18.

The Department continues to provide funding support for older youth in care, between the ages of 18 and up to the age of 21, who are living in apartments or other living arrangements under the Department's voluntary extended care agreement policy (V9). In most cases, state child welfare funds are being used to support the youth's placement because these youth are no longer eligible for Title IV-E reimbursement. We remain committed to continuing to provide financial support for youth between the ages of 18 and up to the age of 21 to prevent our youth from leaving care and being in a "homeless," or "transient" living situation. The Chafee program's provision that allows for program funds to be expended for "room and board" expenses for older youth in care has been used to assist older youth in care with their living costs when other funding support hasn't been available. Because of the systemic supports outlined above, we've found that we rarely have needed to use Chafee funds for room and board costs.

During FFY-2002 and continuing into FFY-2003, we utilized one specialized Department Quality Assurance staff person to provide program assistance for the Independent Living Program. This staff person has been conducting on-site reviews of both contracted and non-contracted group and residential care facilities serving older youth in care. He has evaluated the quality and content of life skills assessments, independent living case plans, and the life skills instruction provided for older youth in care residing in these programs. Each group and residential program receives specific written feedback with respect to the quality and content of their provision of independent living preparation services. The role of the Quality Assurance staff person also includes support to other Independent Living Program initiatives such as activities sponsored by the Youth Leadership Advisory Team.

Life Skills Educator Services and Youth Leadership Development Activities:

During FFY-2002 and into FFY-2003, the Department's six specialized Life Skills Educators continued to work in a focused and efficient manner. They are a highly competent group of individuals with a great deal of experience delivering comprehensive independent living program services to the older youth in care that they work with. These Life Skills Educators are particularly effective in developing trusting relationships with the youth and help them make post-secondary education and career path plans that fit their aspirations and abilities. The positive relationships with the youth have given our older youth in care hope for a productive and meaningful future once they leave Departmental care. This is what our youth have repeatedly told us is helping to make a significant difference for them as they make their plans for their future. They say that we treat them with respect and as an "individual" as one older youth in care told us. Our Life Skills Educator's years of experience working with older youth in care ranges from 7+ years to more than 14 years. Our Life Skills Educators conduct group life skills training sessions, whenever possible, to assist adolescents with learning basic life skills, to provide information about topics such as opportunities for higher education, and to talk about the benefits of remaining in the care of the Department after age 18. However, most of the work that the Life Skills Educators do is directly with the individual youth with respect to their individual life skills goals and needs. During the past year and a half, our older youth in care continued to receive group life skills instruction from contracted foster care, group care, and residential care programs. When appropriate, a Life Skills Educator will consult with one of these care providers with respect to the independent living case planning needs for an individual youth. However, the primary daily life skills and independent living case plan work is done by the agency care provider staff and foster parents.

Our Life Skills Educators continued to provide a great deal of assistance and advocacy for older youth in care between the ages of 18 and up to the age of 21. Services provided included direct service support, advocacy, referral to community programs, employment skills training and support, assistance with finding housing, and referrals to mental health and substance abuse service support. Referrals to employment training and support programs, both public and private were made for a significant number of our older youth in care to help them with job readiness and job maintenance skills that included efforts to help the youth find a "career or job skills track" to pursue. Many youth who were referred for these services have special employment support needs and many were referred to other state programs such as vocational rehabilitation services and other supported employment programs operated under the Department of Labor.

During the past year, a number of older youth in care were referred to the Department of Behavioral and Developmental Services prior to the age of 18 so that they would receive adult services offered by the Department after the age of 18. These services included permanent housing support, mental health services, employment support services, social support services, and any other services that were required. Our Life Skills Educators were often directly involved with the transition planning for a significant number of youth with these special needs. The

Department of Human Services and Department of Behavioral and Developmental Services have been working on improving the process of effecting a more timely and smoother transition of youth with mental challenges and youth with significant mental health diagnoses from the foster care system to the DBDS adult service system. The Independent Living Program Manager worked with our district management staff to develop a written protocol to govern the transition process between the two Departments for youth who will qualify for adult services. This protocol has been signed by management in both Departments and is now in place.

Our Life Skills Educators and Children's Services caseworkers also continued to assist youth who were reaching the age of 18 with reapplication for medical coverage as adults. These young adults apply for continued medical coverage after age 18 under the state's Medical Assistance Program. The Commissioner of the Department of Human Services consulted with the Director of the state's Medicaid Bureau with regard to the option of expanding Medicaid coverage for youth between age 18 and up to age 21 as described under the Chafee Act. The decision was made to continue the current medical coverage program. Most of our older youth who were in care, or continued in care after age 18, qualify for continued medical coverage under the federally established poverty income guidelines used by the Medicaid Bureau. The few young adults who have not qualified for continued coverage were working full time and did not qualify for coverage based on income guidelines. It should be noted that there seems to be more of an issue of medical coverage for those youth who have reached the age of 21 and lose their medical coverage at that point. However, a new medical coverage program was instituted in the fall of 2002 for low-income individuals that our former youth in care over the age of 21 can apply and be eligible for.

During FFY-2002 and continuing into FFY-2003, each Life Skills Educator was responsible for, and continued to work with, a regional Youth Leadership Advisory Team (YLAT) of older youth in care. Each group participated in planned leadership activities and had meetings on a regular basis. Several of Maine's Youth Leadership Advisory Team members have presented workshops at both in state and out of state conferences during the past year and a half. Maine's Youth Leadership Advisory Team is locally and nationally recognized as being one of the most active and effective youth boards in the country. We have received calls from a number of other states that are seeking to establish their own youth leadership boards and request information about how we operate and manage our youth leadership team. The Maine State Legislature recently established a Legislative Youth Advisory Board to advise them with regard to any issues involving children and young adults. This may well be the first of board of its kind in the nation. One of our YLAT youth leaders is a member of this board. Another one of youth leaders is on the Child Welfare League of America's Youth Advisory Board as well. The YLAT website: www.ylat.org has been revised and updated during the past year and a half. YLAT members have been instrumental is helping develop specific Bureau of Child and Family Services policies. The most recent policies that they have helped to draft and put into place are policies with respect to sibling placement and contracts and driver's education, permit, and license policy

Outdoor, adventure activities continued to be available for older youth in care during FFY-2002 and continuing into FFY-2003. The trips varied in length from one day to up to three or four days. Life Skills Educators co-led trips regionally using a number of different service providers. Trips were planned in a cost-effective manner that allowed for more youth to participate in the trips. Day trips included skiing and snowboarding (including lessons), deep-sea fishing, and learning how to golf! The longer trips included winter dog sledding, cross country skiing, mountain biking, kayaking, hiking, technical rock climbing, and canoe trips. Structured group activities occur during the longer trips. Examples include completing career exploratory inventories and work project components that the youth are paid stipends for. Maine offers an excellent natural environment for these trips. The trips have proven to be a particularly effective way to enhance our relationships with the youth, to seriously discuss their feelings about their future, and to talk about their educational and career plans as well as any other problems that they might be struggling with. We have found that our older youth tend to open up and talk about their fears and feelings about the prospect of leaving care and what might happen to them once they leave care. Our Life Skills Educators have a great deal of experience with planning and conducting these trips. Life Skills work with youth who participated in trips during the past year and a half has continued after the trips with most all of the youth involved. Some of the youth who participated in a trip were working with a Life Skills Educator prior to participating in an outdoor adventure trip.

On February 20 and 21, 2002, Maine's fifth annual Youth Leadership Advisory Team Summit was conducted at the Samoset Resort in Rockport, Maine. 33 youth leaders and 15 staff persons attended the Summit. Youth who attended the Summit worked on the development of an activity and coloring book for younger children coming into care that addresses issues, concerns, and fears that young children have about coming into and being in care. The theme of this Youth Summit was "How Younger Children in Care Can Have a Voice." The activity, coloring, story book was modeled on the handbook for our older youth in care, "Answers: A Handbook by Youth in Care for Youth in Care." The handbook for younger children in care had been something that our youth leaders had been talking about for the past three years. We are now at a point where we're nearly ready to put the children's version of the handbook into print. . Themes were identified and neat games and activities for young children were selected for the book. A professional artist has contributed the artwork for the children's handbook and has done a superb job with it! We expect that the children's handbook will be available before the end of the year 2003. Youth also planned for the 12th annual Teen Conference and had a discussion about the current issues in the foster care program. A draft of the policy with respect to siblings in care was reviewed and revised by the youth leaders. The new sibling policy subsequently went into effect shortly after the Summit.

On February 19 and 20, 2003, Maine's 6th annual Youth Leadership Summit was conducted at the Samoset Resort in Rockport, Maine. 22 youth leaders and 14 staff persons attended the Summit. The Department of Human Services Commissioner and his wife attended this Summit and stayed overnight. This would be the last Youth Summit that the Commissioner would attend

as he was moving on to another position in the state of Iowa. The Commissioner had attended all 6 Youth Summits and every Teen Conference while he was the Commissioner. Our youth leaders wanted to present him with a special award recognizing his care and commitment to them over the years. He was presented with the award by one of our youth leaders who gave a brief speech concluding with the statement that "now you know what it feels like to "age out" of the system!" The Commissioner greatly appreciated the humor of this analogy and was visibly moved when he received his plaque. During the Summit, the youth leaders were provided with training on public speaking and effectively conveying your message to your audience. The youth leaders did a superb job with preparing their messages of concern with respect to the child welfare system. The trainer was amazed at how well the youth worked together on selected issues in their teams with nearly no direct adult involvement other than to answer any questions they had about the process. Before dinner that evening, they were able to present their messages to the Maine Attorney General, the Assistant Attorney General for Child Protective Services, the Commissioner, and the Bureau of Child and Family Services Deputy Director. Their presentation made a very strong impression on these individuals who all stayed for dinner and chatted with youth leaders. Shortly after the Youth Summit, the Deputy Director of the Bureau has arranged for members of the Youth Leadership Advisory Team to meet with the Bureau's eight statewide district management staff twice a year on an ongoing basis. This is the first time that this will have happened in Maine! Bureau management has recognized and has been supportive of having this kind of direct feedback loop for our district management staff. The first series of meetings has been scheduled for the late spring through early fall of 2003. The second morning of the Youth Summit was training with respect to present an effective message through the media as well as some preliminary planning for the 13th annual Teen Conference.

Some of our current and former youth leaders have continued to be part of an Advisory Committee working over the past two years to make plans for a summer camp for siblings in care. A great deal of work and time by both youth leaders and adults has gone into this worthy project. Representatives from the foster parent support organization and some agency foster care service providers have worked with YLAT members to help make the dream of a summer camp for siblings in care in Maine a reality. A camp has been selected located in western Maine and a series of statewide walkathon fundraiser events are in the process of being organized for the fall of 2003. A camp in western Maine has been selected with plans to have the sibling camp for a week in the late summer of 2004.

As part of the work being done on the siblings in care issue, a video production was produced by an organization in Portland, Maine called "YES! To Youth." This is a grass roots organization that produces programs for our local CBS television affiliate using youth from the community as researchers and moderators. YES! To Youth worked with some of our youth leaders, Bureau employees, and others to produce an hour- long show for WGME TV 13 (CBS) on the issue of siblings in care. This program aired in late June 2002. Videotapes of this show were made for use as a training tool for child welfare staff and foster care providers. The production was also web-streamed and connected to the YLAT website so it can viewed over the inter-net.

The 12th Annual Teen Conference planned by our youth leaders was held at Colby College in Waterville, Maine on June 20, 2002. The theme was centered on raising the level of aspirations for older youth in care. The conference was entitled, "Our Future's So Bright, We Gotta Wear Shades!" The keynote speaker was a former foster care youth from Massachussetts who overcame great obstacles to achieve major success both in his personal life and career. Stephen J. Pemberton graduated from Boston College and is now the Vice President of Strategy and Development for Monster.com. He delivered a very inspiring keynote address to the conference attendees. The Brad Levesque Memorial Scholarship Award was given to a young woman in care who has been one of our most dedicated youth leaders. She was the editor of the Independent Living newsletter, "The Quarterly Advocate," and has presented at numerous workshops at conferences. She is currently completing her third year as a student at the University of Southern Maine and attended a college semester abroad in Mexico in the fall of 2002. The Friend of Youth in Care Award was given to a woman in southern Maine who was in care as a child and who has given much of herself to directly helping older youth in care make a healthy and happy transition from care. She manages a congregate independent living apartment program for youth in care in Saco, Maine and is a foster parent of teens as well. For this Teen Conference, our youth leaders decided to create a separate award for a "Friend of Youth in Care" from the foster care system. The person receiving the award from the foster care system at this Teen Conference was the Independent Living Program Manager who was deeply touched by the youth's regard and recognition. This award will be given at succeeding conferences to a person from the child welfare system that the youth feel has been a "friend to youth in care." There were a number of important workshops on various topics available in the morning of the conference and lots of fun activities for the afternoon workshops. The 12th Annual Teen Conference was rated as perhaps being the best ever with the highest number of attendees.

Planning for the 13th annual Teen Conference is well under way. The conference will be conducted at Colby College in Waterville, Maine on June 26, 2003, a favorite site for the youth. The theme for this upcoming Teen Conference is "How You Can Have a Voice as an Individual and Together." Our youth leaders strongly felt that they wanted the previous year's Teen Conference keynote speaker, Steve Pemberton, to return. This has been arranged. Once again, a number of excellent informational and fun workshops will be available. We are in the process of selecting the youth who will receive the Brad Levesque Memorial Award and Scholarship as well as the two individuals who will receive the annual "Friend of Youth in Care" awards. We always have a great day together at the Teen Conference and expect that this year's Teen Conference a lot of fun as well.

The southern Maine Community Mentoring program continued to operate effectively. More than 30 older youth in care are matched with a mentor. There had been some difficulty with recruitment of male mentors. However, with outreach efforts some male mentors have now been recruited, trained, and matched with youth. An interesting new component in the mentoring program is the "Education is for Everyone" workshops designed to provide information about

accessing higher education. Youth, their mentors, and some foster parents attended these workshops. Ongoing mentor and youth support meetings were held over the past year and a half and several fun community events were held. Recruitment efforts and public education for the need for mentors continued as well.

The Chafee Foster Care Independence Program continued to provide varying levels of financial support for more than 85 older youth, per year, in care in a post-secondary education program for the 2001-2002 and 2002-2003 school years. Chafee funds were used to supplement other forms of non-loan financial support under federal and local student financial aid. The state's tuition waiver law went into effect for the school year beginning in September 2000. For the 2002-2003 school year, more than 25 youth applied for the tuition waiver. Since the waiver has a cap of no more than 25 freshman students per academic year being eligible for the waiver, two or three students were not able to qualify for the waiver. Fortunately, we were able to help these students with some Chafee funds. In February 2003, a bill to amend the tuition waiver to increase the cap to 30 was presented to the legislature and was enacted to go into effect in the fall of 2003. It certainly appears that the availability of the tuition waiver has led to an increase in the numbers of older youth in care participating in a post-secondary educational program. We had over 90 older youth in care in a post-secondary education program at the start of the 2001-2002 school year and over 100 at the start of the 2002-2003 school year. There have been a number of youth each year that drop out, or fail out of their post-secondary education program. We do not necessarily view something like this as being failure. We are pleased that these youth at least had the experience of seeing what college was all about. They may decide to return to school at a later date. As of the end of May 2003, 87 older youth in care are still participating in a post-secondary education program. Since the 2000-2001 school year, the numbers of older youth in care in Maine participating in a post-secondary education program have doubled.

We have found that youth in four-year undergraduate degree programs become 21 years of age usually during their junior year of college. This has left them without supplemental Chafee funding support for their last year or so of their undergraduate program. However, our youth who do become college juniors do complete their college undergraduate degree despite losing the supplemental Chafee funding support. They do continue to qualify for federal student grant and loan assistance and if they are attending a tuition waiver school, still qualify for the tuition waiver. Most of these youth have a part-time job and are able to pay some funds toward their own educational costs. For example, we had three young women over age 21 who had been in care that graduated in May 2003 with four-year undergraduate degrees. All three have employment, their own transportation, and a stable living arrangement.

Program Improvement and Support

As mentioned earlier in this report, there continued to a Quality Assurance staff person who was assigned to focus on the quality of services provided for youth who were eligible for Independent Living Program services. The Quality Assurance staff person has been conducting on-site

reviews of group and residential care programs providing independent living preparation services to look at the quality of independent living and life skills services available for youth in these programs and to offer any needed technical assistance. This staff person's duties include program and technical support for the Independent Living Program's major program initiatives such as Youth Leadership Development activities, maintaining database information for selected groups of older youth in care such as youth who will require adult case management services, program support for the Department's district Life Skills Educator's local projects, and any other program initiatives that develop over the next few years. This Quality Assurance staff person is supervised directly, and assigned tasks by, the Independent Living Program Manager.

About a year ago, two of our Chafee Life Skills workers revised and life skills assessment and independent living case plan form for Adolescent caseworkers and non-contracted care providers to use with youth. The life skills assessment and independent living case plan form is being used by Adolescent caseworkers and non-contracted care providers. It covers the same core life skills areas that the Competency Based Assessment system does for our contracted treatment foster care and group and residential care program providers. We feel that we are now consistent with the life skills assessment and independent living case planning format for all older youth in care in Maine.

During the two years, much progress has been made in the Independent Living Program's ability to track and evaluate outcomes for older youth in care as they transition out of care. The automation of the Child Welfare system has been of great assistance in gathering the necessary information. This information is transferred to a specialized Independent Living Program database used to tracking outcomes in areas of educational status, employment status, living arrangement, and issues affecting the youth's educational and employment status. During FFY-2001, 2002, and into 2003, we have been refining the database to reflect the collection of information that should enable us to track the outcome measurements being developed under the Chafee Foster Care Independence Program. Further refinements to the state's automated child welfare system may need to be made to assist us with gathering the Chafee outcome data as reflected in the final version of the Chafee outcome measurement instruments that are expected to be used by the fall of 2004.

A specific protocol for transfer of our older youth in care who have significant mental health diagnoses and those with mental retardation to the adult services of the Department of Behavioral and Developmental Services and the Adult Protective Services of the Department of Human Services was finalized in the fall of 2002. This has been an area of challenge for quite some time. The Chafee Independent Living Program Manager wrote the draft protocol and worked with Bureau of Child and Family Services management and Department of Behavioral and Developmental Services Management to finalize the protocol and begin implementation throughout the state. The new protocol is expected to improve the timeliness and effectiveness of transition for our older youth in care with special needs to the appropriate adult service programs overseen by the Department of Behavioral and Developmental Services. District

management teams from both Departments are meeting quarterly to discuss specific transition cases.

2. INCORPORATION OF TITLE IV-E INDEPENDENT LIVING PROGRAMS INTO INTO A COMPREHENSIVE PROGRAM

Title IV-E Chafee Foster Care Independence Program activities in Maine have continued to be an integral part of a continuum of independent living program services which include informal learning, formal instruction, "scattered site" apartment living, and some aftercare support.

Activities and services for older youth in care to acquire necessary life skills continues to be provided by specialized Department of Human Service's staff called Life Skills Educators, by agencies with contracts with the Department, and by therapeutic and non-therapeutic foster homes, group homes, transitional independent living programs, and other programs providing services to older youth in care. A wider range of independent living program service providers are now available to meet the needs of our older youth continuing in voluntary care who are between the ages of 18 and 21.

Aftercare services are primarily available through the Department's Life Skills Educators who are able to provide services for youth up to the age of 21 who were discharged from care after their 18th birthday, directly, through referral to community agencies, or both. The Department's Extended Care Agreement (V9) for youth who have aged out of care at age 18, revised two years ago has enabled more older youth in care to take advantage of remaining in voluntary care up to the age of 21 and make progress on their transition goals. The revision of the Extended Care Agreement policy has resulted in all older youth in care having a fair opportunity to take advantage of the continued support of the Department, both financial and otherwise, up to the age of 21. An important feature of the revised policy is the opportunity for a youth to request to return to voluntary care at any point between the age of 18 and up to the age of 21 if they have chosen to leave care at any point during those ages. These youth are expected to have a plan with regard to their education and employment goals and be willing to work toward those goals. The revised policy has enabled between five and seven young adults a year to return to care and resume working on their independent living goals. As was mentioned earlier, youth in voluntary care between the age of 18 and up to age 21 receive the state funded support of the Department for their room and board needs. Many of these youth are paying a portion of their apartment rent and other living costs. More than 60 youth in care who are under the voluntary extended care agreement are living in an apartment partially, or fully funded by the Department. Most youth living in apartments share apartment living costs with a roommate.

We have also continued to work toward the goal of filling the gaps in the continuum of Independent Living Program services in the following two areas: 1. Encouraging foster parents and other service providers to begin life skills work with youth at an earlier age, so that when they reach age 16 our Life Skills staff will be able to focus on more specific planning around

education and employment issues. Many foster parents and group care providers are already working both formally and informally with youth younger than age 16 on learning basic life skills. If a youth younger than age 16 is living in a placement under a contracted provider agency, we have found in most cases that this type of life skills work is taking place. Our Quality Assurance Program Specialist encourages our group and residential care providers to provide life skills teaching and independent living case planning services to youth under the age of 16. Many service providers are now doing this. 2. Finding ways, including mentoring, for someone to be available for our older youth even after they leave care. The Community Mentoring Program operated under a Chafee funded contract with the University of Southern Maine's Muskie School continues to be successful. A number of our group and residential care services providers now have their own mentoring programs for youth in care living in their facilities.

3. PURPOSES FOR WHICH FUNDS WERE SPENT

During FFY-2002 and a portion of FFY-2003, Chafee Foster Care Independence Program funds were expended to:

- Increase and enhance educational achievement, vocational and employment skills, and the academic knowledge of older youth in foster care. (Supplemental post-secondary education financial support funded out of Chafee)
- Improve and enhance the skills of older youth in care related to employment preparation, employment maintenance, and career planning.
- Increase the knowledge and practical functioning of older youth in care by helping them learn daily living skills.
- Expand the resources available to youth in their community as they transition out of care to living on their own.
- Increase our older youth in care's knowledge of how to access and utilize resources in their community.
- Promote open communication between older youth in care and between older youth in care and adults in the foster care system.
- Encourage and promote meaningful and productive communication between older youth in care and Department management staff. (e.g. Youth Leadership Advisory Team activities, etc)
- Expand the capacity of Departmental staff, foster parents, group care providers, and other adolescent service providers to assess the life skills strengths and needs of youth in care to enable them to acquire the skills necessary to function as young adults in the community.
- Increase the availability of, and access to, diverse resource materials by Departmental staff and foster parents for their use in assisting older youth in care to acquire life skills.

- Develop a sound basis for Departmental policy, programs, and practice related to preparing older youth in care for a productive life after they leave Departmental care. Policy is now in place that promotes increased opportunities for older youth in care to successfully transition out of care.

4. OUTCOMES

Some data is now available to begin to assess the extent to which Independent Living Program services have assisted older youth in care to transition successfully out of care. Information on the Independent Living Program's database provides outcome information, in most cases, with regard to the youth's living arrangement, educational status, and employment experience when they leave care. The database also tracks the number of years that an individual youth has been the recipient of ongoing Independent Living Program services, the extent of those services, and whether or not the youth has been receiving life skills services from an agency program as well. This database information is being maintained relative to all older youth in care who are not receiving direct services from one of our Independent Living Program's Life Skills Educators. This data has been provided earlier in this report. We have more specific information available on the educational status of youth in care who are receiving Independent Living Program services that includes, not only the grade level of the youth, but the level of their actual academic functioning. (i.e. special education needs and vocational education needs) Information is available as well for older youth in care, whether they are receiving Independent Living Program services or not, who are transitioning for continued services to the Department of Mental Health, Vocational Rehabilitation, Adult Protective, or other community based services. One limitation that currently affects the quality of the information gathered from the Maine Automated Child Welfare Information System (MACWIS) is the nature of the information recorded in the youth's record in the system. On occasion, it is difficult to determine from the automated case record, what the youth's true educational status, or special needs are. Most of the specific information about the youth educational and other needs are contained the youth's "hard copy" records. However, in most cases the information available on MACWIS is adequate, or excellent. Life Skills Educators are reporting complete and detailed information for the youth that they are working with. Having access to this information has made it possible for us to hopefully be in a better position to gather meaningful data with regard to several outcome areas that are identified under the Chafee Program's outcome measurement and tracking system.

5. ADDITIONAL INFORMATION

A. Characteristics of Eligible and Participant Youth

Eligible Youth

On October 1, 2001 there were 969 youth in Departmental care who were, or would become, eligible for Independent Living Program services for some portion of Federal Fiscal Year 2002.

This number includes youth continuing in voluntary care after the age of 18 and up to the age of 21. An additional 68 youth between the ages of 16 and 18 entered Departmental custody after that date and were also eligible for services during FFY-2002. Of the total of 1,037 program eligible youth in care, 327 (31.54%) were determined to be Title IV-E eligible. Most of the remaining 710 program eligible youth were determined not to be eligible for purposes of Title IV-E reimbursement. A few youth's Title IV-E reimbursement eligibility determination was pending or was in the process of being re-determined. Nearly all youth between the age of 18 and up to the age of 21 were not IV-E eligible due to having graduated high school, or were ineligible for other reasons. Some older youth in care were determined to be ineligible for Title IV-E reimbursement due to living in an unlicensed foster care placement. However, some of these youth were moved during FFY-2002 to a licensed placement and subsequently did become eligible for IV-E reimbursement. Maine's Chafee Foster Care Independence Program provides services to both Title IV-E eligible youth and non Title IV-E eligible youth.

These numbers include all eligible youth regardless of the length of their eligibility during this time period. Of these eligible youth, 326 were discharged from the Department's care before October 1, 2002. This was 40 more youth discharged from care than for the previous year. 50 youth were discharged from care on their 18th birthday because they refused the offer of the Department's Voluntary Extended Care Agreement in order to remain in care for continued services beyond their 18th birthday. 6 youth were adopted by their foster parents prior to age 18. 12 youth were transferred to the guardianship and care of the Department of Behavioral and Developmental Services at or shortly after the age of 18. 82 youth were discharged from care to the custody of a parent and 6 were discharged to the custody of a relative before the age of 18 by judicial review court order. 170 youth were discharged from care after their 18th birthday due to deciding, at some point after age 18, not to continue with their Extended Care Agreement, successfully achieving their goals for self-sufficiency, not keeping with the terms of their agreement primarily in the area of not being in an educational program, or due to reaching the age of 21.

Of the total of 1,037 eligible youth who were in care at any point between October 1, 2001 and September 30, 2002, 553 (53%) were males and 484 (47%) were females; 967 (93%) were Caucasian, 30 (2.9%) were Native American, 20 (1.9%) were African-American, 14 (1.4%) were Hispanic, and 6 (.6%) were Asian.

The ages, as of October 1, 2001 for all youth eligible during any portion of FFY 2002 were:

AGES	FEMALE	MALE	TOTAL
Age 15	143	157	300
Age 16	127	159	286
Age 17	102	116	218
Age 18	51	71	122
Age 19	40	36	76

Age 20	21	14	35
TOTAL	484	553	1,037

As of October 1, 2001, the living arrangements for these youth were:

Foster home or other non-relative home	27.87%
Group home or residential treatment facility	34.91%
Apartment, living with peers, transitional independent living program	12.73%
Correctional facility	4.63%
Parent/s	5.41%
Relative other than parent	5.98%
Hospital	1.64%
Emergency Shelter	2.71%
College dorm	2.90%
Whereabouts Unknown	1.26%

Of those eligible at some point during FFY 2002, the length of time these youth had been in care on October 1, 2001 (or would have been had they not been discharged) was:

Less than 6 months	63	6.51%
6 months to 1 year	87	8.98%
1 to 2 years	150	15.48%
2 to 3 years	129	13.32%
3 to 4 years	110	11.36%
4 to 5 years	89	9.19%
5 to 6 years	69	7.13%
6 to 7 years	66	6.82%
7 to 8 years	48	4.96%
8 to 9 years	51	5.27%
9 to 10 years	33	3.41%
10 to 11 years	24	2.48%
11 to 12 years	17	1.76%
12 to 13 years	11	1.14%
13 to 14 years	7	.73%
14 to 15 years	6	.62%
15 to 16 years	5	.52%
16 to 17 years	2	.21%
17 to 18 years	2	.21
18 to 19 years	0	0

19 to 20 years	0	0
20 to 21 years	0	0
TOTAL	969*	100%

*68 youth between the ages of 16 and 18 entered Departmental care after October 1, 2001.

PRELIMINARY INFORMATION FOR FFY-2003 ELIGIBLE POPULATION

The information contained in the following paragraphs relates to preliminary data for the Chafee eligible population for FFY-2003 starting October 1, 2002 through May 31, 2003. A more complete analysis of the data for all of FFY-2003 will be submitted for the APSR due at the end of June 2004.

As of May 2003, adolescents ages 16 to 18 comprised 17.92% of the total population of children in the custody of the Department. This represents a decrease of .71% than in FFY-2002. There are 2,936 children in custody up to the age of 18 and 8 children in voluntary care up to the age of 18. 526 of these youth are between the ages of 16 and 18. This represents a decrease of 25 less youth in care in this age bracket than were in care in FFY-2002. This is due to the work done with the Department of Corrections to secure other options for youth involved with the correctional system short of ordering custody of the youth to the Department of Human Services. There are an additional 90 youth who are not yet 16 years of age as of the end of May 2002 who will become 16 years old before the end of September 2003.

Youth who "aged out" of foster care at age 18 and continued in care on a voluntary extended care agreement between the age of 18 and up to age 21 comprised 6.11% (191 youth) of the population; a slight decrease (.71%) from FFY-2002. The number of youth remaining under the voluntary care of the Department after the age of 18 has remained fairly consistent over the past four years.

Note: 159 youth left Department custody, or care between October 1, 2002 and the end of May 2003. 35 youth were returned to the custody of a parent or relative prior to age 18. 28 youth declined the offer of voluntary extended care with the Department. 80 youth left voluntary care between the age of 18 and up to the age of 21. 11 youth were transitioned to adult mental health, or mental retardation case management services, and 5 youth were adopted.

Participant Youth for FFY-2002

422 youth in Departmental care during FFY 2002 received direct services funded by the Chafee Foster Care Independence Program. 173 (41%) were males and 249 (59%) were females. 388 (91.95%) were Caucasian, 12 (2.85%) were African-American, 8 (1.90%) were Native American, 8 (1.90%) were Hispanic, and 6 (1.43%) were Asian. Of the 422 youth receiving Independent

Living Program services, 124 (29.39%) were determined to be Title IV-E eligible at the beginning of FFY-2002. The remaining 298 youth were either determined not to be eligible for purposes of Title IV-E reimbursement, or had eligibility determination pending.

The ages of the 422 participant youth, as of October 1, 2001 were:

AGES	TOTAL	FEMALE	MALE
Age 15	60	39	21
Age 16	91	55	36
Age 17	102	59	43
Age 18	83	43	40
Age 19	59	34	25
Age 20	27	19	8
TOTAL	422	249	173

As of October 1, 2001 the recipients of Chafee Foster Care Independence Program services were living in the following placements:

Foster home or other non-relative home	146 (35%)
Group home or residential treatment center	100 (24%)
Apartment, living with peers, transitional independent living program	96 (23%)
Parent/s	12 (3%)
Relative other than a parent	28 (6%)
Correctional facility	4 (1%)
Hospital	5 (1%)
Emergency Shelter	5 (1%)
College dorm	25 (6%)
Whereabouts Unknown	1 (1%)

With respect to the above data for FFY-2002, there was a significant increase (from 62 youth to 96 youth) in the number of youth living in an apartment, living with peers, or living in a scattered site or congregate apartment program. There was a slight increase in the number of youth living in a college dorm. There was a decrease in the number of youth living in a foster home, or other non-relative home.

As of October 1, 2002 those served under Independent Living Program funds had been in the Department's care (or would have been had they not been discharged from care) for the following lengths of time:

Less than 6 months	2	.5%
6 months to 1 year	7	1.6%

1 to 2 years	42	10%
2 to 3 years	53	12.5
3 to 4 years	48	11%
4 to 5 years	56	13%
5 to 6 years	43	10%
6 to 7 years	39	9%
7 to 8 years	35	8%
8 to 9 years	19	4.5%
9 to 10 years	26	6%
10 to 11 years	16	4%
11 to 12 years	11	2.6%
12 to 13 years	9	2%
13 to 14 years	5	1%
14 to 15 years	3	1%
15 to 16 years	2	.5%
16 to 17 years	2	.5%
17 to 18 years	2	.5%
18 to 19 years	2	.5

The majority of youth served with Chafee Foster Care Independence Program funds during FFY-2002 were students in a range of secondary, special education, un-graded, alternative education (adult education, or GED preparation, and vocational educational programs. 44% (186) of the youth served were, or became, high school graduates, had their GED, or were youth who were in a post-secondary educational program at some point during the year. More than 93 youth served were, or had been, in a post-secondary educational program during FFY-2002. There were 8 more students who were, or had been, in a post-secondary education program during FFY-2002 than there were during FFY-2001. Since the Maine foster care tuition waiver law went into effect in the fall of 2000, the numbers of older youth in care attending, or at least giving post-secondary education a try, have more than doubled. We believe that the availability of the tuition waiver has had a significant impact on the numbers of older youth in care deciding to pursue post-secondary education. 63% (264) of the youth served were employed at some point during FFY-2002, or had some previous employment experience. 158 youth served had never had any employment experience. In the total Chafee Foster Care Independence Program eligible population, 428 (41%) of the youth were employed at some point during FFY-2002, or had some previous employment experience. Nearly all of the youth were employed part-time. Some youth were employed only during the summer months, particularly if they were under age 18. Most jobs continued to be available in the central and southern parts of the state and were minimum wage jobs. Some youth experienced difficulties with maintaining responsible employment because they were unprepared for employer expectations with regard to employment, or made irresponsible decisions with regard to their employment.

One hundred and twenty seven of those receiving Independent Living Program services were discharged from the Department's care or custody at some point during FFY-2002. 99 of these youth were discharged from Departmental care after they became 18 years old. These youth had been on the Department's Voluntary Extended Care Agreement (V9). Most of these youth were discharged from care due to not keeping the terms of the V9 Agreement; mostly due to not being in an educational program, or deciding not to continue the agreement. Some of these youth successfully transitioned out of care, or became 21 years of age. 11 youth were discharged from Departmental care at age 18 because they refused to sign the V9 Agreement. 13 youth were dismissed to the custody of one of their parents prior to age 18. 4 youth were transitioned to either the adult mental health services, or mental retardation services of the Department of Behavioral and Developmental Services.

57% of the youth receiving Chafee Foster Care Independence Program services in FFY-2002 also received independent living/life skills services in FFY-2001. 26% of those youth receiving CFCIP services in FFY-2002 also received independent living/life skills services in both FFY-2000 and FFY-2001. This has enabled most of these youth to move along a continuum of services that has helped them make a successful transition out of care and into the community. Life Skills Educator activities continue to focus on working with youth around educational and career aspirations and to reengage youth who are not in school in an educational program. Provision of services to pregnant and parenting youth also remains a Life Skills Educator priority. There were 55 youth in care in the total eligible Chafee Foster Care Independence Program population who had children during FFY-2002. Of these 55 youth who had children, 9 of their children were in Departmental custody. As of September 2002, there were an additional 18 young women in care who were pregnant.

Most Chafee Foster Care Independence Program eligible youth are now receiving independent living and life skills services through their foster home program, group home program, or residential service provider. A significant number of youth who are not being served directly by a Life Skills Educator are receiving individual and group independent living and life skills education services in through their group and residential care provider, or treatment foster care home. The progress made with respect to incorporating improved independent living and life skills practice into foster care agency programs in Maine has been mentioned earlier in this report. Youth receiving program services are telling us that these services are helping them prepare for leaving care. A significant amount of progress has been made during FFY 2002 and FFY 2003 to build a system that provides comprehensive supports for youth as they plan their transition out of Departmental care. More complete information with respect to the youth served under Chafee for FFY 2003 will be provided in the APSR due at the end of June 2004.

CHILD DEATH/SERIOUS INJURY REVIEW

REPORT OF THE

MAINE CHILD DEATH &

SERIOUS INJURY REVIEW PANEL

1998 - 2001

All data analysis and writing for this report was completed by Emily M. Douglas, PhD, Staff Assistant to the Maine Child Death and Serious Injury Review Panel

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For information about this report or to request copies, please call the Maine Department of Human Services, Bureau of Child & Family Services: (207) 287-5060.

Report of the
Maine Child Death &
Serious Injury Review Panel
1998 – 2001

Case Reviews, Findings & Recommendations

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The bullets below outline some of the key aspects of this report by the Maine Child Death and Serious Injury Review Panel.

1. Between 1998-2001 the Panel reviewed 31 deaths and serious injuries. Twenty-two of these cases were child deaths; nine were serious injuries to children.

2. The most common causes of death or serious injury were head trauma or asphyxia.

3. 25% of all Maine children, who died between 1998-2001, were under the age of one.

4. The Panel outlined five key findings in the systemic response to child maltreatment:

   - Professionals and residents of Maine alike often failed to recognize signs of child abuse and neglect when they were present.

   - Child welfare workers sometimes failed to accurately identify and articulate the emotional and physical threats of harm and risks of harm in a child's home environment.

   - Some psychological evaluations that were intended to assess a person's capacity to parent his or her children were of poor quality.

   - Relying on an exclusively strength-based approach to the assessment of and service delivery to families often results in the very issues that caused or allowed the abuse and neglect to occur, go unresolved.

   - While the Panel is aware of the cultural importance of firearms in many Maine families, it is important that their presence be considered in a context of risks and benefits.

FORWARD

This report documents cases that were reviewed between 1998 and 2001 by the Maine Child Death and Serious Injury Review panel. The mission of the Panel, now in its tenth year, is to provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children in order to promote prevention, to improve present systems and to foster education of both professionals and the general public. Furthermore, the panel strives to collect facts and to provide opinion and articulate them in a fashion, which promotes change. The final mission of the Panel is to serve as a citizen review panel for the Department of Human Services as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247.

One year-old "Tammy" was upset and crying. Her new step-father was unable to console her and he became enraged. He picked her up and threw her head first to the floor. Testing later revealed that Tammy had multiple bruises, cuts and bone fractures in various stages of healing. In fact, at one time when both of Tammy's arms were broken the only way she could eat was to lower her head to her high-chair tray. Tammy's mother said that she was "just being lazy." Tammy died from the head trauma perpetrated by her step-father.

The Child Abuse and Serious Injury Review Panel follows the review protocol outlined below.

1. The Panel conducts reviews of cases of children up to age eighteen, who were suspected to have suffered fatal child abuse/neglect or to have suffered serious injury resulting from child abuse/neglect.

2. The Panel conducts comprehensive, multidisciplinary reviews of any specific case. Reviews may be initiated by the Bureau of Child and Family Services, by the Commissioner of the Department of Human Services or by any member of the multidisciplinary review panel.

3. Cases may be selected from a monthly report that includes major injuries and deaths in the preceding month, as well as a summary of deaths and major injuries from the preceding year.

4. All relevant case materials are obtained by the Department of Human Services staff and disseminated to the members of the review panel.

5. After review of all confidential material, the review panel will provide a confidential summary report of its findings and recommendations to the Commissioner of the Department of Human Services.

6. The review panel may develop, in consultation with the Commissioner of the Department of Human Services, periodic reports on child abuse fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

The Maine Child Death and Serious Injury Review Panel is comprised of representatives from many different disciplines. Its composition, which is mandated by state law, includes the following disciplines.

1. Judiciary
2. Forensic pathology
3. Forensic and community mental health
4. Pediatrics
5. Family practice
6. Nursing
7. Public health
8. Civil and criminal law
9. Law enforcement
10. Public child welfare
11. Doctoral candidates completing their clinical or field placements regularly participate in these case reviews as part of their education and training

Each member of the Panel volunteers his or her time to review extensive case records in preparation for monthly retrospective reviews.

There are several unique functions of the Panel. Most states only review child fatalities; Maine's panel reviews serious child abuse and neglect injuries, as well as child abuse and neglect fatalities, or suspicious deaths. Some states have multiple local review panels in addition to a central state-level panel. In such cases only selected cases are reviewed by the state-level team. Because the state of Maine is less populous than other such states, the full, central, state-level team reviews all cases. The centralized forensic medical examiner system and representation on panel promotes standardized forensic child death investigations and post mortem exams. The State of Maine has specialized medical examiner training for child death investigation units of law enforcement, which include Maine State Police, Bangor and Portland Police Departments. Representatives from this training sit on the Panel. The Panel is established in state statute that permits confidentiality of the Panel's work and grants the Panel the power to subpoena relevant case documentation and testimony. This latter feature allows the Panel to conduct in-depth retrospective reviews of all relevant records, supplemented by oral presentations by key, involved service providers. Finally, the Maine Child Death and Serious Injury Review Panel belongs to the consortium of Northern New England Child Fatality Review Teams.

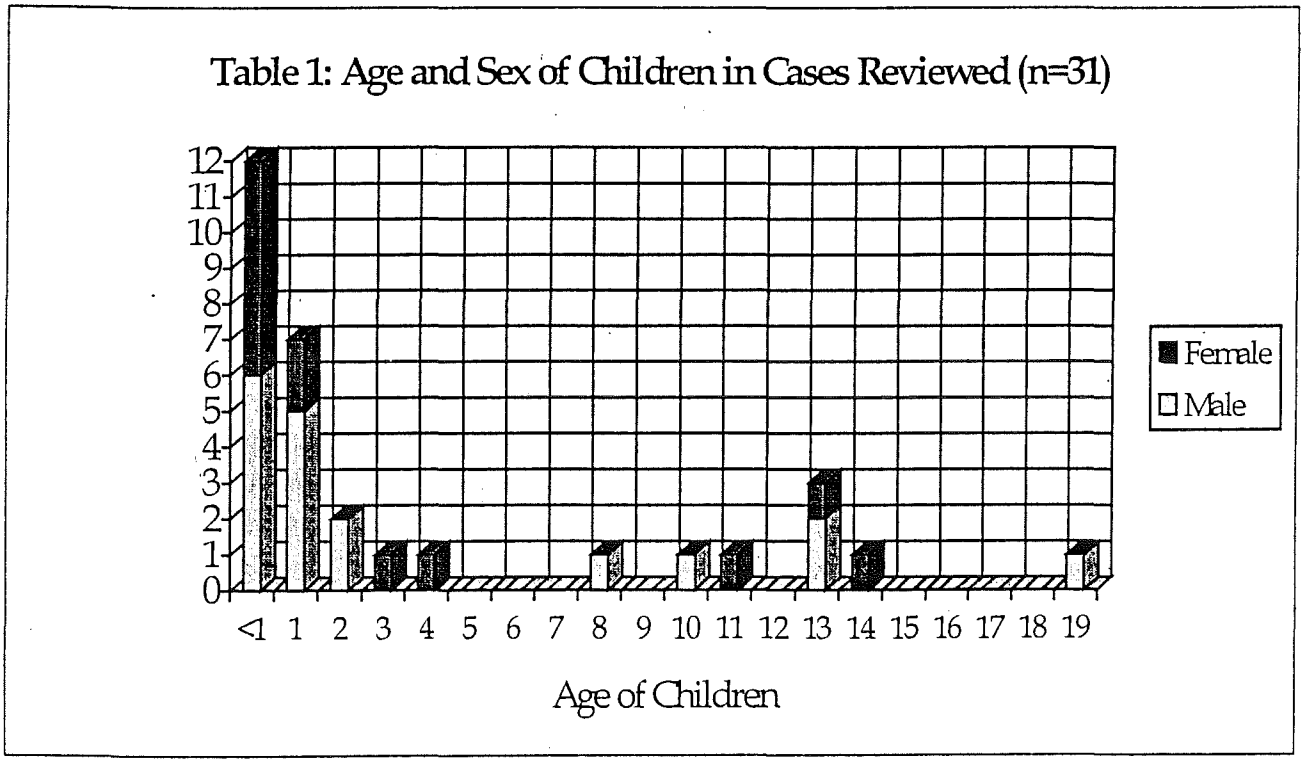
Newborn baby "Todd" was brought home to live with his mother, as his parents had recently separated. The home was not properly heated, did not have running water, the floor was littered with animal feces and his mother, who already had a history of depression and multiple suicide attempts, had pneumonia and was caring for a special-needs sibling. Four weeks later his mother put her hand over his mouth and nose and suffocated him.

CASE DEMOGRAPHICS: CASES REVIEWED BY THE MAINE CHILD DEATH AND SERIOUS INJURY REVIEW PANEL 1998-2001

Between 1998 and 2002, the Maine Child Death and Serious Injury Review Panel reviewed thirty-one (31) cases. Below is a summary of these cases, including demographic information about the children and families reviewed, causes of the deaths and injuries, and summaries of finding and recommendations of the Panel.

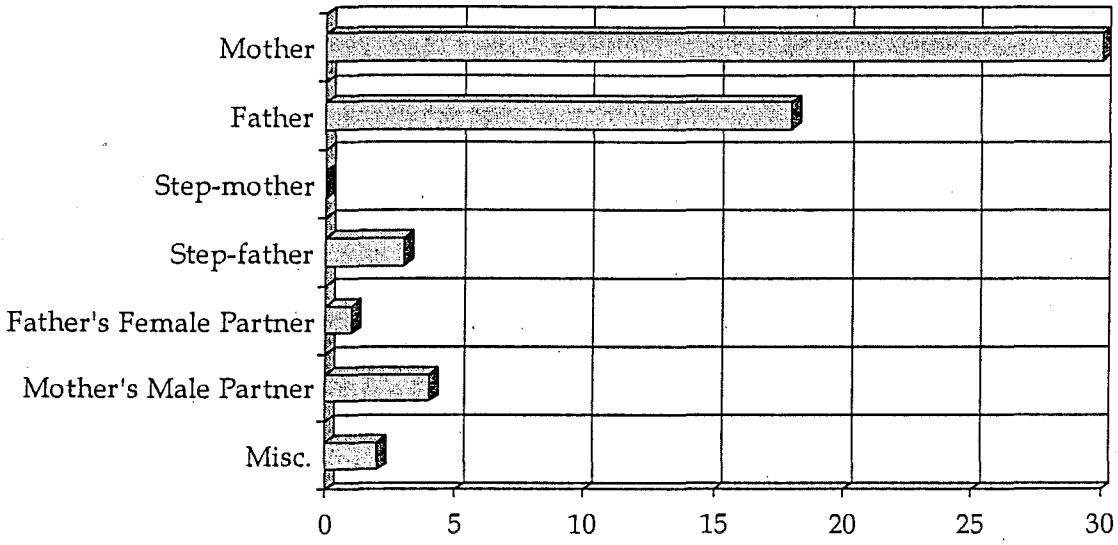
Demographic Information

The ages of the children in the cases reviewed by the Panel ranged from newborn to nineteen years; eleven (11) cases involved children under the age of one and seven involved children one year of age. Eighteen of the cases, or 58% focused on male children.

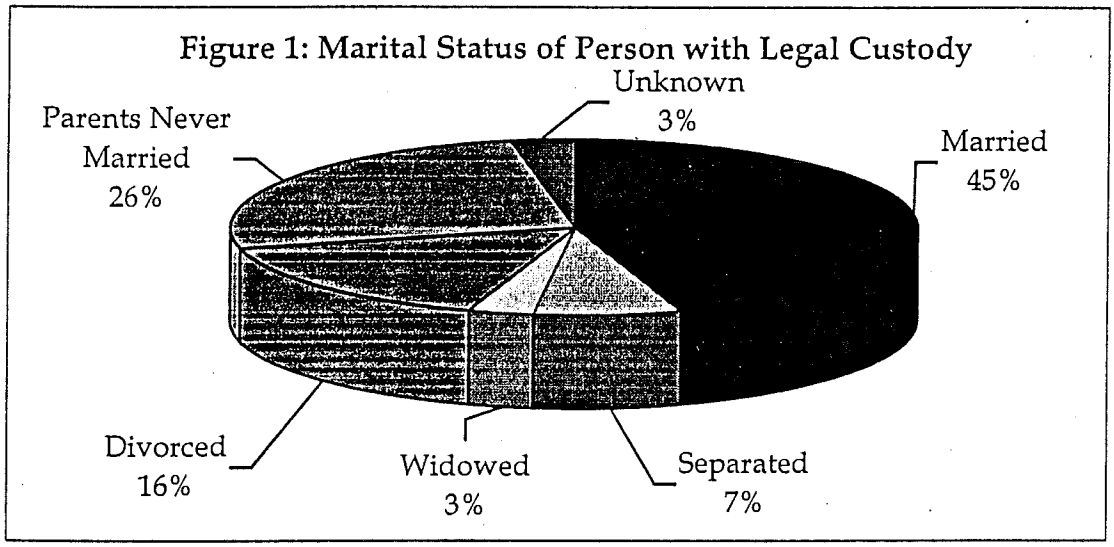


Most of the children from the cases that the Panel reviewed lived in homes with two caregivers. In the majority of cases the caregivers were the biological mother and father. In 97% (n=30) cases reviewed, children lived with their biological or adoptive mothers; 58% (n=18) of the time, children lived with their biological or adoptive fathers. Eight children resided with their parents' partners. More specifically, 10% (n=3) of children lived with a step-father; 3% (n=1) lived with the father's female partner; and 13% (n=4) lived with their mother's male partner. In 6% (n=2) of cases reviewed there were other non-related persons residing with their family. (Note that these percentages do not total 100%; there is considerable overlap among these categories.)

Table 2: Members of Household in Cases Reviewed (n=31)



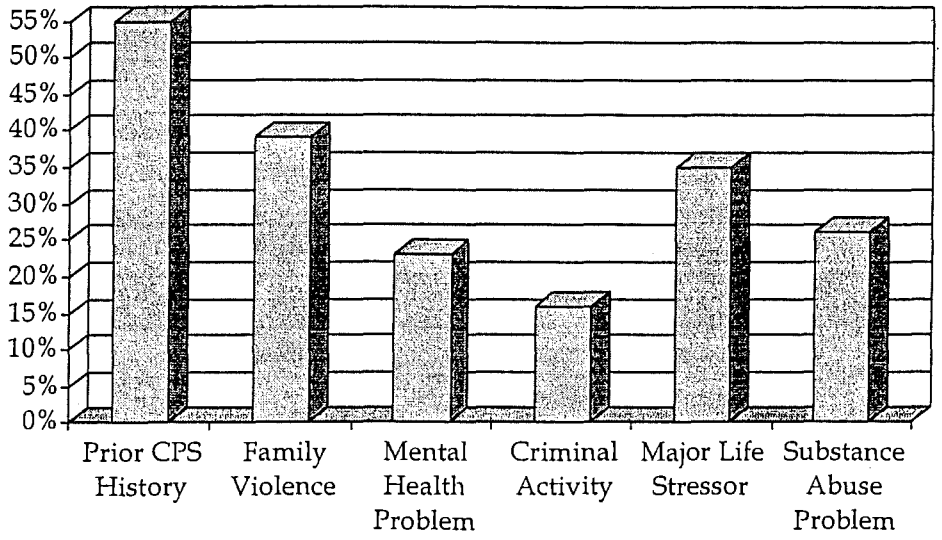
There was an average of four people living in the households of cases that the Panel reviewed. In 58% (n=18) of cases, there were other children living in the home. The average age of these children was 7 years (median = 5.5; standard deviation = 5.4). The average age of caregivers in the cases that were reviewed was 30 (median = 28; standard deviation = 9.7). The caregivers who held legal custody of the children were most often married (45%); followed by parents who were never, or not married (26%) and parents who were divorced (16%).



Parental Risk Factors

The caregivers in the cases that reviewed presented with a multitude of significant risk factors. Fifty-five percent (n=17) of the cases had prior histories or open cases with child protective services. Thirty-nine percent (n=12) of the cases had a history of, or a current problem with violence in the household and 35% (n=11) had experienced a major life stressor within the twelve months prior to the child's death or serious injury. Twenty-six percent (n=8) of cases had parental caregivers with substance abuse problems, 16% (n=5) had a history of criminal activity and finally, 23% (n=7) of the cases involved at least one caregiver with a mental health problem.

Table 3: Family Risk Factors in Cases Reviewed (n=3



Nature and Causes of Deaths and Serious Injuries

The Panel reviewed a total of thirty-one (31) cases between 1998-2001. Twenty-two (22) of these cases were fatalities and nine (9) were serious injuries. The causes of the injuries, along with the age of the children at the time of the event are listed in the tables below. Tables 4-A and 4-B list the causes of injuries or deaths along with the age and sex of the victim and perpetrator, while Table 5 summarizes the incidents according to injury or cause of death.

Table 4-A: Causes of Deaths and Serious Injuries in Cases Reviewed			
DEATHS			
Victim Age	Cause of Injury	Perpetrator – Relation to Victim	Perpetrator Age
1 year	Undetermined	Unknown	--
11 days	Severe acute pulmonary hemorrhage; cause unknown; co-sleeping	Unknown	--
13 years	Firearm wound to head	Brother	17
4 weeks	SIDS (co-sleeping)	None	--
4 years	Blunt force head trauma	Mother	32
10 years	Hypoxia and cardiac arrest resulting from house fire	None	--
4 months	Shaken baby injury	Mother's boyfriend	25
1 year	Drowned in home while parents at home	None	--
1 year	Accidental suffocation – collapsed bed; children left alone for 13 hours	None	--
3 years	Undetermined	Unknown	--
4 weeks	Asphyxia - smothered	Father	33
5 months	Positional asphyxia	None	--
9 months	Respiratory failure - medication error by mother	None	--
13 years	Self-inflicted firearms wound	Self	--
11 years	Asphyxia due to strangulation	Step-father	36
4 weeks	Undetermined	Unknown	--
2 years	Left in running vehicle for several hours	Mother	27
4 weeks	Smothered	Mother	25
1 year	Shaken-impact injury	Step-father	28
19 years	Aspiration pneumonia	None	--
13 years	Self-inflicted firearms wound	Self	--
14 years	Self-inflicted hanging	Self	--

Table 4-B: Causes of Serious Injuries and Deaths in Cases Reviewed			
SERIOUS INJURIES			
Victim Age	**Cause of Injury**	**Perpetrator – Relation to Victim**	**Perpetrator Age**
6 weeks	17 bone fractures	Father	24
8 years	Self-inflicted burns	None	--
1 year	Fracture of tibia; cause unknown	Unknown	--
2 years	Major trauma to head; bruises to body	Mother's boyfriend	28
4 weeks	Non-organic failure to thrive; parent could not meet child's basic needs	Mother	26
Newborn	Newborn in toilet bowl	Mother	20
5 months	Left in vehicle for five hours on warm day	Father	45
1 year	Burns – fire started by parent to kill self and child	Mother	43
1 year	Shaken-impact injury	Child care provider	34

Table 5: Cases of Serious Injuries and Deaths		
Cause of Injuries or Deaths	*Number of Cases*	
Bone Fracture		2
Head Trauma		5
SIDS		1
Injuries Resulting from Fire		3
Drowning		1
Asphyxia		5
Firearms		3
Hanging		1
Failure-to-Thrive		1
Left in Vehicle		2
Undetermined		3
Miscellaneous		4
TOTAL		31

The most common causes of injury or death were head trauma perpetrated by a caregiver or asphyxia. Those categories with few events include SIDS, drowning, hanging and failure to thrive. In 48% (n=15) of the cases, the event, which caused a serious injury or death, was witnessed by at least one person. Fifteen (n=48%) of these cases were inflicted injuries. The Panel determined that 71% (n=22) of the time the injuries or deaths could have been prevented.

FINDINGS & RECOMMENDATIONS OF THE PANEL 1998-2001

The Panel focuses on systemic problems, the management of and conceptualizations of child abuse cases and responses to child maltreatment in Maine. Therefore, most of the findings and recommendations are specific to the Maine child welfare system. Other findings concern social service providers and agencies, which also have regular contact with at-risk or abused and neglected children and their families. Below is a discussion of the Panel's most consistent conclusions.

Significant Concerns of the Panel

Inability to Recognize Signs of Risk to Children

In more than a third of the cases that the Panel reviewed, there were significant problems with the inability of professionals to recognize or take action concerning serious risk to the physical and emotional safety of children in their care. The Panel encountered this across numerous professions, including education, child welfare, medicine, mental health, child-care and community intervention providers. Such events usually occur in one of two ways. First, despite the fact that such providers have had training about child maltreatment, they often miss or overlook important risk factors. Even though these providers see the symptoms they are not able to sum the components into a picture that indicates danger for the child.

There are also providers who know that children are at risk and they do not take action. Often this is because providers worry that a report to child protective services may terminate a relationship with a family and that they will no longer be able to monitor the family if the Department of Human Services does not take action. Other times providers may have a good rapport with a family and they may be reluctant to "turn the family in." One provider reported to the Panel that even though his client's child was in danger, he felt that it would be "blaming the mother" to make a report about the abusive nature of the father. That child is now dead.

The Panel strongly urges all Maine residents, whether providers, citizens or relatives, to make reports about suspected or known child maltreatment. The Panel further recommends that mandated reporters follow their legal obligation to report all suspected and known child maltreatment.

Failure to Conceptualize a Case

In a high proportion of cases, the Panel concluded that the response of child protective services could have been stronger. There are a number of ways in which this was true. Sometimes a case was "screened out" as it was determined to be a low risk case, when in fact it proved be a moderate or high risk case. Other times caseworkers failed to gather pertinent information about the child, such as a full review of medical records. However, the most frequent finding in this category was that child protective services misjudged the protective capacity of caregivers or failed to accurately identify and articulate the emotional and physical risk of the family environment.

Child protective services has made improvements in this area since the initiation of the Panel in 1992, in part, because clinical consultation has been made available to child protection teams and in part, because safety and risk assessment tools have been improved. Despite this progress, this matter remains of significant concern to the Panel; the members support all efforts of the Department of Human Services to bring about changes in practice and policy to alleviate this problem.

Moderate Concerns of the Panel

Psychological Evaluations

In a small number of the cases that the Panel reviewed, the psychological evaluations conducted on the abusive or neglectful parents were of poor quality. In most instances the evaluator failed to focus on the capacity of parents to protect their children from abuse and neglect. There was also a tendency to overlook risk factors or to minimize the severity of these factors.

In some instances this problem can be ameliorated by better communication between child protective workers and mental health evaluators. Caseworkers need to be more forthcoming about the specific concerns they need to have addressed and evaluators should have complete understanding of the purpose of the evaluation before starting an evaluation.

It is also important for child welfare workers and mental health professionals to recognize that the evaluation of an individual's capacity to parent his or her children is a professional specialization and cases should be referred only to people who are demonstrated experts in this arena. Finally, state sponsored trainings in this area of specialization would result in a larger pool of individuals capable of performing such evaluations.

"Strength-Based" Approach

The Department of Human Services contracts with Community Intervention Programs to provide services to low and moderately low risk families. These contract agencies do not perform child protective assessments on families. However, their caseworkers have regular contact with families, which enable them to monitor family functioning. They are also able to assist in finding appropriate services, such as housing, parenting classes, medical and mental health treatment and so forth. This opportunity to use additional resources has been a great asset to the Department because it means that almost all families that are considered "appropriate" for an assessment receive some kind of service, even if the Department is unable to send a child protective worker to their home. Since this contractual service is relatively new to child protective work, the Panel has only reviewed a few such cases. These cases clearly demonstrated that Community Intervention Programs use a "strength-based" approach when providing services to their clients. The success of a strength-based model appears to be dependent upon the ability of the family to accurately identify the areas in which they need help to support and protect their children. This runs a risk of falling short in families where parents lack insight or are not able to be honest with their providers regarding areas where their children have needs for care and protection, and which they are unable to independently meet.

Children's Access to Firearms

The Panel reviewed four cases where children killed themselves or others with a firearm. While the Panel is aware of the cultural importance of firearms in the homes of many Maine families, it is important that their presence be considered in a context of risks and benefits. It is clear from the work of the Panel that locking guns away or storing them unloaded does not prevent children from gaining access to firearms and harming themselves or others.

Accomplishments Worthy of Praise

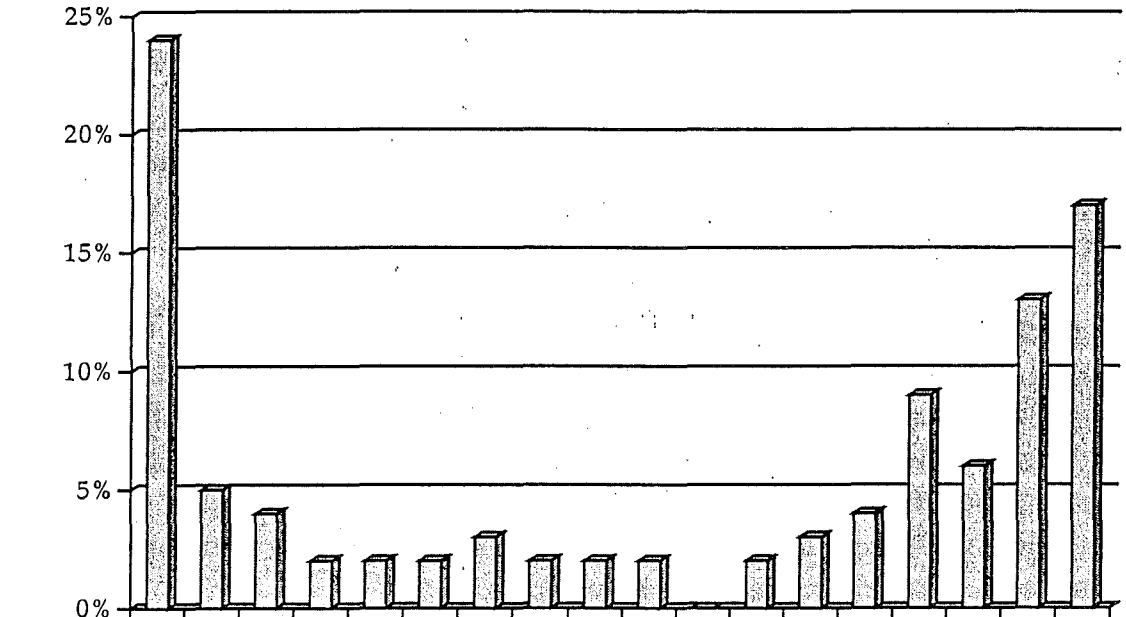
The year 2002 marks the Panel's tenth year of case reviews. Since its inception, the Panel has witnessed considerable progress in many areas, such as more complete assessments of families in the child protective system, higher quality psychological evaluations of maltreating parents, increases in sentencing for child abusers who kill children and so forth. However, the one area that consistently improves is the collaboration between multiple agencies, which respond to the abuse, neglect or death of children. Especially fine work has been noted between child protective workers and law enforcement officers, medical examiners and law enforcement, medical professionals, child protective workers and law enforcement and excellent work between local police departments and state police. Their collaborative work is often of highest quality and is worthy of the Panel's recognition.

ALL CHILD DEATHS IN MAINE 1998-2002
STATE OF MAINE OFFICE OF CHIEF MEDICAL EXAMINER

Total Deaths

Between 1998 and 2001, 255 children died in the state of Maine. Almost 25% of these children were under the age of one, and 17% were 17 years of age. Half of the deaths were the result of accidents, while five percent were homicides. Sixty-four percent of the children were male. More deaths occurred in Cumberland County than any other region, followed by Penobscot County.

Table 6: Ages of Children who Died in Maine 1998-2001



	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Percent	24%	5%	4%	2%	2%	2%	3%	2%	2%	2%	0%	2%	3%	4%	9%	6%	13%	17%

Age of Children

Figure 2: Manner of Deaths of Maine Children 1998-2001

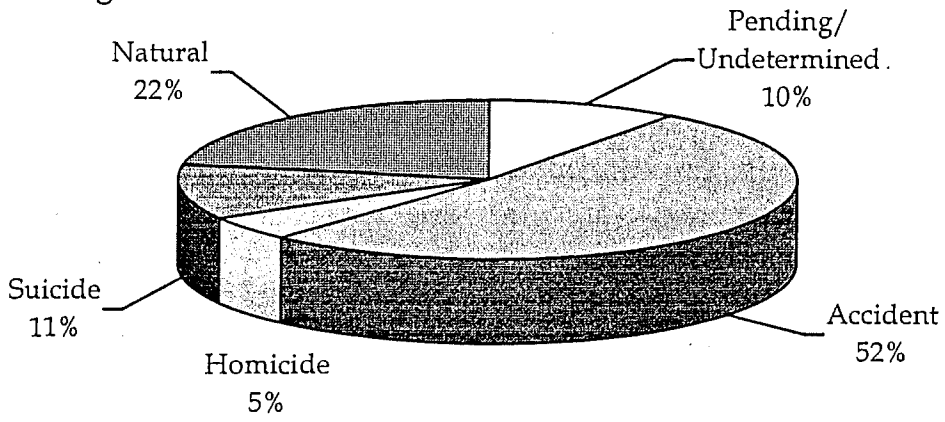


Table 7: Maine Deaths 1998-2001 by County	
County	Percent
Androscoggin	9%
Aroostook	6%
Cumberland	18%
Franklin	2%
Hancock	4%
Kennebec	10%
Knox	4%
Lincoln	4%
Oxford	4%
Penobscot	12%
Piscataquis	2%
Sagadahoc	2%
Somerset	7%
Waldo	5%
Washington	2%
York	9%
Total	100%

Deaths By Abuse or Neglect

Between 1998 and 2001, ten children died at the hands of their caregivers. Their stories are below.

- A one year-old girl died when her step-father, in a rage, threw her head-first onto the ground. *1998*
- A two-year boy was left in a running vehicle for several hours while the mother "partied" with friends. The child died from hypothermia. *1998*
- Two children, ages two and four were shot by their father in a double-murder-suicide. *1998*
- A sixteen year-old girl was beaten and strangled by her step-father. *1998*
- A one month-old girl was suffocated by her father. He placed her body in a box and hid it in a bedroom closet. Her body was found several weeks later. *1998*
- A four-month old boy was shaken to death by his baby sitter when he would not stop crying. *1998*
- An eleven year-old girl was raped and then strangled by her step-father during a summer evening walk. *1999*
- A girl, almost two years old, died after weeks of being beaten by her mother's boyfriend. *2000*
- A five year-old girl was bound to a chair with duct tape by her foster mother. Tape was placed over her airways and she suffocated. *2001*

CRIMINAL JUSTICE OUTCOMES IN CASES OF CHILD FATALITIES
1998-2002
STATE OF MAINE

In the 1999 report of the Maine Child Death and Serious Injury Review Panel, we examined the criminal justice outcomes in cases of fatal child abuse or neglect. Some of those cases were pending and have since been resolved. Below are the outcomes of cases between 1998 and 2001, followed by a graph depicting incarceration terms since 1994.

In the last 8 years, only 2 of the 10 child abuse and neglect deaths have resulted in murder convictions.

Table 8: Incarceration Terms in Cases of Fatal Child Abuse in Maine 1994-2002

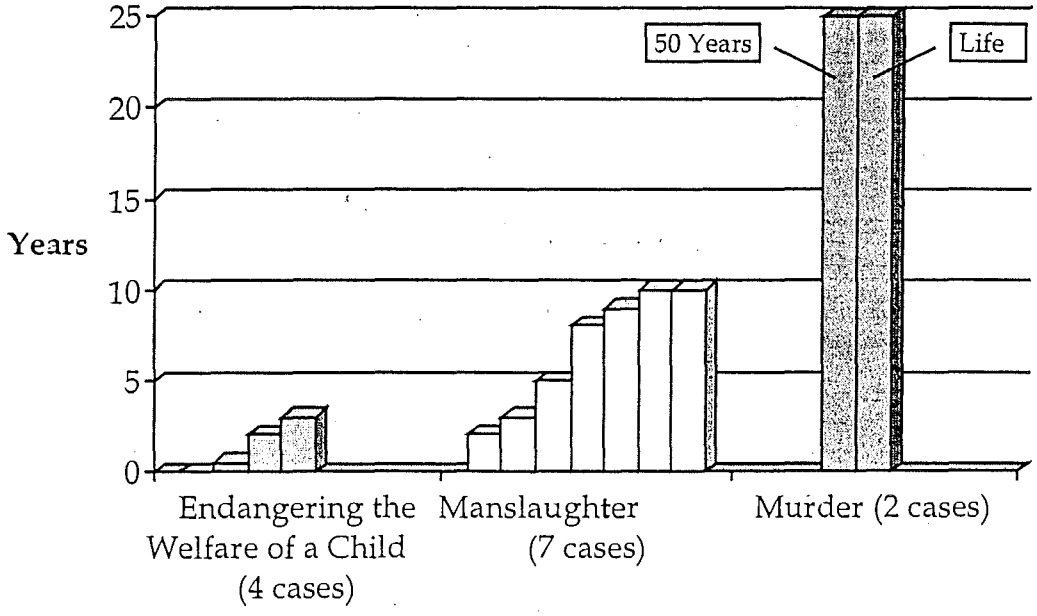


Table 9: Fatal Child Abuse Outcomes in Maine 1998-2001							
Date of Death	VICTIM		OFFENDER		Relation to Victim	Status of Case	Sentence
	Age	Sex	Age	Sex			
1998	1 mo.	F	35	M	Father	Conviction: Manslaughter	25 year jail term, all but 20 suspended
1998	1 yr.	F	28	M	Step-father	Conviction: Manslaughter	10 year jail term
			22	F	Mother	Conviction: Endangering the welfare of a child	3 year jail term
1998	16 yrs.	F	28	M	Step-father	Conviction: Murder	Life
1998	2 yrs.	M	29	F	Mother	Conviction: Endangering the welfare of a child	Suspended 9-month jail term; 1 year probation; 520 hours community service
1998	4 yrs.	F	34	M	Father	Closed: Murder-suicide	
1998	2 yrs.	M	34	M	Father	Closed: Murder-suicide	
1998	4 mos.	M	44	F	Child care provider	Conviction: Manslaughter	10 year jail term
1999	11 yrs.	F	35	M	Step-father	Conviction: Murder	50 year jail term
2000	2 yrs.	F	29	M	Mother's boyfriend	Pending in NH	
2001	5 yrs.	F	40	F	Foster mother	Pending	

"JAKE'S LAW"

In March, 2000 Governor Angus King signed into law a statute that requires judges to consider the ages of victims who die as a result of abuse or neglect. More specifically, the law mandates that courts give special consideration to the age of a victim when determining length of incarceration terms. Named for infant-victim Jake Belisle, "Jake's Law" was proposed by Jake's mother, Pamela, who fought tirelessly for the passage of the statute. This policy now states that when a victim of child abuse fatality is under the age of six, this fact may be used to help determine the length of a jail term.

Similar laws have been adopted in half the states across the country. These so-called "child fatality" laws are intended to increase the jail terms of offenders who take the lives of children through abuse or neglect.

The original bill for Jake's Law outlined much harsher penalties for offenders than the version that was adopted into law. This 1999 legislative action requested a mandate of murder for all persons who have killed a child under the age of four by means of abuse or neglect. Such a law would have resulted in a sentence of no less than 25 years for this crime. The bill was amended, and now requires judges to *consider the age of the victim* rather than mandating a uniform sentence for child abuse fatalities. The resulting laws are stated below.

Crime of Murder: *"In setting the length of imprisonment, if the victim is a child who had not in fact attained the age of 6 years at the time the crime was committed, a court shall assign special weight to this objective fact in determining the basic sentence in the first step of the sentencing process." [Title 17-A, Chapter 51§1251]*

Other Crimes: *"In using a sentencing alternative involving a term of imprisonment for a person convicted of the attempted murder, manslaughter, elevated aggravated assault or aggravated assault of a child who had not in fact attained the age of 6 years at the time the crime was committed, a court shall assign special weight to this objective fact in determining the basic term of imprisonment as the first step in the sentencing process." [Title 17-A, Chapter 51§1252-5B]*

Jake's Law was successfully used for the first time in the fall of 2002 to lengthen the sentence of a woman found guilty for manslaughter in the death of her foster child.

STATE OF MAINE CHILD PROTECTIVE ACTIVITIES 1998-2001
DEPARTMENT OF HUMAN SERVICES

Activities Based on Reports

Between 1998 and 2001 the State of Maine child protective system received 59,658 reports about the well-being of Maine children. Over that period of time, 40% of the reports did not concern allegations of abuse or neglect and were determined inappropriate for action from child protective services (CPS). In 1998, 43% of reports that were determined to be appropriate for CPS intervention were not assigned for assessment because of insufficient staff. However, by 2002, only 2% of appropriate reports were unassigned because of insufficient staff. Beginning in 1998, the Department of Human Services began referring low to moderately low risk cases, for which there were insufficient staff, to Community Intervention Programs. Although these agencies do not perform child protective assessments on families, their case workers have regular contact with families and therefore are able to monitor family functioning. They are also able to assist in finding appropriate services, such as housing, parenting classes, medical and mental health treatment and so forth.

Table 10: State of Maine Child Protective Activities 1998-2001

Category	1998	1999	2000	2001	Total: All Years
Inappropriate reports	5958	6167	6044	5894	24063
Appropriate report, assigned to community intervention programs	353	3012	4116	4901	12382
Appropriate report, not assigned due to insufficient staff	3438	1318	241	205	5202
Appropriate report, assigned for assessment	4121	4263	4833	4794	18011
TOTAL Reports made about the well-being of children	13870	14760	15234	15794	59658

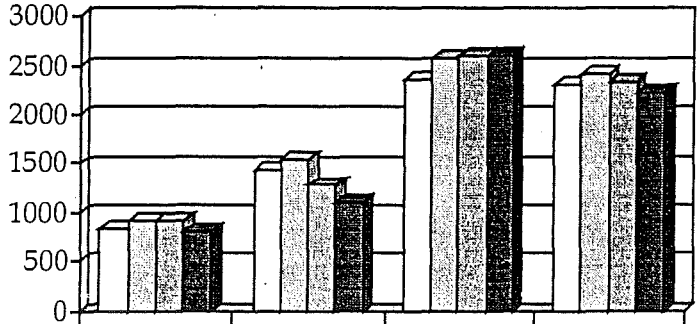
Family Assessments and Findings

Between 1998 and 2001, the Department of Human Services conducted 17657 assessments on Maine families suspected of abusing or neglecting their children. Through these assessments the Department substantiated that maltreatment occurred an average of 55.5% of the time. (See the following table for rate of substantiation for each individual year.)

Table 11: Department of Human Services Child Maltreatment Substantiation Rate: 1998-2002					
Year	1998	1999	2000	2001	Average
Rate of Substantiation	61%	59%	52%	50%	56%

Maine state law defines child abuse as "a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these by a person responsible for the child" *(Title 22, MRSA, Chapter 1071§4002)*. With this in mind, the Department assesses for several different kinds of abuse when interviewing families, including sexual abuse, physical abuse, neglect and emotional maltreatment. Between 1998-2001, Maine's child protective system substantiated an average annual number of 863 cases of sexual abuse, 1336 cases of physical abuse, 2532 cases of neglect and 2313 cases of emotional abuse.

Table 12: Substantiated Cases of Child Maltreatment: 1998-2001

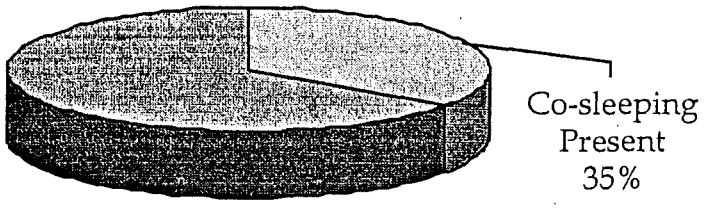


	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
1998	830	1424	2357	2297
1999	910	1537	2574	2405
2000	910	1278	2599	2321
2001	802	1106	2596	2229

CO-SLEEPING AND INFANT DEATHS IN MAINE: 2001-2002

Within the last decade there has been increasing concern among experts in the medial and child welfare professions about a possible relationship between infant deaths and co-sleeping between infants and their caregivers. Although there are benefits associated with co-sleeping, such as synchronizing sleep patterns and encouraging breastfeeding, statistics suggest that, under certain conditions, co-sleeping increases the risk for sudden death in infants. Recent data from the Office of the Chief Medical Examiner in the State of Maine revealed that between January 2001-September 2002, seven of the twenty sudden death cases in the state of Maine, or 35%, involved co-sleeping with a caregiver.

Figure 3: Presence of Co-Sleeping in Sudden Death Cases Among Infants, January 2001-September 2002



To help provide guidance for medical and child welfare professionals, the American Academy of Pediatrics has developed guidelines about reducing the level risk to infants who co-sleep with their caregivers.[1]

1. Unless otherwise directed by a physician, healthy infants should be placed on their back regardless of their sleeping environment.
2. Cribs are designed to meet safety standards for infants. Adult beds are not so designed and may carry a risk of accidental entrapment and suffocation.
3. If infants sleep with their caregivers, special care should be taken to avoid soft sleeping surfaces. Quilts, blankets, pillows or comforters should not be placed under infants.
4. Caretakers sharing a bed with children must not smoke while in bed. It is also unwise for caretakers who are obese, overtired or who have used alcohol or drugs that may impair arousal, to co-sleep with infants.
5. Co-sleeping with multiple individuals can increase the risk of suffocation.

[1] "Does Bed Sharing Affect the Risk of SIDS?" Pediatrics, Volume 100, No. 2, 1997.

APPENDIX

No one knew that "Jane" was pregnant. She gave birth to her second child in secrecy. After delivery, Jane wrapped a sock around the baby's neck and strangled her. She put the body in a garbage bag and several weeks later asked her boyfriend to throw it in the woods. The body was found. Jane was charged with manslaughter and sentenced to two years in jail.

ABUSIVE HEAD TRAUMA IN MAINE INFANTS: MEDICAL, CHILD PROTECTIVE, AND LAW ENFORCEMENT ANALYSIS[2]

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Lieutenant Timothy Doyle, (d)

Introduction

In the United States, physical abuse is the leading cause of both serious head injury and of injury-related death in infants (American Academy of Pediatrics, 1993). In 1974, Caffey introduced the term "whiplash shaken baby syndrome" to describe head injury in infants secondary to what he believed were acceleration-deceleration stresses from shaking (Caffey, 1974). The clinical features he described included subdural hemorrhages, retinal hemorrhages, and little or no external evidence of injury. The term shaken baby syndrome (SBS) has come to describe the medical sequelae of such violent shaking of infants. Recently, the term Abusive Head Trauma (AHT) has been introduced describe nonaccidental head injury in infants and toddlers. (Jenny, Hymel, Ritzen, Reinert, & Hay, 1999) AHT is defined as inflicted cranial injury irrespective of whether shaking or impact or both have been found to have been the cause.

Despite the extensive literature on SBS as summarized by Duhaime, Christian, Rorke, & Zimmerman (1998), no study has attempted to describe the findings of the full investigative process (medical, child protective, and law enforcement) associated with inflicted head trauma in infants. In response to the recommendations in the first report of the Maine Child Death and Serious Injury Review Panel in 1994, this retrospective review was undertaken to identify the medical, psychosocial, and criminal justice characteristics of inflicted head trauma in Maine children.

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Methods

All records from Maine's two tertiary pediatric care medical centers, Maine Medical Center in Portland and Eastern Maine Medical Center in Bangor, were screened using the following ICD-9 N-Codes:

N348.5 .....Cerebral edema
N362.81 .....Retinal hemorrhages
N800-801.9 .....Skull fracture
N803-804.9 .....Other skull or face fractures
N850-854.1 .....Intracranial injury
N905 .....Late effects of skull fractures
N907 .....Late effects of intracranial injury
N995.5 .....Battered child syndrome

In addition, records from the Maine Medical Examiner's office were reviewed for any deaths during the study period not identified in the hospital records.

Ninety-five admissions of children 24 months of age or less were identified using these codes from 1991 through 1994. From these, 20 hospitalizations (20/95, 21%) involving 19 children were selected as likely abuse related using the following criteria: the presence of intracranial trauma such as extra axial blood and/or parenchymal injury plus one or more of the following: admitted or witnessed assault, inconsistent history, suspicious bruises, suspicious fractures, or extensive retinal hemorrhages. Determination of inconsistency in the history and/or suspiciousness of the injuries were made by the primary author (LRR) using a model similar to Duhaime et al. (1992).

Medical records including autopsy reports were reviewed by one of the authors (LRR) and the following information was collected: age, sex, length of hospitalization, presenting complaint, signs and symptoms on presentation, changing history, delay in seeking treatment, past history (injury, medical symptoms or medical evaluations), results of radiographic studies, results of lumbar puncture, diagnosis regarding abuse, whether and when CPS and/or law enforcement were notified, final disposition, and sequelae. Information about prior symptoms and signs were taken from the inpatient medical records and when available from primary care records.

Child Protective Service (CPS) records were reviewed by one of the authors (PM) and the following information was collected: prior CPS history, family constellation, risk factors (substance abuse, prior abuse allegations, child abuse in the caretaker's childhood, domestic violence, mental illness, history of unrealistic expectations, history of attachment disorder), history of child stressors (such as colic or feeding difficulties), whether abuse was substantiated, whether a perpetrator was identified, whether a triggering event occurred, and the final disposition of the child.

Law Enforcement records were reviewed by one of the authors (TD) and the following information was collected: whether or not a perpetrator was identified, perpetrator demographics; previous criminal history of the perpetrator; whether criminal prosecution was attempted and the results of that prosecution, whether there was a confession, and what, if any, were the identified impediments to investigation.

The study was reviewed and approved by the Institutional Research Review Committees of the participating hospitals.

Medical Results

Twenty head injury hospitalizations involving 19 children (one child was admitted twice with acute AHT from the same home and will be counted twice for some of the tables) were identified as abuse related (Table 1). The mean age of the children at the time of hospitalization was 7.5 months with a standard deviation of 5.7 months and an age range of 2 weeks to 17 months. Eleven of the 19 children (58%) were male.

Table 1

Demographics of children with AHT

Number of hospital admissions	20
Number of children	19
Mean age	7.5 months
Age range	2 weeks to 17 months
Males	58% (11/19)
Average age of males	8.2 months
Females	42% (8/19)
Average age of females	6.6 months

The chief complaint on presentation was a minor injury (e.g. fall less than 4 feet) for 12 children (60%). Eight of the 12 injuries (67%) were described as witnessed. However, none were witnessed by more than one adult. There was a history of prior injury in 6 (30%), a history of prior symptoms suspicious for abuse in retrospect in 9 (45%), and a history of prior medical evaluations for signs and symptoms possibly abuse related in 13 (65%).

Of the 9 children with prior symptoms, all had a history of irritability (100%), while 2 (22%) had vomiting and 4 (44%) lethargy. Of the 13 children who had been evaluated previously for medical conditions, 3 (23%) presented previously with irritability and lethargy, 1(8%) with irritability and vomiting, 2 (15%) with seizures, 1 (8%) with increasing head circumference, and 4 (31%) with injuries, including 1 child with a bruise at 6 weeks of age and 1 with a fractured femur at 2 months of age (Table 2). None of these 13 children were suspected by the primary care provider as abused during those outpatient presentations.

Table 2

Signs and symptoms during prior evaluations for medical conditions (n=13)

Irritability and lethargy	3	23%
Irritability and vomiting	1	8%
Seizures	2	12%
Increasing head circumference	1	8%
Injuries (e.g. bruising, fractures)	4	31%

At hospital presentation, nine children (45%) were in coma, six (30%) were apneic, and 11 (55%) had a tense anterior fontanel and/or enlarged head circumference. Twelve children (60%) had bruising specific for inflicted trauma (face, arms, chest and/or bilateral and/or in a specific fingerprint pattern). Fifteen (75%) had either evidence of prior injuries in the form of healing bruises, healing fractures or old intracranial injuries, or a history of prior injury. Nineteen children (95%) had retinal hemorrhages (typically extensive and severe). Nine children (45%) received a lumbar puncture. All nine (100%) were positive for blood and of these five (55%) were described as positive for xanthochromia. The medical records of the remaining four did not note either the presence or the absence of xanthochromia.

The most common radiographic finding was a skull fracture which was present in 9 of the 20 children (45%). Rib fractures were seen in 3 children (15%) and metaphyseal fractures in 2 (10%). In addition to skull, rib, and metaphyseal fractures, 2 children had long bone shaft fractures. Thirteen children (65%) received bone scans, 2 (15%) revealed findings not seen on the radiographic survey. One was a subtle tibial fracture while the other was a recent rib fracture.

Nineteen children (95%) received a CT scan of the head (the one exception was a child who died in the emergency room). Three children (15%) also received an MRI of the brain. Brain imaging studies revealed subdural hematomas in 19 (100%), cerebral edema in 10 (53%), and parenchymal injury in 6 (32%).

In 16 of 20 cases (80%), the hospital identified the child as a victim of abuse. Two children (10%) who died prior to diagnostic assessment at the medical facility were later identified by the medical examiner as abused. Of the two misidentified cases (10%), one appeared to be a result of medical providers feeling that the family presented well even though the injuries were suspicious, and the other the result of the providers believing the history of an accidental injury. However, Child Protective Services was called in all

cases, immediately in 16 (80%). Law enforcement was called by medical personnel in only 1 case.

Of the 20 children hospitalized, three (15%) died, 8 (40%) were discharged to foster care, 5 (25%) went home without the alleged perpetrator in the home, while 4 (20%) went back to the original home environment. In one of these cases the hospital thought the child had been abused but felt that the parents did not seem capable of abuse. In another, the diagnosis of abuse was missed. This child later returned with a new inflicted head injury. In the third case, because of conflicting medical opinion about whether the injury was abusive, child protective services decided that they had insufficient evidence to remove the child. In the fourth case, the child was discharged to another state, where child protective services apparently felt the home was safe.

Community or Public Health Nursing was involved in only 5 families (26%). Two of these 5 families (10%) had identified minor social problems. None was identified as high risk for abuse.

Child Protective Services Results

Child Protective Services in Maine investigated 18 of the 20 cases (90%). One case not investigated involved a child who died without surviving siblings while the other was a child who resided out of state. Only 2 of 20 cases (10%) had any prior CPS history. CPS found that 14 children (70%) resided with both their mother and father while 2 (10%) resided with mother and stepfather, 1 (5%) with mother and boyfriend and 2 (10%) with mother alone. The average maternal age was 24.7 years while the average age of father or father figure was 27.5 years. Only 2 cases (10%) involved a teenage parent. Both caretakers were employed in 7 of the 19 homes (37%). Father alone was employed in one home (5%) and mother alone was employed in 4 homes (21%).

A number of parental risk factors were identified by CPS in the 19 homes (Table 3). Substance abuse was present in 10 households (53%) and domestic violence in 8 (42%).

Table 3

Parental risk factors for abuse identified by CPS (n=19)

Substance abuse	10	(53%)
Domestic violence	8	(42%)
Unrealistic expectations of child	8	(42%)
Parent abused as a child	7	(37%)
Attachment problems	6	(32%)
Criminal history	6	(32%)
Mental health history	3	(16%)
Unemployment	1	(5%)
No risk factors identified	4	(21%)
Only 1 risk factor present	3	(16%)
Risk factors inadequately assessed	10	(53%)

In 7 cases (37%), at least one parent had been abused as a child. A criminal history was present in 6 (32%), and a mental health history in 3 (16%). Unemployment was identified as a risk factor in 1 household (5%). In 4 homes (21%), no risk factors were identified, and only one risk factor was present in 3 (16%). In 10 homes (53%) however, risk factors were incompletely assessed and/or incompletely documented.

An attempt was made to identify child risk factors and abuse triggers from the CPS records. In 5 homes (27%), the child was described as "difficult," particularly for the father, while in an additional 4 homes (21%), the child was described as persistently crying. Attachment problems, although not clearly defined, were described in 6 homes (32%) and in 8 homes (42%) there were unrealistic expectations of the children's ability to control their own behavior. A trigger for the abuse could be documented in 12 cases (63%). These included crying in 8 of the 12 cases (67%), toileting issues in 3 (25%), and vomiting in 1 (8%).

CPS substantiated abuse in 18 cases (90%). In 2 cases abuse could not be substantiated. In one there were conflicting medical opinions, while in the other the medical providers said that the child had not been abused.

Law Enforcement Results

Law Enforcement identified a perpetrator in 15 of 19 cases (79%) (Table 4). In 10 of the 15 cases (66%), the father was the identified perpetrator. Other identified perpetrators included the stepfather in 1 case (7%), boyfriend in 1 (7%), mother in 1 (7%), and sitter (1 male and 1 female) in 2 (13%). Overall thirteen of the 15 identified perpetrators (87%) were male, with an average age of 26. Six of these (40%) had a previous criminal history. In the 15 cases where a perpetrator was identified by law enforcement, that person was alone with the child at symptom onset in 14 cases (93%).

Table 4

Law Enforcement Findings

Perpetrator identified by law enforcement	15/19	79%
Perpetrator alone with child at symptom onset	14/15	93%
Perpetrator confessed to inducing injury	4/19	21%
Number of cases prosecuted	13/19	68%
Found guilty	2/13	15%
Pled guilty	7/13	54%
Acquitted	3/13	23%
Died prior to trial 1/13 8%		

In 4 of the 19 cases (21%), a perpetrator confessed to injuring the child. One child was shaken because of apparent jealousy, one was shaken because of crying, one was shaken because of a toileting accident and one child was slammed down in anger.

Thirteen cases (68%) were prosecuted. Two individuals (15%) were found guilty at trial while 7 (54%) pled guilty, 3 (23%) were acquitted, and one died prior to trial.

Law Enforcement noted the following barriers to investigation: there was a delay notifying police in 6 of the 20 cases (30%), there were multiple possible suspects in 10 cases (50%), and there were conflicting medical expert opinions in 3 cases (15%).

Discussion

One in five children (21%) less than 24 months of age admitted for head trauma to the two Maine tertiary care pediatric hospitals during the study period was a victim of AHT. These results are similar to those of Reece and Sege (2000) who reported that 19 % of 287 children age 1 week to 6.5 years admitted with head injuries were victims of AHT.

The presentation of AHT is often dramatic and obvious yet sometimes subtle and confusing. In our study, as well as in an earlier study (Ludwig & Warman, 1984), the majority of victims presented to the hospital and/or medical office with serious central nervous system symptoms such as apnea, seizures, or coma, often accompanied by a tense fontanel and/or enlarged head circumference.

In some instances however, the diagnosis of shaken baby syndrome can be missed by the health care provider, in part, because of the subtlety of the presentation. The American Academy of Pediatrics (1993) has stated that victims of SBS can present with signs as subtle as poor feeding, vomiting, lethargy or irritability occurring for days or weeks prior to the time of initial health care contact. Greenes and Schultzman (1998) reported that 19 of 101 (19%) infants who had evidence of intracranial injuries such as skull fractures and subdural hematomas were asymptomatic. Jenny and colleagues (1999) reported that 31% (51 of 173) children under the age of three who presented to the hospital with AHT were missed by a health care provider during an earlier presentation for signs or symptoms likely related to AHT. This study also reported that AHT was more likely to be missed in very young children, in white children, in children from intact families, and in children who present without respiratory compromise or seizures. In our study, 65% of children had been previously seen by a medical provider for signs and symptoms that could arguably have been abuse related.

Bruising is an important though not universal finding in the physically abused head injured child. Caffey's original paper (1974) noted infrequent bruising. On the other hand, we found that bruising that was suggestive of physical abuse (i.e., in abusive locations such as the upper arms, face, or chest; in an abusive pattern such as fingerprint; or in an abusive distribution such as bilateral) occurred in over half of the cases. Nonspecific bruising was found in 25% of the children in our study, similar to the findings of Ludwig and Warman (1984), who reported that 7 out of 20 children with SBS were found to have nonspecific bruising. It is important to remember however that

any bruising in an infant who has not yet begun to ambulate is suspicious. (Sugar, Taylor & Feldman, 1999)

Similar to other studies (Duhaime et al., 1987; Alexander, Sato, Smith, & Bennett, 1990), evidence of blunt head injury was present in over half of our cases. Notably, evidence of prior injuries (in the form of healing bruises, fractures, subdurals and retinal hemorrhages or a history of prior suspicious injury) was present in 15 of 20 (75%) of our cases. Evidence of prior injury, also described by Alexander, Crabbe, Sato, Smith, & Bennett (1990), coupled with the frequency with which these children were seen by medical providers for suspicious signs and symptoms indicates both that abuse rarely occurs as a single episode and that it may be preventable in its more severe recurrent forms if closer attention is paid during the medical visit to possible indicators of abuse.

Nine children received a lumbar puncture (LP), typically because head trauma was not initially suspected. Of the nine specimens, all were positive for blood and at least 5 were also positive for xanthochromia, a finding, if present in a freshly spun specimen, indicating that blood is not from a traumatic tap but rather from older subarachnoid blood (Apolo 1987). Yet, the significance of this finding was never noted in the records of these children.

Little has been written about family risk factors specifically associated with AHT. Goldstein, Kelly, Bruton, & Cox (1993), in a series of 14 cases of severe inflicted head trauma, found that at least two of the following three findings were present in each case: an inconsistent history, retinal hemorrhages, or parental risk factors as defined by parental age, educational level, marital status, welfare status, history of substance abuse, history of spousal abuse, and previous referral to child protective services. In an earlier study, Goldstein, Eguiguren, Feldman, Cox, & Todres (1991) found that the combination of parental risk factors with either retinal hemorrhage or an inconsistent history was 100% predictive of abuse. Dashti, Decker, Razzaq, & Cohen (1999) found a history of alcohol or drug abuse in 16% of families of children with head trauma. Although Goldstein et al. (1993) reported a correlation between AHT and parents under the age of 18 who were single or unmarried, in our study, AHT rarely occurred in homes where the caretakers were teenagers (10%) and often occurred in homes where the parents were married (70%).

We found that risk factors for abuse were present in at least two thirds of families where AHT occurred. However no risk factors were found in 16%, while only one factor was found in an additional 21%. The absence of identifiable risk factors in a significant minority of these families suggests that any attempt to prevent AHT should look beyond seemingly high risk families. Disturbingly, child protective risk factor assessment was inadequately documented if not inadequately assessed in fully half of these families. When assessed, substance abuse and domestic violence were the most common risk factors for abuse.

Christian (1992) reported that certain factors in the child increase the risk of abuse. These include complex medical problems, developmental delays, an unwanted child, a "difficult" child (e.g., colic or hyperactivity). Shaking in such circumstances may represent frustration resulting from the infant's crying. We found that shaking most commonly occurred when the father found the child difficult to care for, particularly if the child was crying.

In this study, only 2 of 20 (10%) children with AHT had any prior family CPS history. This surprising finding suggests perhaps that CPS is not being notified of infants at risk or that some children are at risk for AHT without preexisting recognizable red flags.

Identification and prosecution can be challenging. The child cannot give a history and rarely is there a witness or a confession. In this study only 4 of 20 perpetrators confessed to shaking or slamming the child. Absent a confession or a witness, exclusive opportunity for one individual to have committed the crime offers the best prosecutorial opportunity. Establishing exclusive opportunity is often contingent on forensically skilled medical providers identifying the time frame during which the injuries could have occurred. We found that in 50% of our cases exclusive opportunity could not be established. Even so, after careful law enforcement investigation, a perpetrator was identified in 15 of 19 cases, and of these, prosecution occurred in 13. Three of 5 jury trials ended in acquittal with many jurors reporting that they could not distinguish between alternative suspects even though they believed that abuse had occurred. Sentencing of those who were convicted or who pled guilty was inconsistent, with some convicted perpetrators receiving sentences of several months while other received sentences of few to several years.

In Caffey's original report (1974), the majority of SBS perpetrators were female. Since then, however, several studies, including this one, have documented an overwhelming predominance of male perpetrators of AHT. Lazoritz and Baldwin (1977) found the perpetrator more often to be male. Starling, & Holden (1995) found that fathers were responsible for 37% of AHT in children and mother's boyfriends were responsible for 20%. In a follow up study, Starling and Holden (2000) found a similar gender distribution in a study of a southern population of perpetrators as in the original western population. Morris, Smith, Cressman, & Ancheta (2000) reported a predominance of male abusers and also noted that female babysitters were of concern in two of nine cases. Lancon, Haines, and Parent (1998) stated that in both military and civilian populations, up to 90% of perpetrators are male with the biological father being the most common perpetrator, followed by the mother's boyfriend and child-care providers.

We are aware of a number of potential limitations of this study. The small number of cases presented here precludes statistical analysis and limit broader conclusions. Additionally, since only two hospitals in Maine were screened for cases of inflicted

head injury, it is possible that a few cases were seen in smaller community hospitals and not identified for this research. Adding such cases could increase the percentage of head injured children who were abused. However, given that one author (LRR) is notified of virtually all serious child abuse cases in the state, this seems unlikely. We also did not look at children with accidental head injuries admitted to other than the two tertiary care hospitals in Maine. Adding such cases would likely decrease the percentage of head injured children who were abused. The risk analysis of the 19 families suffered from incomplete data in the CPS records. Thus, the findings of the study should be considered a conservative estimate of the frequency of various risk factors. Finally, the analysis and profile of likely perpetrators could suffer from circular reasoning. For example, although in 14 of 15 cases the identified perpetrator was with the child at the time of symptom onset, it may be that the person who was with the child at the onset of symptoms was identified as the most likely perpetrator. Likewise, although there is a clear predominance of males identified in this and other studies (Starling et al., 1995; Jenny et al., 1999) such identification could be influenced by a biased perception that males are the most likely perpetrators.

Conclusion

If Maine, with a population of 1.2 million, averages 5 identified cases of AHT per year then it is likely that there are over a thousand cases of AHT medically identified and treated per year in the United States. The actual incidence of AHT could be far greater since is difficult to know how many cases of AHT are never medically evaluated or, if evaluated, are not correctly diagnosed.

The role of the medical provider in child abuse diagnosis and treatment includes suspicion for abuse (particularly for subtle signs and symptoms), identification of abuse when present with at least enough certainty to fulfill mandatory reporting requirements, completion of the appropriate medical-legal evaluation, documentation of all injuries, and reporting to child protective services and law enforcement. We found that many children with AHT have been seen by medical providers for signs and symptoms possibly related to abuse, yet, were not identified as possible abuse victims, that at least in these cases the medical workup and reporting at two tertiary care teaching hospitals was well done.

The role of the mandated child protective agency is to investigate child abuse reports, assess underlying risk factors, determine if child abuse has occurred, assess parental capacity and determine how best to protect children from abuse. Frequently and disturbingly, CPS in Maine had no forewarning that a particular child was at risk of AHT. Our study found that, in Maine, the initial assessment of safety was well done but that risk factor assessment was often incomplete. In response to these and other concerns, the Maine Department of Human Services had developed a specific risk assessment tool.

The role of law enforcement is to investigate a crime, identify a perpetrator, and present the case to the state's attorney for prosecution. An important role of law enforcement is to obtain the initial history for comparison with the medical forensic opinion of the case. Rarely did the hospital call law enforcement and despite protocols for law enforcement to be called by CPS in some cases such calls were delayed. Finally, our study suggests that law enforcement should look particularly closely at the individual with the child at symptom onset.

As a result of this study and other work by the Maine Child Death and Serious Injury Review Panel, Maine has enacted procedures for early multidisciplinary notification of law enforcement, child protective workers and forensic medical child abuse specialists; improved educational programs for medical providers emphasizing early identification of at risk children; improved child protective risk assessment tools and improved public community education programs, particularly targeting the male caretaker in the home both to educate caretakers about the dangers of shaking babies and to teach them ways to deal with the stress of managing a crying baby.

Practical Implications

Medical providers should think of abusive head trauma whenever an infant presents with irritability, vomiting, altered level of consciousness, increasing head circumference, or any bruises or fractures. If a spinal tap reveals blood, xanthochromia should be looked for as a possible sign of trauma. Law enforcement should be called by medical providers, along with child protective services, for any suspect serious physical abuse case. Child protective services should look closely at family risk factors but not be swayed by the absence of risk factors. Law enforcement should look closely but not exclusively at the individual alone with the child at the time of symptom onset.

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Child Death Addendum
2002

Age	Sex	Injury or Cause of Death	Perpetrator
2 years	Female	Drowning	Accidental
6 months	Female	Shaken baby /multiple fractures	Mother
5 months	Female	Rib fractures, fractured skull, burns	Mother/boyfriend
14 years	Male	Near death; induced illness	Mother
14 years	Male	Hanging	Self inflicted
3.5 years	Male	Suffocation	Foster parent–out of state
15 months	Male	Burns	Undetermined

INDIAN CHILD WELFARE ACT

Indian Child Welfare Act

This past year has been a time of consolidation, maintenance and continued progress.

A historic agreement was signed between the State of Maine and the Houlton Band of Maliseets. The signing ceremony was attended by the Commissioner of the Department of Human Services, the Attorney General and the Tribal leaders of the four Maine Tribes. The agreement sets forth how the Maliseets and the state will work together in matters related to child welfare.

Both State and local meetings continue to oversee the implementation of the agreement between the State of Maine and the Houlton Band of Maliseets. The consensus is that the conflict resolution protocols have rarely been used, but are effective when needed.

The Tribes and the State are moving forward on securing Medicaid Targeted Case Management funds to support Tribal Child Welfare activities. Given the impact of drug abuse on Indian families, the demands being made on the Tribal Child Welfare agencies are tremendous.

Activities Completed This Year

- A one-day program for new child welfare staff on the letter and the spirit of ICWA. The program was a joint effort by the state and the Tribes.
- Laminated Maine maps were distributed to all child welfare supervisors to be hung on the wall. The maps show 1) where all the Tribes are located, 2) how to contact the Tribes, 3) the major requirements of ICWA, and 4) how to contact the State ICWA coordinator. Maps have also been distributed to the Department of the Attorney General and the Courts.
- The first year of the Independent Living Plans were implemented. Creative engagement of older Indian youth was accomplished. The Tribes combined to have one event available to Indian youth from all Tribes.
- Bi-monthly meetings between Tribal and State Child Welfare representatives continue. Planning for future training is part of these meetings.
- A checklist to be used by Department staff to assure ICWA compliance was added to the policy manual.

Activities for the Coming Year

- Continue bi-monthly planning, training development and conflict resolution meetings.
- Continue to work toward Targeted Case Management for the Tribes.
- Provide technical assistance to the Child Welfare Department of Indian Township, which has had many personnel and organizational changes over the past two years.
- Assist in the development of this year's Independent Living Plans of the Tribes.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

The CAPTA State Grant Program exists to improve each state's response to abused and neglected children by providing funds to enhance the state agencies' child protective activities.

Compliance Update

Maine continues its compliance with all eligibility requirements, except for the requirement related to sharing certain information in child death and near death cases. Our statute does contain the provision related to child death cases, but does not have "near death" stated specifically in statute. The Department submitted a proposal to the Legislature during this year's session to remedy this situation, but the proposal did not pass. The Department will submit this legislation again during the next session.

CAPTA Requirements

There have been no changes in Maine's compliance with the requirement for a Citizen Review Panel, expungement of records, Review of Substantiation Decisions, Disclosure of Information in Child Fatality or Near Fatality and not requiring reunification when certain aggravating circumstances are present.

Summary of Citizen Review Panel Findings and Recommendations

1. Finding

   The Review Panel is concerned about the existing framework within which discussions about the very serious issue of child abuse and neglect takes place. It is perhaps in the legislative/political arena that the most concern exists.

   Put simply, the discussion has gone from one about the harm children can and do suffer at the hands of their parents and how society wants to address this issue to what must be done to protect parent's from unwarranted intrusion by the State when allegations of abuse and neglect have been made or found to be true. This is not to say that there is not genuine concern for children who are or maybe abused. There is indeed concern. Legislative changes over the last several years have however reflected a strengthening of parental rights with no such strengthening in children's rights.

   Recommendation

   a. The Department of Human Services and the Attorney General conducted a review of the Child and Family Services and Child Protection Act to see if there are ways to improve the protection of children through legislation.
   b. The Department of Human Services provides leadership in the training of child protection issues publicly and legislatively that creates a supportive environment for children as well as for adequate services to assist parents in their efforts to be able to care for and protect their children.

2. Finding

   Child Neglect is the most commonly substantiated type of abuse and neglect. In spite of this, Maine's response to this is not adequate. There is a need for multi-disciplinary education,

program development, and focus on the issue of neglect. More children die in homes where neglect is the major issue than any other type of abuse or neglect. Repeat maltreatment cases where children are seriously harmed over a long period of time are almost always neglect cases.

Recommendation
The State should undertake a major initiative to improve the response to children who are abused and neglected and their families.

3. Finding
The Department of Human Services has undertaken a major reform effort aimed primarily at improvements in how it delivers services to its clients. Emphasis is on client engagement and involvement in a way that enhances information gathering, collaborative planning and problem solving and enhancement of the child welfare professional role within the broader social services system. The actual new approaches are just beginning and the Department views making the desired changes as a long term (5 years) process. The Panel applauds the Department's efforts.

Recommendation
a. The Department to continue its reform efforts.
b. That careful evaluation of the impact of the new approaches on the families served by the Department is done. Based on real experiences and data collection, any required modifications to an approach should be made.
c. The Department should make every effort to inform all stakeholders of the changes being made and the reasoning behind the changes.
d. The Department is cautioned not to lose sight of its primary mission of safety, permanency and well-being for children.

Proposed Activities

CHILD MALTREATMENT PROJECT

This project is located in the District Court with the purpose of providing the Court with comprehensive clinical reports that have been found to have abused and neglected a child.

Activities for Last Year

- Training for providers.
- Training for Judges.
- Continuum of what type of evaluations for what type of cases developed.
- Set up peer supervision process

Activities for the Coming Year

- The protocol and process will be piloted in District 3 (Lewiston) with revisions made as necessary.
- The program will go statewide.
- Training for providers will continue.
- Work will continue on guidelines for Judges and the Department on what kinds of cases require what types of evaluations.

Summary:
The pool of providers has initially expanded which is one goal of the project. These "new" specialized providers need more training and peer review.

Child Death and Serious Injury Review Panel

Purpose:
To facilitate and support the operations of the Child Death and Serious Injury Review Panel. Professional staff was hired to support the work of the Panel. A special role of the staff is to develop and implement a plan to have the findings of the Panel have a greater impact on the child protective system. Panel members and the Child Abuse Action Network will assist in these efforts.

Multi-disciplinary Training
Staff from the Department of Human Services and other key state agencies require specialized training in order to carry out their respective roles and responsibilities. The Basic State Grant supports these activities by funding attendance at professional conferences both in and out of state.

Funds are also used to co-sponsor training and conferences which are developed by the Department and other agencies. A Children and Trauma Conference is planned for the coming year.

Budget

Child Maltreatment Project	$67,000
Child Death & Serious Injury Review Panel (Personnel costs)	$20,000
Multi-Disciplinary Training (conference & training attendance)	$22,000
Conference Sponsorship	$10,000
Supplies	$4,315
Newsletter	$3,500
Indirect* (@ .061 + sq. $596 state cap)	$1,185

Maine Department of Human Services
The Bureau of Child and Family Services

2003 Children's Justice Act Grant Application

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INTRODUCTION: THE CHILD ABUSE ACTION NETWORK

The Maine Department of Human Services (the Department) is the state agency designated by the governor to apply for Children's Justice Act (CJA) grant funding. The Department's Division of Child Welfare (the Division) is the administrative agent for Children's Justice Act grants. The Division is also the designated state entity, for the Department, for the Child Abuse Prevention and Treatment Act (CAPTA) Basic State Grant - a prerequisite for CJA grant eligibility.

In compliance with eligibility requirements, the Department established a multidisciplinary Task Force to plan for the use of the CJA funds. The Task Force is called the Child Abuse Action Network (The Network) which reports to the Governor's Children's Cabinet, thus furthering the Governor's goal of promoting collaboration among the state's agencies serving children. Since 1989 (except from 1994 to 1995), the Department has contracted with the University of Southern Maine's Edmund S. Muskie School of Public Service to administer the CJA grant, which also funds the staff position and administrative support to carry out the Network's mission and goals.

The Network's singular mission and responsibility is to focus primarily on the needs of multidisciplinary professionals who intervene in child abuse and neglect in order to improve the investigation and prosecution of these cases in a manner which mitigates further victim trauma. To that end, the Network continually undertakes a variety of activities, which support and enhance the expertise and interdisciplinary collaboration of these professionals. This multidisciplinary approach, in a sparsely populated state such as Maine where professionals have the unique opportunity to interact, has created a more effective child protection system on behalf of Maine's children.

The Network's activities have included diversified trainings, public awareness campaigns and research projects. These include statewide interdisciplinary conferences, a study of juvenile sex offenders, establishment of a statewide training system to identify the incidence of young sex offenders, publication of the newsletter: *Child Abuse and Neglect: The Maine Health Perspective,* a directory of treatment providers for victims, survivors, offenders and families involved in child and family maltreatment, a telephone survey to assess the knowledge and opinions of Maine residents about child maltreatment and a study of child abuse head trauma.

The CJA grant also provides staff support for the Department's multidisciplinary Child Death & Serious Injury Review Panel (the Panel), which conducts monthly retrospective case reviews. The Panel is established in statute, reports directly to the Department's commissioner and publishes periodic public reports of its findings and recommendations.

Staff support to the Network and the Panel continues to include: a) broadening multidisciplinary participation, b) coordinating projects and goals, c) developing frameworks for future activities, d) writing/publishing periodic reports of activities and recommendations, and e) planning, coordinating, facilitating an annual Network retreat in order to complete its annual review/reassessment and planning process.

A. Investigative, Administrative and Judicial

RECOMMENDATIONS

1. *CAAN as an entity and some CAAN members, on a workaday basis, will continue to be involved in the efforts of maintaining the standards of sound forensic interviewing techniques within both the Department of Human Services (DHS) and law enforcement jurisdictions, as taught April 2002 in the state-wide collaborative forensic training for child protective and law enforcement staff.*
2. *There continues to be a need for state agencies to maintain improved methods of investigating and managing cases involving child abuse and neglect fatalities and serious injuries and to develop other improved methods. Continued improvement in the collaboration and coordination between all relevant departments is recommended. There is a need for an improved protocol when a child known to a DHS district office dies or is seriously injured. Although some improvements have been made, there is a continuing need for increased education and the development of protocols for the medical community's response to child abuse and neglect fatalities and serious injuries.*
3. *There continue to be many improvements made within Maine's judicial system during the past four years. CAAN will continue to support further improvements in this area.*
4. *CAAN will educate professionals who work with children about issues pertaining to child welfare through the bi-annual publication of the CAAN newsletter, Child Abuse and Neglect: The Maine Health Perspective.*

ACTIVITIES TO MEET EACH RECOMMENDATION

Number A1

Recommendation

CAAN will maintain the standards of forensic interviewing techniques within both the Department of Human Services and law enforcement jurisdictions through formal and informal, train-the-trainer methods.

Proposed Activity and Outcome for 2002-2003

Proposed Activity: *CAAN will support the continued maintenance of child protective caseworkers' and law enforcement officers' forensic interviewing techniques that result in defensible, legally sound assessments, interventions and prosecutions. All new Department child welfare caseworkers must participate*

in this pre-service training in order to move into their case-carrying responsibilities. Similarly, new law enforcement staff receives this training and both entities are able to work collaboratively to investigate and intervene effectively, on behalf of abused and neglected Maine children.

***Proposed Outcome**: It is expected that continued collaborative working relationships among child protective caseworkers and law enforcement officers will maintain the skills acquired during the training session held for that purpose, "Cops and Caseworkers", sponsored by CAAN on April 3 and 4, 2002, and thereby mitigate further trauma to victims.*

Actual Activity and Outcomes

Actual Activity: It was expected that smaller, statewide sub-committees of "Cops and Caseworkers" would meet formally and regularly as an outgrowth of the larger forum held April 2002.

Outcome: While this has not happened, as a result of the unfilled CAAN coordinator position, until mid-January 2003, to assist with more planned, formal follow-up, informal follow-up has occurred at local levels, although it is not possible to assess those outcomes in any measurable way.

Number A2

Recommendation

There is a need for state agencies to develop further improved methods of investigating and managing cases involving child abuse and neglect fatalities. Improvement in the collaboration and coordination among relevant departments is recommended. There is a need for an improved DHS review protocol when a child known to a DHS district dies, or is seriously injured due to abuse or neglect. Finally, there is a need for increased education and the development of protocols for the medical community's response to child abuse and neglect fatalities and serious injuries.

Proposed Activities and Outcomes 2002-2003

***Proposed Activities:** Multidisciplinary review of child abuse and neglect fatalities and serious injuries by the DHS Child Death and Serious Injury Review Panel will continue into its eleventh year, and continued collaborative investigations will occur through the practice and maintenance of forensic interviewing skills by DHS caseworkers and law enforcement officers as they co-investigate child abuse and neglect. Educational and collaborative work will be completed at two upcoming annual conferences which focus on child maltreatment: Child Abuse Conference, held at Colby College in Waterville, Maine July 7 and 8, 2003 and the annual Spurwink Conference on Child Abuse in Portland, Maine September 11 and 12, 2003. DHS personnel contribute to the planning and participate as presenters at these events, both of which are hosted by the Spurwink Child Abuse Program. A pivotal planner and presenter at both of these conferences is on the CAAN Steering Committee and serves as Chair of the Department's Child Death and Serious Injury Review Panel. The DHS protocol for the review of child abuse and neglect fatalities and serious injuries will be developed by DHS Central Office management, who will also provide*

training to district office staff on the appropriate use of the protocol. Finally, there will be at least 2 training sessions for a total of 100 medical professionals about developing protocols for child abuse fatality risk factors.

Proposed Outcomes: *Continued collaborations between multiple agencies will facilitate a better working relationships and better outcomes for surviving siblings when future child deaths occur. The DHS internal child death and serious injury review protocol is expected to determine what can be learned about these critical incidents that will enhance and improve outcomes for Maine children and families. The development of protocols for the medical community will help identify deaths associated with maltreatment and may also help to protect the surviving siblings.*

Actual Activities and Outcomes for 2002-2003

Actual Activities: The Child Death and Serious Injury Review Panel reviewed ten cases since April 2002. These comprehensive, retrospective reviews have focused on systemic problems in assessing and responding to cases of child abuse and neglect fatalities and serious injuries. The Panel has also continued to participate in the annual Northern New England Child Fatality Review Consortium (NNE-CFRC), with the states of Vermont, Massachusetts and New Hampshire. Two annual child abuse conferences were held in Maine during the past year. The Department of Human Services plays a crucial role in the development, planning and presentations of these conferences. The annual, "Child Abuse Conference," was held at Colby College in Waterville, Maine in July 2002 and the annual "Spurwink Conference on Child Abuse" was held in Portland, Maine in September 2002. Both of these conferences were well attended by child welfare caseworkers, law enforcement officers, mental health and substance abuse providers, and other community intervention service providers throughout the state. Altogether these conferences provided training, by nationally recognized trainers, for over three hundred professionals around the state. The DHS "Child Death and Serious Injuries Review Format" was developed and disseminated to districts in early Spring 2003. This protocol provides specific areas for assessment to address both policy compliance and good practice within the context of the Bureau's mission, values and principles.

Outcomes: Although there continue to be some systems problems in the response to child abuse fatalities, there have been significant improvements resulting from the Child Death and Serious Injury Review Panel. In particular, collaborative response by child protective services and law enforcement has improved the outcomes for surviving children and resulted in longer sentences in the prosecution of some child homicides. Conferences, such as the annual July Colby College "Child Abuse Conference" and the "The 7th Annual Northern New England (Spurwink) Conference on Child Maltreatment", held annually in September, have helped to reduce gaps between agencies, increased communication and knowledge about the roles and responsibilities of all professionals responding to child abuse and neglect and continued the annual tradition of providing state of the art, practical and research-based education. Although there have been no methodological attempts to measure this dynamic,

progress is well documented by professionals in the field. The DHS internal review format for child fatalities and serious injuries has not been in use long enough to measure its effectiveness or outcomes. No outcomes can be reported for the anticipated training of physicians to develop medical protocols for responding to child abuse and neglect fatalities and serious injuries. While there has been some individual physician-to-physician training, by the only physician in Maine who is also a nationally recognized pediatric expert on child abuse and neglect, the demands on his schedule are such that the development of statewide protocols has not yet occurred.

Number A3

Recommendation

Many improvements have taken place within Maine's judicial system during the past three years. CAAN will continue to support further improvements in this forum.

Proposed Activities and Outcomes 2002-2003

Proposed Activities: *The Maine Judicial Branch and the Maine Department of Human Services will jointly initiate the Child Abuse and Neglect Evaluator's Project (the Project), a program strongly modeled on the Maine State Forensic Service, which provides comprehensive evaluations to the courts in criminal proceedings. This new program will focus on improving court-ordered comprehensive evaluations in civil child protective custody cases. Toward this goal, CAAN will provide information, consultation and expert opinion for the development of this program.*

Proposed Outcomes: *CAAN anticipates that this new program in the Maine Judicial Branch will provide courts with higher quality evaluations to assist the presiding justice with dispositional alternatives in more complex child protective cases. It is anticipated this program will be expanded to all the district courts through a pool of evaluators trained and credentialed in conducting these evaluations.*

Actual Activities and Outcomes 2002-2003

Actual Activities: A statewide "kick-off" conference was held April 2003 to initiate The Child Abuse Evaluator's Project. A Coordinator has been hired to focus on improving these court-ordered child maltreatment evaluations in child protective custody cases. The Coordinator's duties include: 1) implementing and coordinating a system of making referrals from the courts to mental health providers and reviewing evaluations received from the providers; 2) developing training for the evaluators and others involved in child protection proceedings; 3) coordinating a system of peer review among evaluators, and 4) coordinating the activities of the Advisory Board on project development.

Outcomes: The new Child Abuse Evaluator's Project has developed an evaluator protocol, is functioning in one district court and anticipated to be expanded statewide. Already the court is finding improved comprehensive child maltreatment evaluations beneficial to dispositional decision-making and more

positive outcomes for abused and neglected children. As the Project expands and has an evaluation component, measurable outcomes will be possible.

Number A4

Recommendation

CAAN will educate professionals who work with children about issues pertaining to child welfare and child maltreatment through the publication of "Child Abuse and Neglect: The Maine Health Perspective." This newsletter will be published bi-annually.

Proposed Activity and Outcomes 2002-2003

Proposed Activity: *CAAN will publish two editions of "Child Abuse and Neglect: The Maine Health Perspective." Each edition will be distributed to roughly 1,500 professionals who work with children in Maine.*

Proposed Outcome: *The newsletter will allow the community to become aware of CAAN publications, CAAN conferences and training, and timely practice issues, which CAAN is currently addressing.*

Actual Activities and Outcomes 2002-2003

Actual Activity: CAAN published one edition of "Child Abuse and Neglect: The Maine Health Perspective," in the summer of 2002. The contributions to the Summer 2002 newsletter are listed below.

1. "The Psychological Impact of Maltreatment" by Kerry Drach, PsyD
2. "The Mental Health Status of Rural Maine Children: Preliminary Findings from a NIMH Longitudinal Study" by James Harrod, PhD
3. "Myths and Facts About Child Maltreatment" A Joint Writing Project by Selected CAAN Members
4. "Munchausen Syndrome by Proxy: The Ultimate Betrayal" by Dawn Dorah Wilsey, Esq

Outcomes: The newsletter is mailed to over 1,500 professionals who work with children, such as educators, mental health providers, substance abuse professionals, medical professionals, judges, assistant attorneys general, law enforcement officers, child welfare caseworkers, etc. The main purpose of this newsletter is to keep professionals, who intervene on behalf of abused and neglected children, informed about child maltreatment, associated risk factors, the "facts of child maltreatment in Maine" and intervention strategies. It is difficult to measure the impact of an educational project such as the newsletter.

B. Experimental, Model and Demonstration Programs

RECOMMENDATIONS

1. ***CAAN supports the development of a collaborative relationship between DHS and the Maine Office of Substance Abuse. More specifically, CAAN recommends that substance abuse professionals work alongside child welfare professionals in some of the Department's district offices.***
2. ***CAAN recommends the development of a work product produced by the clinicians participating in CAAN sponsored specialty-focused training for seasoned mental health providers, entitled, "Selected Topics in Assessing and Treating Complex Children." This work product will be a published guide for Maine providers working with complex children. The training, itself, will provide specialized state-of-the-art training and expanded peer support for clinicians who work with challenging issues pertaining to child maltreatment.***
3. ***CAAN supports the joint efforts of DHS and the Department of Corrections to utilize information obtained in joint research projects related to training Juvenile Corrections staff about juvenile sex offenders.***
4. ***CAAN supports continued efforts to facilitate effective assessments and interventions in cases where domestic violence and child maltreatment co-exist.***

ACTIVITES TO MEET EACH RECOMMENDATION

Number B1

Recommendation

CAAN supports the development of a collaborative relationship between DHS and the Maine Office of Substance Abuse. More specifically, CAAN recommends that substance abuse professionals work alongside child welfare professionals in some of the Department's district offices.

Proposed Activities and Outcomes 2002-2003

Proposed Activities: *CAAN will bring together substance abuse treatment professionals and child welfare professionals to address their related work with regard to child maltreatment and services to families. In the coming year, these professionals will meet between four and six times to begin collaborative work and to discuss training sessions for the year after next. The Department and the Office of Substance Abuse also plan to place a licensed substance abuse counselor in the Department's Washington County office. This individual will be available for parental substance abuse assessments, full evaluations and case consultation.*

Proposed Outcomes: *Both of the activities proposed above will begin to lay the foundation for true collaborative work, including increased communication and improved case planning/intervention between the Department and the Office of Substance Abuse within the coming years.*

Actual Activities and Outcomes 2002-2003

Actual Activities: There have been several meetings held between substance abuse treatment professionals and child welfare professionals. Together they have discussed more effective ways to incorporate their two professions. They have also successfully placed a substance abuse counselor in the Washington County office. This provider assists child welfare staff in parental substance abuse assessments, full evaluations and case consultation. Finally, with the assistance of substance abuse providers, the Department has adopted a new substance abuse screening tool, UNCOPE, on which all child welfare workers have been trained.

Outcomes: These group meetings have been instrumental in laying the foundation for collaborative work between the substance abuse and child welfare profession. Additionally, the presence of substance abuse counselor in a child welfare office has been very helpful to the staff in the development of case plans. More pronounced outcomes are expected in the near future.

Number B2

Recommendation

CAAN recommends the development of a work product from the CAAN-sponsored training, "Selected Topics in Assessing and Treating Complex Children to address the issue of integrating specialized information among mental health providers' assessment and treatment repertoires. This will provide a common base of knowledge for providers working with complex children and will provide peer support for individuals who work with the challenging issues related to child maltreatment.

Proposed Activities and Outcomes 2002-2003

Proposed Activities: *CAAN provided Master's and PhD level clinicians, with at least five years experience and who work at a managerial level, or who have a private practice, with a specialized training program entitled, "Selected Topics in Assessing and Treating Complex Children." It is the goal of the Network to provide this training to individuals who have the capacity to incorporate the training into their daily work, and to train peers in their agency or practice. This monthly training was provided in a centralized location for 15 clinicians from around the state. The training sessions were framed and treated much like a course, with monthly readings and required attendance. This activity was expected to be completed by March 2002, however due to the CAAN Coordinator staff vacancy and re-scheduling by two trainers, the program is expected to conclude July 11, 2003.*

Proposed Outcomes: *This training will provide a unique way of working with and providing treatment for maltreated children, which may have the capacity to influence treatment statewide. Outcomes of this training will include: 1) an attendee-developed-guide for use by peers and other service providers, 2) provision of a common base of knowledge for providers, 3) the development of regional peer groups which will provide support for clinicians grappling with*

treatment modalities, and 4) better informed assessments and interventions on behalf of children with complex challenges related to maltreatment.

Actual Activities and Outcomes 2002-2003

Actual Activities: CAAN sponsored trainings for seasoned Master's and PhD level clinicians on "Selected Topics in Assessing and Treating Complex Children" will be completed July 2003.

Outcomes: The "Selected Topics" clinician-attendees are developing a work product from this Training program that will be a guide for other clinicians and a variety of other service providers who encounter complex cases in their practice.

Number B3

Recommendation

CAAN supports the joint efforts of DHS and the Maine Department of Corrections to utilize information obtained in joint research projects related to training Juvenile Corrections staff about juvenile sex offenders.

Proposed Activities and Outcomes 2002-2003

Proposed Activities: *In the coming year, there will be continued joint trainings for DHS and Department of Corrections staff addressing the assessment of juvenile sex offenders for the community, family and self. CAAN will assist with these trainings by providing professionals for panel presentation, resources and consultation.*

Proposed Outcome: *CAAN anticipates that joint trainings will enhance the working relationship between DHS and the Department of Corrections, and that the skills acquired at these trainings will better meet the needs of abused and neglected and children and their families.*

Actual Activities and Outcomes 2002-2003

Actual Activities: All of the targeted staff within the Department of Corrections received the training as planned. Multiple other trainings with the Department of Human Services have prevented full training for the Corrections staff.

Outcomes: The outcomes of this training to date are limited due to the interrupted training schedule and staff shortages at the Department of Corrections.

Number B4

Recommendation

CAAN recommends continued efforts to facilitate effective interventions in cases where domestic violence and child maltreatment co-exist.

Activities and Outcomes 2002-2003

Proposed Activities: *The Department, in collaboration with state domestic violence agencies and DHS child welfare caseworkers, will develop protocols to strengthen the collaborative relationship between the Department and family violence professionals, thus aiding workers in the services that they provide to vulnerable children and their families.*

Actual Activities and Outcomes 2002-2003

Actual Activities: The protocols for handling joint cases of child maltreatment and domestic violence have been revised and are currently being rewritten. They were distributed to all child welfare professionals in September 2002.
Outcomes: Child welfare professionals in Maine received well researched information describing protocols for dealing with dynamics of co-occuring domestic violence and child maltreatment.

C. Legal and Procedural Reform

RECOMMENDATIONS

1. ***CAAN will participate in forthcoming reviews of Maine's child welfare system to be conducted by a legislative commission.***
2. ***CAAN recommends that the Department use its 2001 Report of the Child Death & Serious Injury Review Panel to inform legislative action, Departmental procedures and collaborative multidisciplinary work.***

ACTIVITIES TO MEET EACH RECOMMENDATION

Number C1

Recommendation

CAAN will participate in forthcoming reviews of Maine's child welfare system which will be conducted by a legislative commission.

Proposed Activities and Outcomes 2002-2003

Proposed Activities: *CAAN will develop a subcommittee, which will participate in and help to guide the review of the Maine child welfare system. This will be accomplished by providing the commission with information which CAAN deems to be relevant to the review.*

Actual Activities and Outcomes 2002-2003

Actual Activities: There were fewer opportunities to participate in this review than CAAN anticipated and desired. The committee did provide copies of "The Multidisciplinary Decision-Making Model of Child Abuse in Maine" to all members of the legislative reviews. Moreover, there was oral and written testimony from some members of the CAAN committee.
Outcomes: Although the Maine Legislative committee was provided with oral and written testimony from members of the CAAN committee, the Legislature did not extend opportunities for further involvement

Number C2

Recommendation

CAAN recommends that the Department use its future Child Death Report 2001 to inform legislative action, Departmental procedures and collaborative multidisciplinary work.

Proposed Activities and Outcomes 2002-2003

Proposed Activities: *The Maine Child Death and Serious Injury Review Panel, which is a multidisciplinary committee of the Department, will publish its annual report in June 2001. CAAN will provide consultation and assistance to the Department about this publication.*

Proposed Outcomes: *CAAN anticipates that the contents of this report will be used to influence legislative action, Departmental procedures and collaborative multidisciplinary work*

Actual Activities and Outcomes 2002-2003

Actual Activities: The public Report of the DHS Child Death and Serious Injury Review Panel has been completed. The DHS Acting Commissioner has not released the report to date.

Outcomes: It is anticipated that upon release of the report, legislative action, DHS procedures and associated training of child welfare staff, will be influenced as a result of information provided.

A. Investigative, Administrative and Judicial

RECOMMENDATIONS

1. *CAAN will continue to support the efforts for forensic interviewing within both the Department of Human Services and law enforcement offices.*
2. *There is a need for state agencies to develop further improved methods of investigating and managing cases involving child fatalities. Moreover, improvements in the collaboration and coordination between all departments is recommended. Finally, there is a need for increased education and the development of protocols for the medical community with regard to this issue.*
3. *There have been many improvements made within Maine's judicial system during the past three years. CAAN will continue to support further improvements in this area.*
4. *CAAN will educate professionals who work with children about issues pertaining to child welfare through the publication of Child Abuse and Neglect: The Maine Health Perspective. This newsletter will be published bi-annually.*

ACTIVITIES TO MEET EACH RECOMMENDATION

Number A1

Recommendation

CAAN will continue to support the efforts for forensic interviewing within both the Department of Human Services and law enforcement offices.

Proposed Activity and Outcome for 2003-2004

Proposed Activity: *The group that planned the recent training "Cops & Caseworkers" for law enforcement officers and child protective workers will expand to include ten-fifteen people. This group will meet quarterly. The topics at meetings will include areas of contention, disagreement or misunderstanding between the two professions. Local speakers may also be featured two or three times a year.*

Proposed Outcome: *The activities of this workgroup will help to identify areas of contention, disagreement or misunderstanding between law enforcement officers and child protective services in the State of Maine. CAAN expects that these activities will help to increase communication, resolve differences, development of common base of knowledge and improve responses to reports of child maltreatment.*

Number A2

Recommendation

There is a need for state agencies to develop further improved methods of investigating and managing cases involving child fatalities. Moreover, improvements in the collaboration and coordination between all departments is recommended. Finally, there is a need for increased education and the development of protocols for the medical community with regard to this issue.

Proposed Activities and Outcomes for 2003-2004

Proposed Activities: *The Maine Child Death and Serious Injury Review Panel will continue to meet for the coming year. Approximately ten cases of deaths or serious injuries will be reviewed during this time. In the event to further improve communication between child protective workers and law enforcement officers, a subcommittee will also continue to meet throughout the year, addressing areas of contention, disagreement and misunderstanding between the two professions. Efforts for increased education and development of protocols include (1) key members of CAAN from the medical community speaking to medical professional associations, such as the Maine Osteopathic Associations and (2) a training course that is delivered to key medical providers in Maine about signs and symptoms of child abuse maltreatment.*

Proposed Outcomes: *The proposed outcome of these activities is to enhance the quality of collaborative work between multiple disciplines in responding to child abuse fatalities.*

Number A3

Recommendation

There have been many improvements made within Maine's judicial system during the past three years. CAAN will continue to support further improvements in this area.

Proposed Activities and Outcomes for 2003-2004

Proposed Activities: 1) Applications will continue to be received from mental health evaluators by the Child Abuse & Neglect Evaluation Project Director. A larger pool of evaluators to be selected for this program will receive multidisciplinary training from CAAN. CAAN will continue to provide information, consultation and expert opinion for the development of this program. 2) CAAN will provide expertise and consultation to the newly developed Family Drug Court in the mid-coast area of Maine. This program is designed to bring to bear the authority of the court, in child protective proceedings, where substance abuse is the major contributing factor in child maltreatment.

Proposed Outcomes: *CAAN anticipates that this new program will provide the court with high quality examinations of parents working with the Department. During the first year of the project, the Department will implement this program throughout the state and to develop a pool of psychologists capable of performing evaluations for the Department.*

Number A4

Recommendation

CAAN will educate professionals who work with children about issues pertaining to child welfare through the publication of Child Abuse and Neglect: The Maine Health Perspective. This newsletter will be published bi-annually.

Proposed Activities and Outcomes 2003-2004

Proposed Activity: *CAAN will publish two editions of "Child Abuse and Neglect: The Maine Health Perspective." Each edition will be distributed to roughly 1,500 professionals who work with children in Maine. Upcoming issues will focus on:*

1. *The* ***myths*** *and* ***facts*** *of child maltreatment.*
2. *The status of children's mental health, mental health services for children and use of psychotropic medication by children in Maine*
3. *The psychological impact of abuse on children*

CAAN plans to educate professionals about the status of children in Maine through a study that investigated the opinions and knowledge of Maine residents about child abuse and neglect. That 500 sample, random digit-dial telephone survey, was written by CAAN members and the results need to be utilized in public awareness and professional education campaigns.

Proposed Outcomes: *The newsletter will allow the community to become aware of CAAN publications, CAAN conferences and training, and timely issues, which CAAN is currently addressing.*

The results of the study concerning the opinions and knowledge of Maine residents concerning child maltreatment educated professionals and the public, revealed gaps in knowledge about child abuse, provided information for education campaigns and served as a tool for intervention techniques. The outcome will be a more well- informed public and a more responsive professional community.

B. Experimental, Model and Demonstration Programs

RECOMMENDATIONS

1. ***CAAN continues to support the development of a collaborative relationship between DHS and the Maine Office of Substance Abuse.***

2. ***There should be continued efforts to facilitate effective interventions where domestic violence and child maltreatment co-exist in families.***

ACTIVITIES TO MEET EACH RECOMMENDATION

Number B1

Recommendation

1) The model that placed a substance abuse evaluator in one DHS district office has proven to be highly successful. CAAN will work to implement that same model in at least two more district offices by supportive funding, technical assistance and training. 2) The revised substance abuse assessment tool, which adds the domain of parental functioning, especially related to child maltreatment issues, is being piloted in the mid-coast Maine area by two community-based substance abuse service providers. CAAN proposes to support the statewide dissemination and utilization of this evaluation tool and CAAN will provide training and technical support and assistance.

Proposed Activities and Outcomes for 2003-2004

Proposed Activities: *The substance abuse-child welfare group will continue to meet the goal of developing a new assessment tool that will be used by substance abuse evaluators. The current tool does not assess the ability of parents to protect their children.*

Proposed Outcomes: *The collaborative work between these two groups of professionals will open lines of communication and will possibly influence philosophical thinking about providing services to families. More concretely, the group will develop an assessment tool that is more responsive to the concerns of child welfare professionals.*

Number B2

Recommendation

CAAN recommends the development and publication of a guide as a product of the "Selected Topics in Assessing and Treating Complex Children", a CAAN-sponsored training to integrate state-of-the-art assessment and treatment skills among Maine mental health clinicians and other service providers. This guide will provide a common base of knowledge for providers working with complex children and will provide support for service providers who work with complex child maltreatment issues.

Proposed Activities and Outcomes 2003-2004

Proposed Outcomes: and Activities

The "Selected Topics in Assessing and Treating Complex Children" training will provide a unique way of working with and providing treatment for maltreated children, which may have the capacity to influence treatment statewide. Outcomes of this training will include an assessment and treatment guide, a common base of knowledge for providers and the development of regional peer groups, which will provide support for clinicians grappling treatment modalities. The training will also provide an opportunity to assess possible presenters at a CAAN-sponsored consortium on child neglect, anticipated to occur in April 2004. The revised course subjects for "Selected Topics" include:

- *Trauma*

- *Attachment*
- *Substance Abuse & Trauma*
- *Parental Mental Illness: Treatment Focus & Relationship*
- *System Structure for an Abuse/Neglect System for a State*
- *Child & Adolescent Psychiatry*
- *A Pediatric Approach to Disruptive Behavioral Difficulties*
- *Child Neglect*

Number B3

Recommendation

There should be continued efforts to facilitate effective interventions in cases where domestic violence and child maltreatment are present in the same home.

Proposed Activities and Outcomes for 2003-2004

Proposed Activities and Outcomes: *The review and redesign of the domestic violence and child welfare protocols remain to be finalized and upon completion, will strengthen the collaborative relationship between the Department and family violence professionals, thus aiding workers in the services that they provide to children and their families.*

C. Legal and Procedural Reform

RECOMMENDTAIONS

1. ***CAAN will participate in the continuing activities of the Maine Legislature's Health and Human Services Committee and the Department's efforts at reform, known as, "Getting it Right for Children and Families."***
2. ***CAAN recommends that the Department use its Child Death Report to inform legislative action, influence state agencies' policies and procedures, and inform collaborative multidisciplinary work.***

ACTIVITIES TO MEET EACH RECOMMENDATION

Number C1

Recommendation

Proposed Activities: *CAAN will undertake a two year initiative to address the challenging issue of child neglect by sponsoring a statewide Consortium on Child Neglect in April 2004, where one or two nationally recognized experts will present empirically-based information on child neglect to assist the invited attendees to develop assessments, interventions and prosecutions that integrate current thinking on this complex issue.*

Proposed Outcomes: *As a result of the Consortium on Child Neglect, Maine professionals who assess, treat and prosecute child neglect will have developed a commonly understood definition of child neglect that informs their particular discipline and practice and will result in better outcomes for Maine children who suffer child neglect.*

Number C2

Recommendation

CAAN recommends that the Department use the 2001 report of the DHS Child Death & Serious Injury Review Panel to inform legislative action, Departmental procedures and collaborative multidisciplinary work on behalf of maltreated children.

Proposed Activities and Outcomes for 2003-2004

Proposed Activities: *The Maine DHS Child Death and Serious Injury Review Panel anticipated the Department would publish and release its four-year report in June 2002. While the report has been completed for six months, it has yet to be released. This report summarizes the findings and recommendations of the Panel's work over the past four years.*

Proposed Outcomes: The report will make recommendations to professionals who intervene on behalf of children at risk of, or who have suffered fatal child abuse or neglect or serious injuries.

CHILD WELFARE TRAINING INSTITUTE

MAINE CHILD WELFARE TRAINING INSTITUTE
COOPERATIVE AGREEMENT FOR FY 2004 BCFS TRAINING

OCTOBER 2003

This Cooperative Agreement is under the auspices of the Memorandum of Understanding between the Department of Human Services and the University of Southern Maine regarding the DHS training institute (5/13/93). This is the thirteenth year of a continuation project. In accordance with the General Policy Agreement for the State/University Cooperative Projects, to qualify for exemption from competitive bidding, individual activities must include benefits and responsibilities on the part of the State and University. Following is an outline of the Outcomes (benefits) and Responsibilities under this agreement.

1. Benefits and Outcomes for the State:

- Concrete deliverables in the areas of staff training, organizational development and planning
- Increased knowledge and skills of BCFS staff, adoptive and foster parents and providers
- Enhanced funding for training and continuing education of BCFS staff, adoptive and foster parents and providers
- Ongoing consultation which allows BCFS to maximize the content expertise of line staff, supervisory staff and management
- Resources and support to stay current in field of expertise
- Research and Consultation to promote retention of excellent staff and adoptive/foster families in Maine's Child Welfare System
- One (1) student trained as Adoptive and Foster Family Education Coordinator

2. Benefits and Outcomes for the University:

- Internships, assistantships and capstone projects for university students, including one graduate student and two undergraduate students provided with stipends.
- Support for ongoing MSW courses (through onsite course delivery and tuition reimbursement) for all interested staff through the University of Maine System.
- Support for two onsite MSW courses to be collaboratively developed and offered through the University of Maine System.
- Tuition reimbursement that attracts students to university courses.
- Expanding USM's course offerings to non-credit and certificate programs.
- Access to state administrative and program data to conduct research and evaluation studies.
- Resources and support to stay current in field of expertise.
- Contributing to increased efficiency and cost-effectiveness of state government.

- Funding for graduate courses in supervision.
- Promotes and provides for access to state-of-the-art learning technology including interactive video and Web Based Courses.

3. Responsibility and Costs for the State:

- Contributes to direct costs of projects.
- Provides space in state offices for meetings and project work.
- Assignment of staff to work on committees.
- Contribution of time for collaborative work in design and implementation.
- Gives access to DHS data, policies, procedures, technology.
- Participates in joint hiring of staff for cooperative projects.

4. Responsibility and Costs for the University:

- Contributes a percentage of assessed indirect as match to project budget.
- Provides space in Augusta and Portland for project staff meetings and training.
- Manages fiscal aspects of project.
- Provides human resources management for project staff.
- Gives access to university resources (library, computer services, telecommunications, etc.).

COOPERATIVE AGREEMENT FOR 2002-2003 BCFS TRAINING

I. BACKGROUND

The Maine Child Welfare Training Institute is the result of a collaborative effort between the State of Maine Department of Human Services/Bureau of Child and Family Services and the Edmund S. Muskie School of Public Service of the University of Southern Maine. The goal of the Child Welfare Training Institute (CWTI) is to coordinate the continued professional and personal development of staff at all levels throughout the Bureau of Child and Family Services (BCFS), as well as foster parents, adoptive parents and other providers of child welfare services in Maine, in order to enhance the quality of services delivered to clients and to advance organizational objectives.

The framework for this training plan, which marks the thirteenth year of this partnership, comes from priorities identified by BCFS for the upcoming year and information obtained through studies of child welfare practice in Maine and nationally. Training and Professional Development goals are set by various stakeholder groups which share the responsibility for enhancing practice and implementing the new state and federal statutes impacting child abuse and neglect. The Bureau of Child and Family Services, Casey Strategic Planning Group, and CWTI have worked to align training and professional development goals with the Bureau Reform Initiative, released during the past year.

Current issues for the Bureau based on recent work with the public, the legislature, and other system stakeholders include issues pertaining to safety, permanency, and well-being for children from the beginning of the Bureau's involvement in a family's life. Additional collaboration among the Bureau, will continue to shape the direction of training and support for Bureau initiatives and goals. This agreement describes and defines the ongoing work that the Child Welfare Training Institute will undertake in FY 2004, and is developed in concert with two other agreements: the MACWIS (Maine Automated Child Welfare Information System) Training Agreement and the Casey Reform Agreement, sponsored by the Annie E. Casey Foundation.

The coming fiscal year will include the core programs which have become the foundation of collaboration between the University and the Bureau, including training and professional development opportunities for staff, adoptive families, foster families, and other identified service providers. CWTI will also collaborate with other statewide initiatives, for example the initiative to better serve children in care through working with educational and school systems and the national pilot grant for Competency Based Independent Living Training.

II. OBJECTIVES

A. Pre-Service Training:

- To deliver pre-service training to new BCFS caseworkers.
- To provide coaching, assessment, and ongoing support for new workers and their supervisors.
- To administer, review, and revise curriculum, enhance regional support for the preservice training, and plan for expanded delivery modalities for the training program.

B. Ongoing Staff Training:

- To deliver centralized in-service training for staff, supervisors and managers.
- To deliver regionalized training programs for staff, supervisors and managers.
- To administer, plan for, and evaluate ongoing staff training.

C. Innovations in Child Welfare Practice:

- To deliver centralized training in support of administrative initiatives to innovate practice in child welfare.
- To deliver regionalized training in support of administrative initiatives to innovate practice in child welfare.
- To administer and evaluate training-related innovative practice activities.

D. Professional Development Activities:

- To provide research, consultation, and training in support of retention of Child Welfare Staff.
- To deliver ongoing educational, resource and membership assistance along with academic and professional development opportunities towards attainment of graduate degrees in Child Welfare related fields for all staff members.
- To provide guidance and oversight for CWTI sponsored Professional Development activities and allocations.

E. Adoptive and Foster Family Introductory Training:

- To deliver regionalized training for foster and adoptive parents and relatives providing care and to provide ongoing consultation and feedback to the staff of the Bureau of Child and Family Services to support their work in promoting safe placement and effective care of children.

- To maintain the relevancy and currency of the Introductory Curriculum for prospective foster and adoptive parents and relatives providing care and to ensure others delivering the curriculum are knowledgeable in the approaches necessary to achieve desired outcomes.

- To administer and evaluate Introductory Training within the Adoptive and Foster Family Training Program.

F. Adoptive and Foster Family In-Service Training:

- To deliver a range of In-Service training that responds to the professional development needs of foster and adoptive parents.

- To increase access to training by providing a variety of formats and delivery methods and through the use of Outreach Education for Foster Parents (student interns).

- To increase the retention of foster and adoptive parents through provision of training, recognition, and respite.

- To provide guidance and oversight for CWTI sponsored Professional Development activities and allocations.

- To administer and evaluate the In-Service Training Programs within the AFFT program.

G. Maine Caring Families:

- To administer and evaluate a training program for foster parents and staff in the Maine Caring Families Program

- To deliver ongoing educational, resource, and professional development opportunities for MCF staff and foster parents.

H. Specialized Programs Training:

- To provide centralized training for specialized program area staff on topics which are specific to their role and responsibilities.

- To administer and evaluate the Specialized Programs training program.

I. Children's Transportation Training:

- To provide training in the CWTI Children's Transportation Curriculum to all new drivers employed by contracted transportation service providers who transport children.

J. *Post Adoption Services:*

- To enhance the development of the post-adoption program by providing support for ongoing training for staff and providers.
- To expand the availability and effectiveness of post adoption support groups in Maine
- To contribute to the development of resources available to adoptive families by researching and developing adoption preservation services geared to the most pressing needs of children in adoptive placement

III. WORKPLAN

A. Pre-service Training

The goal of Pre-service training is to deliver a holistic, competency-based training for new child welfare professionals, providing basic knowledge of national and statewide child welfare practice standards, legal basis and parameters for intervention, and current social work precepts. This year's training plan will continue to focus on integrating MACWIS and the new federal and state laws into practice. In addition, web-based training allows for local delivery of key topics such as job shadowing activities, the legal framework for practice, Maine's Automated Child Welfare Information System (MACWIS), and policy issues for casework staff. Work with supervisors to prepare new staff for training and their career, as well as ongoing coaching and support, represent a continuum of training and learning events for the new caseworker. The preservice team will work with the Preservice Review Committee on the development and implementation of a 'Portable Toolbox' to assist workers and supervisors in critical learning events during the first two years of service. Ongoing committee and workgroup involvement in updating and reviewing curriculum will continue.

Objective One: To deliver Pre-service training to new BCFS caseworkers.

Outputs:

- Up to one-hundred (100) new caseworkers will have received twenty-three (23) days of Pre-service training.

- All new casework staff will participate in Web Based Training Modules from their district offices to have ongoing access to training from the start of their employment.

Objective Two: To provide coaching, assessment, and ongoing support for new workers and their supervisors in the context of the regional offices.

Outputs:

- Supervisors will participate in a half-day meeting prior to and following centralized training which will allow them to consult with trainers and new caseworkers to build a customized development plan (50 contact days).

- New Caseworkers will participate in fifteen (15) days of structured job shadowing and on-site trainings as indicated in plan using Web Based Training materials published through CWTI.

- CWTI will develop a portable learning tool set which will assist supervisors and new workers at critical learning moments post-residential training during the first two years.

Objective Three: To administer, review and revise curriculum, enhance regional support for the Pre-service training and plan for expanded delivery modalities for the training program.

Outputs:

- The pre-service curriculum will have been updated based on the 2003 review of the program.
- The Staff Training Committee (18 people) will have met four (4) times and will have developed recommendations for FY 2003 training.
- CWTI staff will have sent notice of Pre-service training to potential participants and provided registration, evaluation and record keeping services.

B. Ongoing Staff Training:

The goal of ongoing training is to deliver training for all child welfare professionals which provides state-of-the-art knowledge of national and statewide practice standards, legal basis and parameters for intervention, and current social work precepts. In the coming fiscal year, training information and registration will continue to be offered to Bureau Staff and Tribal representatives who address child welfare issues within their communities. Many training topics are open to all staff, however in concert with efforts to recognize and retain staff at all experience levels, and to develop focused training, some topics will be delivered for specialized groups. Regionalized training delivery provides an opportunity for staff to learn within the context of their own unique communities. Trainings delivered in this format often include local professionals from related disciplines, either as presenters or participants, thus strengthening the local response to child abuse and neglect. Topics that are suitable for this training format are identified either by the district staff/training committee in conjunction with their liaison or are selected from a menu of topics disseminated by CWTI.

New Caseworkers continue to develop through mandatory Core training topics, listed below. During the coming year, the topics listed below will be offered with the remaining three topics, Dynamics of Substance Abuse, Batterer Intervention and D.V, and Trauma and Childhood, being offered in FY 2005.

Training in work with Maine's Automated Child Welfare Information System (MACWIS) is delivered under separate contract.

Objective One: To deliver centralized In-service training for staff, supervisors, and managers.

Outputs:

- New Caseworkers will attend seven (7) centralized training sessions on the basics of Child Welfare during their first year of employment, four of which will be offered in FY 2004.
    1. *Losses, Moves, and Attachment*
    2. *Medical Indicators of CA/N*
    3. *Dynamics of Sexual Abuse*
    4. *Documentation and Writing Skills*

- Three training topics will be held , open to all staff and representatives from tribal governments:
    1. *Permanency for Children*
    2. *The Multi-Ethnic Placement Act*
    3. *The Indian Child Welfare Act*

- Four (4) training topics related to supervision will be offered to all supervisors over the course of eleven (11) days.
    1. *How to Promote Reflection and a Learning Organization in the Office*
    2. *What do I ask Next? Hiring, Interviewing, and Retention Strategies for Supervisors*
    3. *Supervision in Social Services (Tony Morrison)(two deliveries, four days each)*

- New Supervisor Orientation (three days of training) and two centrally held workshops (2 days) will be available for new supervisors.
    4. *Getting What You Need from MACWIS: Child Welfare Supervision and Information Systems.*
    5. *Motivational Interviewing for Supervisors*

- Two (2) topics for Managers and Program Specialists will be offered over two (2) days:
    1. *Leadership in the Office and Beyond: The Manager's Role in Public Child Welfare*
    2. *Emotional Intelligence and Leadership (Tony Morrison, 1 day)*
- Ongoing support for Sr. Management learning circles, informal learning workgroups, will be provided including facilitation, resource provision and development, and support for travel.

Objective Two: To build local training partnerships through regionalized training programs for staff, supervisors and managers, district liaison work with local leadership, and ongoing mentoring as appropriate.

Outputs:

- Thirty (30) days of on-site regional workshop/workgroup training will have been delivered.

- CWTI training specialists will be assigned a district and will spend one day per month in the district offices and will work with each District to develop and implement a training plan that is tailored to the training needs of that office.

Objective Three: To administer, plan for and evaluate ongoing staff training.

Outputs:

- The Staff Training Committee/Diversity Training Workgroup will have met two (2) times and will have developed recommendations for FY 2005 training.

- CWTI staff will have sent quarterly notice of trainings to potential participants, including stakeholders and tribal representatives, and provided registration, evaluation, and record keeping services.

- CWTI will continue to update and maintain a website with an added interactive feature allowing online registration for participants.

C. Innovative Practices in Child Welfare

This goal supports ongoing administrative initiatives that are designed to fundamentally enhance the functioning and the outcomes of child welfare practice within the State of Maine. This year's training will be developed and delivered in conjunction with the Bureau's Program Improvement Plan to promote enhanced child focused, family centered practice. This fiscal year also includes the results and training implications of the 2003 Federal Child and Family Services Review of services to Children and Families in Maine.

Objective One: To deliver centralized training in support of administrative initiatives to innovate Child Welfare practice.

Outputs:

- CWTI will continue to support training and planning meetings for the Bureau's Strategic Planning and Senior Management groups in collaboration with and succession to the Casey Strategic Planning Team and in support of the Casey Reform Grant.

- Statewide training on topics identified with BCFS Management and other stakeholders will be offered for up to 4 additional days of training for all staff.

Objective Two: To deliver regionalized training in support of administrative initiatives to innovate Child Welfare practice.

Outputs:

- CWTI will work with the Senior Management and Reform Team Groups to develop strategies for dissemination of information and facilitated learning on key issues including: (up to 6 days of training)

    1. *Relative and Kinship Placement Issues*
    2. *Concurrent Planning*
    3. *Visitation*

Objective Three: To administer, plan for, and evaluate training related innovation activities.

Outputs:

- CWTI Directors and/or staff will have participated in eight (8) days of Bureau and Senior Management meetings.

- CWTI staff will have sent notice of trainings to potential participants and provided registration, evaluation and record keeping services.

- CWTI Staff will participate in activities to support the Bureau's Program Improvement Plan based on the 2003 Federal review, including surveys and focus groups with key stakeholders to gather information relevant to outcome measures described in the review process.

- CWTI will continue to work with other New England Training Directors under the auspices of the New England Child Welfare Commissioners' Association.

D. Professional Development Activities:

The goals of professional development activities are to promote the learning of new knowledge and skills, to maintain or enhance the academic and professional credentials of BCFS staff and to encourage staff retention.

Professional development opportunities outside of the formal training system promote interaction with non-Bureau providers and the University system. The Clinical Supervisory Mentoring Program pairs individual supervisors with local mental health clinicians for the purpose of consultation regarding complex issues being encountered by the supervisor. The annual fall conference will be held again in 2004, under separate contract, as an initiative to support the Reform Plan as sponsored by the Annie E. Casey Foundation.

The Professional Development Committee meets quarterly and provides a unique opportunity to unite the academic and professional organizations in the state with Child Welfare professionals in the effort to collaborate for enhanced practice. A Steering Committee composed of members of the Professional Development Committee, Senior Mangement group, and representative students and graduates from the tuition assistance programs will continue to consult on policy and placement issues for staff participating in both the onsite and reimbursement programs. One of the initiatives through the Reform Team work with Strategic Management is to promote improved retention and recruitment. Recommendations by that workgroup included a plan to update and enhance the panel hiring program, analyze exit interviews, and compile input and data related to improved retention. These efforts will continue and recommendations by the committee will be supported through the Professional Development Program.

Objective One: To assist the bureau in ongoing support and retention of excellent staff in Child Welfare in Maine through research, consultation, and training opportunities.

Outputs:

- Thirty (30) supervisors will have access to up to 12 hours of clinical mentoring from Mental Health professionals familiar with organizational and child welfare issues.

- The following workshops will be offered to BCFS Staff with experience, based on the findings of the Caseworker Retention Study:

    1. *What do I ask Next? Hiring, Interviewing, and Retention Strategies for Supervisors*
    2. *Taking that Next Step: The Move to Supervision (two days)*
    3. *Reflective Practice for Experienced Caseworkers*
    4. *Staff Resiliency in Child Welfare Services*

D. Professional Development Activities:

The goals of professional development activities are to promote the learning of new knowledge and skills, to maintain or enhance the academic and professional credentials of BCFS staff and to encourage staff retention.

Professional development opportunities outside of the formal training system promote interaction with non-Bureau providers and the University system. The Clinical Supervisory Mentoring Program pairs individual supervisors with local mental health clinicians for the purpose of consultation regarding complex issues being encountered by the supervisor. The annual fall conference will be held again in 2004, under separate contract, as an initiative to support the Reform Plan as sponsored by the Annie E. Casey Foundation.

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    4. *Staff Resiliency in Child Welfare Services*

- CWTI will collaborate with BCFS to develop a Supervisory Academy: a program which utilizes multiple methods to deliver education, professional development, and support to supervisors in the effort to further professionalize the role of Child Welfare Supervisor.
- The annual Fall conference will be held to bring all BCFS staff together to explore progress and continued vision for 'Getting it Right for Kids and Families'.

Objective Two: To deliver academic and professional development opportunities towards attainment of graduate degrees in Child Welfare related fields for all staff members.

Outputs:

- Fifteen (15) supervisors and managers will have completed one of two graduate courses in clinical supervision and advanced supervision, through UMO.
- $30,000 will be available to pay for onsite graduate courses in Social Work to be delivered in DHS offices. Cut to $20,000?
- $15,000 will be available for tuition to the two graduate courses offered through CWTI and the University of Maine at Orono.
- $60,000 will be available for payment of tuition reimbursement for graduate and undergraduate courses in Social Work. Cut to $40,000?
- $6,000 will be available for the purchase of books and other resource materials for Districts and Central office.
- $20,000 will be made available for Workshop Registration fees for all staff, to be distributed through Program Administrators and Central Office Administration.
- $3,000 will be made available for Journals/Memberships in Professional Organizations for all staff.

Objective Three: To provide guidance and oversight for CWTI sponsored Professional Development activities and allocations.

Outputs:

- The Professional Development Committee (10 members) will have met four (4) times and will have developed recommendations for professional development activities for FY 2003.

- The Graduate Program Steering Committee will have met three times a year to oversee tuition reimbursement and onsite course programs.

- CWTI will continue to track and inform the Bureau of enrollment, matriculation, and degree/certificate attainment by BCFS staff through the tuition and onsite course programs.

- CWTI will have informed BCFS staff of the amount of professional development funds allocated to each office, assisted the Bureau (upon request) in developing and applying criteria for individual awards and processed the bills and maintained usage records for professional development activities.

E. Adoptive and Foster Family Introductory Training:

The goal of Introductory Training is to give prospective foster and adoptive parents, including Native American foster parents and relatives who provide care, the foundation needed to work effectively with children, their families, and the other professionals with whom they will interact as caregivers.

Objective One: To deliver regionalized training for foster and adoptive parents and relatives providing care and to provide ongoing consultation and feedback to the staff of the Bureau of Child and Family Services to support their work in promoting safe placement and effective care of children.

Introductory Training is a 24-hour competency based curriculum that encourages participants to explore their motivations for becoming foster and adoptive parents, and the make-up of their family system, including sources of support and areas needing development. Knowledge of the systems with which parents will interact, the impact of abuse and neglect on children, the importance of the birth family and impact of separation on both children and parents are some of the many areas covered. Participants are encouraged to consider others' views, values, cultures, orientation, etc. as essential ingredients in forming constructive working relationships with others in these systems.

Outputs:

- Thirty four (34) rounds of Introductory Training (24 hours) will be delivered by CWTI educators to 600 participants (14,400 contact hours)..

- Four (4) rounds of specially designed Introductory Training (24 hours) for relatives providing care will be delivered to 80 participants (1920 contact hours)

- One hour closing sessions will be held with district staff and parents completing training to discuss the impact of training on each participant, highlight strengths and challenges (960 contact hours).

- Adoptive and Foster Family Educators will develop written summaries for those who complete training and make them available to Bureau staff for their records.

- Regular meetings will be scheduled with district staff to ensure communication remains open and to address any problems that arise during training. A minimum of ten (10) meetings will be scheduled during the year.

Objective Two: To maintain the relevancy and currency of the Introductory Curriculum for prospective foster and adoptive parents and relatives providing care and to ensure others delivering the curriculum are knowledgeable in the approaches necessary to achieve desired outcomes.

The Introductory curriculum underwent extensive revisions this past year and it was piloted in August 2002. CWTI Educators will begin training the new version this fall. The curriculum remains 24 hours in length and is divided into 8 modules, each 3 hours in length. BCFS staff were included in the pilot and asked to provide feedback and approval on revisions. Private agency staff delivering AFFT curricula will attend an annual two-day review. New trainers will be encouraged to co-train or observe an entire eight-week Introductory Training prior to training the full course.

On-site review of private agency training will continue to be provided by CWTI Coordinators to ensure quality and consistency of the curriculum delivery.

Outputs:

- Thirty (30) private foster and adoptive agency staff will receive training on the curriculum in 2 sessions of Training-For-Trainers. Each session is two (2) days. AFFT staff will consult as needed with other trainers, (360 contact hours).

- Sixty (60) private foster and adoptive agency staff will attend a 1 day annual review, (360 contact hours).

- Staff will provide oversight of private agency delivery of training through direct observation of classes to maintain quality of curriculum.

- Staff will make use of conferences, training programs and professional reading to ensure practice reflects current thinking in the field and the most current and effective training approaches.

Objective Three: To administer and evaluate Introductory Training within the Adoptive and Foster Family Training Program.

The Introductory Training curriculum is competency based. Learning objectives are specified for each of the 8 modules. An extensive evaluation of the revised curriculum will determine the impact of the training on prospective adoptive and foster parents. A combination of qualitative and quantitative methods will be employed. The link between

Introductory and In-Service training will be strengthened through the use of learning objectives, content, and activities which build upon competencies identified in the Introductory training. Quality Assurance will be integrated in the overall program evaluation process.

Outputs:

- Research Associate will conduct qualitative and quantitative studies to measure: the extent to which training improves knowledge and skills, the extent to which training leads to behavioral change after training and longitudinally, and participant satisfaction with trainers, training curriculum and overall training experience.

- Research Associate will design and implement an ongoing quality assurance process which includes internal assessment of the following areas: delivery, trainers, curriculum, marketing, structure and options, and training needs assessment.

F. Adoptive and Foster Family In-Service Training

The goal of In-Service Training programs is to provide training and support to experienced foster and adoptive parents, including Native American parents and relatives providing care, to assist them in their professional development, provide respite and recognition and contribute to the retention of trained and effective caregivers. An important component of this portion of the AFFT program is the development of curricula and other tools that are responsive to the changing needs of caregivers and staff who work with them.

Objective One: To deliver a range of In-Service training that responds to the professional development needs of foster and adoptive parents.

Outputs:

- Six (6) Core Training Topics (6 hours each) will be offered two times a year (Northern and Southern location) to 25-50 participants statewide. This series titled "Toolbox" was designed to assist new foster/adoptive parents in acquiring skill development post-completion of Introductory Training (300 contact hours)

- Five (5) series with 3-4 workshops each will be offered two times a year (Northern and Southern location) to 25-50 participants statewide. These programs will be marketed through the CWTI website, AFFM newsletter, and separate brochures. The series topics were selected based on a comprehensive statewide needs assessment which included provider, foster/adoptive parent, and BCFS staff feedback. The series will be on the following topics: *Clinical/Mental Health Issues; Behavior Management, Sexual Development/Creating Sexual Safety; Collaboration and Communication- DHS/Foster Parents/Providers; Understanding and working more*

effectively with school systems. (a total of 38-40 workshops will be offered) (5700 contact hours)

- The Training Advisory Committee, composed of twenty (20) Bureau, CWTI staff, and foster and adoptive parents, will meet four times (½ day) during the year. District workgroups will meet as needed to ensure training reflects current trends/thinking and is responsive to Bureau/provider needs (320 contact hours).

- The Foster and Adoptive Parent Advisory Committee, comprised of 16 elected foster/adoptive parents (2 per district), BCFS staff, and CWTI staff, will meet four times for ½ days during the year. The Bureau Director chairs the committee which convenes for the purpose of improving collaboration and communication between BCFS staff and the foster/adoptive parent community. Practice issues, concerns, policy clarification, recommendations are areas reviewed in advisory committee sessions.

Objective Two: To increase access to training by providing a variety of formats and delivery methods and through the use of Outreach Education for Foster Parents (student interns).

In-Service Training for foster and adoptive parents and relatives providing care is viewed as essential to the ongoing development of skills contributing to the provision of safe and effective care of children. Many barriers limiting access of parents to training exist: geographic barriers, work schedules, lack of availability of training in some areas, lack of awareness of scheduled training, lack of appropriate child care, etc. CWTI staff will continue to develop a variety of distance learning topics to maximize availability of training opportunities.

Outputs:

- Correspondence Courses will be offered as an additional format for learning. A variety of topics will be available for home-based educational opportunities.

- Four (4) seminars will be available statewide to foster/adoptive parents. 20 participants will have opportunities for round-table discussions facilitated by a contract provider. Seminars will be individually structured in length not to exceed a total of 18 hours (1,440 contact hours).

- CWTI's website will be updated and expanded to include links to agencies delivering training and support to parents as well as to provide a current schedule of training available through the Institute.

- CWTI staff will develop options for offering web-based In-Service training to correspond with the core training topics developed. These Computer Based Trainings (CBT's) will be offered on the CWTI website.

- CWTI will publish a quarterly Child Welfare Newsletter encompassing relevant legislation, policies, and information pertaining to working with foster/adopted children.

Objective Three: To increase the retention of foster and adoptive parents through provision of training, recognition and respite.

There continues to be a shortage of foster and adoptive parents available to provide care to children in the care and custody of the Department of Human Services. Through recruitment efforts, Bureau staff addresses the need for a range of new placement resources. Residential Training opportunities contribute to the retention of existing resources.

Outputs:

- Two (2) weekend Retreats, each accommodating up to 40 experienced parents will be delivered. Foster parents will receive 12 hours of training and team building (960 contact hours).

- One Camp Conference, serving up to 100 families, will be provided. 400 participants will attend 6 hours of training/workshops and have networking and support opportunities (2400 contact hours).

Objective Four: To provide guidance and oversight for CWTI sponsore Professional Development activities and allocations.

- Program Administrators in each of the eight districts will be allotted a total of $10,000 to support requests of foster and adoptive parents to attend training sponsored by other agencies, to purchase training materials or to develop programs within their districts.

Objective Five: To administer and evaluate the In-Service Training Programs within the AFFT program.

In-Service training focuses on the development of skills required by caregivers to meet the various needs of children in their care. A range of programs is provided to meet not only the developmental needs of the caregivers, but also to address their need for skill development in specific areas. Ongoing measurement and evaluation of training topics

will determine how this information can be delivered to ensure higher retention, transfer of learning and skill development.

Outputs:

- Evaluation specialist will evaluate training on quality of the courses, trainee satisfaction about usefulness, trainee knowledge acquisition and comprehension, trainee ability to demonstrate skill in training and on the job.

- The Training Advisory Committee will meet four times during the year, with district workgroups meeting in the interim, to develop specific training programs in response to Bureau priorities and district needs.

- Professional development checklists, focus groups and a database will continue to be utilized to assess the education needs of parents post-completion of Introductory training.

- CWTI staff will notify district staff and potential participants of In-Service training programs and will provide for registration, evaluation and record keeping.

G. Maine Caring Families

This goal supports ongoing initiatives within the Maine Caring Families Program to assist with organizational development, training design, and recruitment/retention efforts to support both foster families and staff.

Objective One: To develop and administer a training program for foster parents and staff in the Maine Caring Families Program

Maine Caring Families is a statewide therapeutic foster care program administered by the Bureau of Child and Family Services. Over the past year, CWTI has worked with MCF staff to develop comprehensive program standards and policies, identify and establish organizational needs/priorities, design/deliver a variety of training, and convene the MCF Advisory Committee. CWTI staff will continue to provide support to the MCF program through various organizational development activities.

Outputs:

- An eight (8) hour CPR course will be offered to 100 MCF foster parents through community- based medical facilities. (800 contact hours)

- A twenty one (21) hour Behavior Management course will be offered to 100 MCF foster parents (2100 contact hours)

- An Advisory Committee will be convened, with representation from the various components of the MCF program: staff, support agency workers, and foster/adoptive parents. Fifteen (15) members will have met for four- ½ day planning meetings, (300 contact hours).

- One annual conference, consisting of one and a half days of training/workshops will be provided to 100 participants, (1000 contact hours).

- CWTI staff will work with the MCF Advisory Committee and Regional Coordinators to develop, edit, and distribute a quarterly newsletter.

Objective Two: To deliver ongoing educational, resource, and professiona development opportunities for MCF staff and foster parents.

- Two (2) full days of training for forty (40) Regional Coordinators and MCF Support Workers will be offered related to increasing effectiveness of ongoing support groups for MCF foster parents, (480 contact hours).

- MCF Regional Coordinators will have a total of $5750 for specialized regional training.

- A monthly 2 hour clinical seminar will be offered to 6 regional coordinators facilitated by a contracted clinician 10 times per year. (120 contact hours)

- A Resource Guide, developed, printed, and distributed by CWTI staff with assistance from the advisory committee and MCF Regional Coordinators, will be distributed to all MCF families and affiliated staff

- 4 one half day trainings will be facilitated by BCFS staff with Regional Coordinators and MCF contracted agency staff with the goal of informing parties as to current BCFS initiatives and the implications for contracted agency practice.

H. Specialized Program Training

This goal provides training resources for specialized program staff within BCFS. This includes, but is not limited to, Foster Home Licensing Staff, Independent Living Specialists, Quality Assurance Staff, Case Aides, and other staff whose training needs require a specialized curriculum.

Objective One: To provide centralized training for specialized program area staff in areas that are specific to their role and responsibilities.

Outputs:

- One (1) days of centralized training and facilitated discussion will be held for Quality Assurance Staff including:
    1. *Legal Issues in Quality Assurance related to Fair Hearings in Levels of Care*

- The following topic will be offered through this contract and will be open to all staff and geared towards Independent Living Specialists and those working with adolescents:

    1. *Empowering practices for Youth in Transition*

- Centralized Intake and After Hours Staff will have one (1) day of training based on the findings of the work-flow study completed in FY 2003.

    1. *Working Effectively based on Workflow Study and Reform Goals*

- Case Aides may participate in one (1) training sessions in the following areas (as well as in all staff ongoing training as appropriate):
    1. *Working with Foster and Birth Parents (Sharing Information)*

- Adoption Staff will have access to the following workshop:
    1. *Assessing and Working with Kin*

- Licensing Staff will have access to the following one (1)workshop
    1. *Analyzing Independently Completed Foster Home Studies*

Objective Two: To administer and evaluate the Specialized Programs training program.

Specialized Program staff will be provided notice of training specific to their functions in addition to ongoing staff training for all BCFS staff. CWTI will develop training, provide notice to staff and assure record keeping and evaluation is completed.

Outputs:

- Program Specialists and their workgroups will be able to access a training specialist for assistance in evaluating training needs and training delivery and developing recommendations for training for the coming year.

- CWTI will send notice of training to potential participants and provide for registration, evaluation and record keeping.

I. Children's Transportation Training:

Since 1998, all Transportation Providers who transport children have been required to train all new drivers using the CWTI Children's Transportation Curriculum. Training is provided on-site at the transportation agency and is delivered by a trained team of transportation, child development and Bureau of Child and Family Services staff.

Objective One: To provide training in the CWTI Children's Transportation Curriculum to all new drivers employed by contracted transportation service providers who transport children.

CWTI will continue to support this program by providing updates and revisions to the Transportation curriculum; management and training of training teams, (including recruiting new trainers and providing Train-the-Trainers sessions); provision of training materials to training teams; and documentation and evaluation of training programs.

Output:

- CWTI will facilitate an annual curriculum review workgroup meeting(s) to solicit feedback and incorporate changes into the training. 5 participants will meet up to 2 times for one-half day (40 contact hours)

- CWTI will convene an annual meeting of all trainers to ensure curriculum revision information is disseminated. 25 participants will attend a 6 hour meeting. (150 contact hours)

- CWTI will contract with child development specialists to deliver the 2 hour training section 10 times each year.

- Six hours of Children's Transportation Training will be provided to an estimated 150 new drivers prior to allowing drivers to transport children. (1,728 contact hours).

J. Post - Adoption Services:

With more attention focused on the predictable needs of adoptive families, it is incumbent on those working with parents and children to be increasingly aware of the most effective and respectful interventions available for responding to their requests and needs for service and support following legalization. The purpose of this program is to provide for ongoing professional development of BCFS staff and others working directly with children and families affected by adoption and to build in additional opportunities for support for parents.

Objective One: To enhance the development of the post-adoption program by providing support for ongoing training for staff and providers.

Outputs:

- One (1) round of 18 hour training, based on the ASAP Curriculum, will be delivered in a central location to 30-40 staff and other providers of direct services to families. (540 contact hours)

- One (1) round of the modified ASAP Curriculum will be delivered to 30-50 providers of direct service to families throughout the state (240 contact hours).

- CWTI staff will work with staff representing Department of Behavioral and Developmental Services, Casey Family Services, and the Department of Corrections to develop a training curriculum and intervention model that is strengths-based and family centered to be implemented with children and families who have experienced issues of abuse, trauma, neglect, and subsequent mental health, attachment, or behavioral challenges.

- A Training series (3 full day or combination seminar/workshops) will be offered to 100 providers (case managers, clinicians, in-home support staff, direct care staff), foster/adoptive parents, and BCFS staff on the above described curriculum. (1800 contact hours).

Objective Two: To expand the availability and effectiveness of post adoption support groups in Maine.

As the number of adoptive families continues to grow so does the need for ongoing, high quality and dependable support. CWTI will continue to offer opportunities to group facilitators to address initiatives, Bureau philosophy, and emergent needs of families as well as support for mentoring initiatives.

Outputs:

- One day of centralized training will be offered to thirty (30) support group leaders to share information and resources while increasing the effectiveness of support provided to parents (180 contact hours).

- CWTI will maintain a listing of all current support groups/facilitators on the website with meeting times and locations.

Objective Three: To contribute to the development of resources available to adoptive families by researching and developing adoption preservation services geared to the most pressing needs of children in adoptive placement.

Factors consistently identified by adoptive parents as contributing to the dissolution of adoptive placements include behavioral and emotional problems which manifest in a

variety of ways and are often associated with issues of loss, attachment, PTSD, sexual abuse, learning disabilities, depression, lack of control, identity development, and other organically-based problems. CWTI will continue to collaborate with BCFS and contract agency staff to ensure that resources and service delivery systems meet the needs of families throughout the state.

Outputs:

- CWTI will offer 2- six hour workshops "*Transitioning from Foster Care to Adoption*" to 50 participants throughout the state (300 contact hours).

- CWTI will annually revise and distribute a resource manual for adoptive parents which will be regionalized. The manual will provide legal rights information and information on how to access subsidized funds, psychological services, and medical/dental services.

- CWTI staff will produce and distribute a bi-annual newsletter regarding information and updates on the Maine Adoption Guides project.

- CWTI will host bi-monthly Cross-Agency meetings with BCFS staff, A Family for Me, and Adoptive and Foster Families of Maine (AFFM) to promote collaborative efforts and increase communication. 8 participants will meet 6 times per year (145 contact hours).

CHILD WELFARE DEMONSTRATION PROJECT/ MAINE ADOPTION GUIDES INTERIM EVALUATION REPORT

MAINE ADOPTION GUIDES INTERIM EVALUATION REPORT: RESEARCH SUMMARY - December 2002

This research summary was developed to provide information about the Maine Adoption Guides Project and its current research results. Six major research questions from the evaluation are:

- *What is the Maine Adoption Guides post-adoption services model?*
- *What issues do parents have before they legalize their adoption?*
- *What are the characteristics of the children and families in the project?*
- *What services do parents use the most, or least, and what types of services do they prefer?*
- *What difference does the MAGS model make in the lives of children and families?*
- *What are the costs involved in caring for children after legalization?*

The research design is a longitudinal control group design with random assignment and observations both before the intervention and then conducted every six months for the duration of the study. There will be four cohorts observed in the study. The outcome evaluation assesses the extent to which the children/families who received the Guided Services Model (experimental group) and the children/families who received Standard Services (control group) differ in regard to a number of outcome measures. The outcome measures include:

- **Rates of Adoption Dissolutions**
- **Number of Days Child in the Home / Displacement Rates**
- **Assessment of Family Functioning**
- **Assessment of Child Functioning/Well Being**
- **Assessment of Access to and Utilization of Services**

This federal Department of Health and Human Services Child Welfare Demonstration Project is the result of planning on the part of the state DHS agency that originated in the mid 1990s. The guiding principles that drive this initiative are:

- Adoption is a life-long process.
- Most adoptive families experience normal crisis in their development.
- Families need more support services post-legalization.

Following are the latest study results, from December 2002 or just over two years into the study, as they relate to each evaluation question.

1. What is the Maine Adoption Guides post-adoption services model?

The core principle of this program is that adoption is different. The dynamics of a family created by adoption are different from the dynamics of a family created by birth. Adoption is lifelong and its impact creates unique opportunities and challenges for families and communities. Adoption is mutually beneficial to parent, child and society. Society is responsible for supporting and aiding integration and preservation of adoptive families.

Participants are recruited from the overall population of families adopting children with special needs from the Foster Care system of the state Department of Human Services (DHS). Every year for four years 140 children and their families are recruited into the project. At the time that families meet with state DHS adoption caseworkers to plan for Title IVE subsidy arrangements, about three months prior to legalization, families are invited to participate in the project. Families are then randomly assigned to either the Standard Services (control) group or Guided Services (experimental) group. Standard Services families receive the adoption subsidy from the state DHS and whatever other supports are provided in their community. Guided Services families receive the adoption subsidies, may access other supports in their local community and have access to a Maine Adoption Guide social worker from Casey Family Services. All families who participate in the project commit to a set of interviews once every six months. Families in the Guided Services group commit to being contacted by their assigned social worker at least once every six months. This clinical case-management type of service delivery model is delivered statewide and is provided by a partnership of the state DHS and Casey Family Services. The Guided Services intervention is designed to be family driven. The adoptive parent(s) is viewed as the expert on their child. The social worker assigned to the family functions as a guide who consults with the family through the expected and normal crisis in the life of an adoptive family. The long-term plan, based on the positive outcomes of this study, is that these same guided services could be expanded to the general population of adopting families.

Figure 1

Post Legalization Program Model Differences

Program Attribute	Standard Services	Guided Supportive Services
Target Population	Children w/Special Needs, and their Families	Children w/Special Needs, and their Families
Program Goals	- Provision of Adoption Assistance Funds Funds - Assistance with process to Legalization	- Decrease Dissolutions - Increase Family Strengths - Maintain/Increase Child and Family Functioning - Provision of Adoption Assistance Funds
Staffing	D.H.S. Adoption Worker	D.H.S. Adoption Worker and Casey Adoption Staff
Services Provided	- One time Assessment/ Planning Session - Financial Support for Post Adoptive Services as per Entitlements - Annual Financial Planning for Continuance of Adoption Assistance	- Initial and ongoing support based on family needs identified in "Family Permanency Assessment". - Scheduled check-ins with family and Casey staff at least once every six months. - Permanent assignment of Casey staff to family in an empowerment role; clinical case management. - Financial Support for Post Adoptive Services, not limited to services pre-defined in subsidy agreement.
Access to Trained Providers	- Provided with List of Trained Providers	- Provided with List of Trained Providers

Model Description - Focus Groups with MAGS Social Workers

Focus groups with social workers provide valuable information on the project model and its process. Focus groups are held with Adoption Guides social workers and supervisors approximately every six months. Staff members are asked to define their roles in the project and provide general feedback on the project's implementation—how the project model compares to their day-to-day work.

In November 2002, the fourth round of focus groups was held with the Adoption Guides social workers. One group was held in southern Maine with 11 social workers and two team leaders. The other group was conducted via telephone with two social workers and one supervisor who work in northern Maine. Unless otherwise noted, the following is a summary of results from both discussions.

The focus group questions focused on gathering in-depth descriptions of a few of the services social workers provide to families. The first type of service discussed was "General Parent Education and Support." This service code is distinguished from "Building/Maintaining Relationships," and from "Clinical Conversations," and serves as a type of miscellaneous category for the kind of education and support social workers provide to families. Workers mentioned that this code includes such things as educating families (and themselves) on a diagnosis; working with a child's developmental stages; educating a family about the therapy process, and helping families decide what they may need for support. Workers also may help a parent think about a child's behavior in a different way. Participants mentioned seeing themselves as a "safety net" or as a "coach" for families and feel that "General Parent Education/Support" is a major element of the model because it allows a more meaningful connection with the family.

The next service code discussed was "Collateral Contacts." Social workers described this as identifying needs and building resources. It can be case management or it can be clinical. Workers also help to educate the collateral contacts. MAGS workers are trained specifically on adoption issues and attachment whereas others involved with a family may not be. Due to this, the Adoption Guides workers' assessments are valued for their clinical insight. Flexibility also plays a role in this service—workers have the opportunity to attend meetings with families, etc., which in turn enables them to have a greater understanding of a family's situation.

The code "General Advocacy" can include services similar to "Concrete Services." Often it's a mixture of the two codes. Again, social workers' clinical experience and adoption awareness benefits them in advocating for a family. People begin listening to workers differently when they learn of their knowledge of adoption issues. The role workers play as advocates is important because parents sometimes get discouraged by the difficulty in finding services. The model's flexibility enables workers to have more time to devote to advocacy, because they don't have to capture everything they do into a billable timeslot.

"Non-therapeutic" services include recreational and informal activities with families, such as having lunch or dinner, going to picnics, attending parties, going to the movies, or playing with children. These types of services are seen as very important to the model because they break down artificial boundaries—making families feel more comfortable and able to trust workers. Often times, non-therapeutic services pave the way to doing clinical work with a family that may have been initially reluctant. The informal activities allow for families' progression. Therefore, this is not a short-term service. Non-therapeutic activities allow parents the opportunity to network with other parents and allow kids with similar issues to come together. Kids and families can connect through these gatherings and can get support in a non-threatening way. These activities also are a great way for families to relieve stress without worrying about the stigma of needing therapy. Workers view these informal connections as a major component of the model.

Implementation of MAGS Model

According to interviews with stakeholders and review of documents associated with project implementation, the model appears to be implemented as intended. Casey social workers are working to connect with DHS caseworkers and from there, establish relationships with the family. Services appear to be provided as needs in the family come forward in the form of a family-centered model of practice.

Significant problems with implementation included no service delivery to Aroostook County for the first year, 2000-2001, due to a failure in establishing service contracts between Casey and other services providers in a timely fashion. Since 2001, a contract has been in place with an additional agency to provide services to the northern region. It appears uncertain as to the effects on quality due to services provided through a contracted agency instead of directly by Casey Family Services. At the very least Aroostook County social workers appear somewhat disconnected from the rest of the Casey staff.

In the second year of the project, 2001-2002, problems occurred with the referral process. Some DHS adoption workers were not inviting families to participate in the Project. This issue was identified and steps were taken to insure that all families are approached about the Project. However, referrals are still not coming in as quickly as estimated. Keeping track of the referral process and reiterating its importance to social workers will remain ongoing throughout the Project. Another factor that will undoubtedly affect the orchestration of the Project is that a key Project member, the contact at DHS, has retired. A major concern at this point of the study is the rate of attrition as families are dropping out of the study over time. These and other issues of implementation will continue to be evaluated for the remainder of the study.

2. What are the characteristics of the children and families in the project?

Results listed below are culled from surveys parents complete at baseline, upon entering the study.

Children

- As of December 2002 there are a total of 120 children in Cohort I (Year One), 153 children in Cohort II (Year Two), and 86 children in Cohort III (Year Three); **N = 359.**

- Mean age of children in the study is **8 years of age.**
  - Guided Services Group Child Age = 8.35
  - Standard Services Group Child Age = 7.73
  - Children Currently Adopted – Total Sample = 7.66 years
  - Children Previously Adopted – Total Sample = 10.02 years

- **Gender of Children:**
  - 178 male (49.6%) and 181 female (50.4%)

- **Racial Characteristics:**
  - 92% are White; this is in keeping with the general demographics of Maine as a mostly White, non-Hispanic population. African-American is the next highest racial group with 13 out of 319 (4%) overall children identified in this category.

- **Legally Adopted** – By six months into the study, 89% of children were legally adopted. By 12 months into the study, 99% of children were legally adopted. By 18 months, 100% were legally adopted.

- **Type of Adoption:**
  - Approximately 88 percent of all children in the study are adopted by current foster parents; this is similar across all Cohorts.

- **Previous versus Current Adoption**: 83 percent of all children in the study are current adoptions.

- **Number of Previous Placements in Foster Care** - Administrative data from state DHS records was available for 268 child study participants. The number of previous placements refers to permanent placements—long-term placements in locations such as foster family homes, residential facilities and hospitals. As counted since the most recent removal from home, the mean overall is two placements per child (2.09 for Guided and 1.87 for Standard).

- **Length of Time in Foster Care** - Administrative data from state DHS records was available for 268 child study participants. The average (mean) number of years these children have been in Foster Care to entry to study is approximately 4.4 (4.5 for Guided and 4.2 for Standard).

- **Time Child in Home Previous to Entry to Study** – for the entire sample, children are in this home on average for 35 months (36 months for Guided and 35 months for Standard children).

- **School Age Children**: 82 percent of children in the study are attending school (86 percent of Guided and 77 percent of Standard children).

- **Receives Special Education Services at School** – For children who are attending school, 47% overall have an Individualized Education Plan (47 percent of Guided; 47 percent of Standard).

- **Clinical Diagnosis** – Parents report that overall, 28% of Guided children and 24% of Standard children have a clinically diagnosed disability.

- **Use of Psychotropic Medication** –In the entire sample, 29 percent of children are taking some type of psychotropic medication (30% of Guided children and 28% of Standard children)

Families

- Twenty-four percent of families report an **annual average income** of more than $65,000. Twenty percent earn between $35,000 - $45,000. Only 2% make less than $15,000.

- **Family Structure:**
  - 84% are married couples and 12% are single female-headed households.

- **Relationship to Child – As Reported by Parent:**
  - 88 percent are Foster Parents

Sixty-nine percent are foster parents who were not related to the child—only 7 (3%) parents thus far in the study have been foster parents and relatives to the child. Five percent of respondents were relatives of the child or friends of the family. Twenty-three percent were neither foster parents nor relatives to the child.

3. What issues do parents have before they legalize their adoption?

Results listed below are culled from surveys parents complete at baseline, upon entering the study.

- **Reasons for Adopting a Child** – Most common reasons cited by all caregivers were: Wanted to Make Relationship Legal; Felt Close to Child; Wanted Child to Feel Secure; and Our Other Children Are Attached to Child.

- **Concerns About Adoption** – Most common concerns cited by all caregivers were: How to Meet Child's Needs; Other Children's (in family) Reactions; Child's Acceptance of Me (caregiver); Ability to Continue to Work; Effect of Adoption on Marriage; and Ability to Afford Additional Costs.

- **Child Behavior Problems Before Legalization**—Parents were asked to choose from one or more of 11 problem type behaviors (including such problems as defiance of rules, destroying property, behavior problems in school, and emotional withdrawal). The scores for all 11 were summed and the mean score for Guided was 3.92, and for Standard was 3.67.

- **Satisfaction with DHS Adoption Caseworkers Pre-Legalization**:
  - Majority of all Caregivers satisfied with DHS Caseworkers – on a scale 1=Very Satisfied to 4=Very Dissatisfied. Means are:
    - Guided = 1.44
    - Standard = 1.49

  - Majority of all Caregivers consistently felt that DHS Caseworkers knew about them the most and about their family the least. (There is a statistically significant difference between the Foster and Non-foster parent groups – a larger percentage of Non-foster caregivers feel that their caseworker knows their child "very well" or "somewhat well.")

4. What services do parents use the most or least, and what types of services do they prefer?

Results listed below are culled from surveys parents complete every six months after entering the study.

Types of Services Families Access in the Community – As Reported by Respondents

- **Contact with DHS:** At six months, the majority of all caregivers in (Guided 75%; Standard 79%) reported ongoing contact with DHS adoption staff. At this point they were contacting DHS staff for assistance with monthly subsidy issues, adoption legalization questions and a child's new emotional needs. At twelve

months the overall number of those contacting the DHS offices drops slightly, but is still a majority (Guided 64%; Standard 61%). The reasons for contact were the same.

- **Services Sought and Received**: Caregivers are asked which type of service do they seek and the top four results are: (1) Individual Counseling Services; (2) Respite Care; (3) Adoption Support Groups; and (4) Other Services*. Caregivers were also asked to identify how many hours of service they received from a service provider. The top services by number of hours were: (1) *Other Services; (2) Respite Care for Adopted Child; and (3) Counseling for Adopted Child.

*The Other Services category includes services such as occupational therapy, speech therapy, physical therapy, caseworker consultation, psychiatrists, substance abuse treatments, neuropsychological evaluations, and homeopathic medicine. There are a few children in the study with very significant medical needs and these services require a large number of service hours. Some children have daily services.

One thing we track in our research is whether the children who are in need of services are receiving services. To examine this, we compare the Child Behavior Checklist scores with this data reported to us by families on the services they receive. The table below displays the percentage of the "**service gap**" -- children who are in the Clinical range on their CBCL scores and are reportedly not receiving counseling. The highest gaps are shown for children at 18 months into the study who are in the clinical range for Total Problems and for Internalizing Problems.

Time in Study:	Total Problems Gap	Internalizing Problems Gap	Externalizing Problems Gap
6 Months	9%	9%	10%
12 Months	8%	0%	10%
18 Months	14%	15%	5%

- **Natural and Professional Types of Supports/Services**: Caregivers were asked which types of supports/services are most important and from where they are provided – either naturally through a friend, family or other social network, or paid for from a service provider. Caregivers stated that their most important source of support was professional (54%) in the forms of: (1) Case Management, (2) Counseling, (3) School/School Services, (4) Financial Supports, and (5) Medical Services. Forty-six percent of the caregivers stated that their most important sources of support were natural and included: (1) Family Support, (2) Friends, (3) Spousal Support, and (4) Support Groups. At six months into the study, 79% of respondents stated they "routinely" access natural forms of support. The most frequently accessed are: (1) Family Members other than Spouse (44%); (2) Friends (37%); (3) Support Group (6%); (4) Church/Pastoral (5%); and Other,

including other adoptive parents, spouse, neighbors, co-workers, other caregivers/parents (10%).

- **Case-Manager/Worker**: At six months into the study, 60% of all respondents stated that they had a regular case manager; 83% of those in Guided Services and 32% in Standard Services. At twelve months, 64% reported having a case manager; 89% of Guided and 30% of Standard. At 18 months, 67% reported having a case manager; 97% of Guided and 35% of Standard.

  At six months in the study, 18% of families that are assigned a caseworker reported having more than one case manager per family. At twelve months, 28% reported having more than one case manager. At 18 months, 36% had more than one caseworker.

- All caregivers across both groups report that case managers provide the following types of direct services/supports: (1) Assist to Develop and Broker for Services; (2) Provide General Supports/Education; (3) Advocates on Behalf of Child(ren); and (4) Provides Direct Therapeutic Services. The major difference between Guided and Standard Services groups was in the provision of direct therapeutic services by the caseworker—at six months 26% of the Guided Services caregivers reported receiving therapeutic services as opposed to only 11% of the Standard Services; at twelve months 22% of Guided as opposed to 3% of Standard and at 18 months 44% of Guided and 0% of Standard caregivers reported receiving therapeutic services from their caseworker. Statistically, there were significant differences between groups for:
  - Case-Manager Develops/Brokers Services (at 12 months)
  - Case-Manager Provides General Support/Educational Services (at 12 and 18 months)

Barriers to Receiving Services

Caregivers identified the following as the four biggest barriers in their pursuit of services or supports for their child/family:

1. Child's Own Needs Creates a Barrier – Not External to Family
2. Lack of Services/Support in Own Community
3. Lack of Accurate Information about Child's Needs
4. Lack of Time

Services Provided through the Intervention – MAGS

- **The most common service provided to families is Parent Education and Support:** approximately 35 percent of all the types of services provided. As of May 2002, the service code for Parent Education and Support was broken into three categories for further clarification: General Parent Education and Support, Building/Maintaining Relationships, and Clinical Conversations. These new

codes will provide a clearer picture of the services provided to families in this category. The second most common type of activity is Collateral Contacts, which accounts for 16 percent of all services. A Collateral Contact is the act of sharing and/or gathering information with other professionals about the child and/or the family. The next most common types of direct services to the family are conducting Initial Assessments and Group Therapy to Adults.

- The amount of time spent providing services varies depending on the type of service. Casey social workers apparently **spend the largest amount of time (per service) providing group therapy to children** (mean 107 minutes per service), and **providing non-therapeutic services, or recreational activities** (mean 107 minutes per activity. The average minutes for all services in general was 45 minutes per service.

- Overall, Casey social workers have provided an **average of 227 services per family in Year One, an average of 130 services per family in Year Two, and an average of 29 services per family in Year Three.** The range of the amount of time spent with each family is very wide; from the minimum of a phone call check-in once every six months to one family receiving 866 hours of services – or at least an hour each month. **The average number of hours spent with each family is 99.** Families are most frequently provided services through telephone contacts and then secondly through at-home visits.

- **Parents are the primary recipient of a service** (48% for Year One; 44% for Year Two; and 43% for Year Three). Next is the family as a whole (30% for Year One; 42% for Year Two; and 47% for Year Three), followed by a service to the adopted child (20% for Year One; 13% for Year Two; and 9% for Year Three), and finally services to other siblings in the family (less than 1% for all three years).

- As this is a statewide model, there is an interest in the amount of time the workers need to travel. **Seventy-five percent of the services did not require any travel time, 9% required 1 hour or less** of travel time, **12% involved between 1 and 2 hours** of travel **and less than 3% required more than two hours** of travel.

Parent Support Groups

One important service Casey Family Services also provides as part of the Adoption Guides project is support groups. Support groups offer adoptive families an opportunity to share parenting strategies and struggles with other parents in similar situations. Called "Parents of Challenging Children," these groups help parents who are raising children with special needs, which may include learning disabilities, psychiatric disorders, socialization/behavioral difficulties, or children who are hospitalized, or have received day treatment or residential services.

An evaluation of the support groups began in October 2002. Support group members will complete surveys about their satisfaction with their group as well as about their own parenting stress levels. Follow-up surveys will be completed six months after the group officially ends.

5. What difference does the MAGS model make in the lives of children and families?

The following results are based on data collected at Baseline, 6 months, 12 months, 18 months, and 24 months into study. The number of study participants at each point in time is outlined in the table below.

Sample Characteristics Length of Time in Study
December 2002

TIME IN STUDY	GUIDED SERVICES (E)	STANDARD SERVICES (C)
Baseline	Child: n = 198 Family: n = 107	Child: n = 161 Family: n = 96
6 Months	Child: n = 147 Family: n = 75	Child: n = 123 Family: n = 64
12 Months	Child: n = 99 Family: n = 49	Child: n = 74 Family: n = 42
18 Months	Child: n = 54 Family: n = 28	Child: n = 53 Family: n = 26
24 Months	Child: n = 43 Family: n = 20	Child: n = 23 Family: n = 13

- **Number of Days Child in Home – Displacement Days:** At baseline, there were seven children who were reported to be out of the home due to a problem—the median number of days was 20. At 6 months, there were ten children out for a median number of 10.5 days. At twelve months, there were nine children out for a median number of nine days; at 18 months, three children were out for a median number of 51 days, and at 24 months, one child was out for five days. The table below displays the medians by assigned group.

Median Number of Days Out of Home – Displacement
December 2002

	Baseline	6 Months	12 Months	18 Months	24 Months
Guided	86 (n=5)	12.5 (n=6)	5.5 (n=2)	51 (n=3)	5 (n=1)
Standard	10.5 (n=2)	3.5 (n=4)	95.5 (n=4)	--	--
Overall	20 (n=7)	10.5 (n=10)	9 (n=6)	51 (n=3)	5 (n=1)

- **Number of Adoption Dissolutions:** There are no dissolutions reported for either group.

- **Child Attached to Family:** Caregivers from both groups rate levels of attachment of child to family as high with no statistical difference between groups over time. At 6 months, Guided Services children rated at 1.15 and Standard Services children rated at 1.09; At 12 months, Guided Services children rated at 1.10 and Standard Services children rated at 1.15. At 18 months, Guided Services children rated at 1.50 and Standard Services children rated at 1.16; at 24 months, Guided Services rated at 1.10, and 1.09 for Standard. The scale is 1=Very Attached to 4=Not at All Attached.

- **Children's Mental Health – Child Functioning**: Levels of child functioning are measured once for children age 1.5 to 5 and once for children age 6 to 18. The following results are for measures at baseline only:

    - Twenty-three percent of the younger children and 45% of older children score in the clinical range on the Internalizing Problem Behavior scale;
    - 25% of younger children and 62% of older children score in the clinical range on the Externalizing Problem Behavior scale;
    - and 23% of younger children and 65% of older children score in the clinical range on the Total Problem Scale.

- **Child's Health and Development:** For both groups, caregivers rate the child's overall health as positive. There are no statistical differences between groups. When caregivers rated their child's growth and development to other children of the same age, both groups rated their child's growth as being similar to other children.

- **Child Positive and Negative Traits:** For both groups, caregivers rated the frequency in which the child demonstrates positive traits as high and for negative traits, the frequencies are low. There are no statistical differences between groups on these outcomes.

- **Child Positive Behaviors to Parent:** For both groups, caregivers rated the frequency in which the child demonstrates positive behaviors to them as high. There are no statistical differences between groups on these outcomes.

- **Child's Satisfaction with Adoption:** For both groups, caregivers rate that the child is very satisfied with the process of adoption. There are no statistical differences between groups on these outcomes.

Family Level Outcomes

- **Caregiver Health – Stress:** Caregivers complete a health assessment rating themselves in eight areas. There are no statistical differences between groups on these outcomes. Using a scale of 0 - 100 with a higher score defining a more favorable health state, caregivers rated their overall general

health: at 6 months Guided = 75.50 and Standard = 76.02; at 12 months Guided caregivers = 76.84 and Standard = 75.00. At 18 months, Guided = 77.86 and Standard = 73.32.

- **Caregiver Satisfaction with Adoption:** For both groups, caregivers rate high levels of satisfaction with the adoption process. There are no statistical differences between groups on these outcomes. At 6 months, Guided caregivers = 1.23 and Standard = 1.17; At 12 months Guided caregivers = 1.18 and Standard = 1.34; At 18 months, Guided caregivers = 1.15 and Standard = 1.18. The scale is 1=Strongly Satisfied and 4=Not at All Satisfied.

- **Parenting Practices:** Caregivers are asked to rate themselves on a set of parenting behaviors that are classified as either Authoritarian or Authoritative. For both groups, parents tend to view themselves as more Authoritative than Authoritarian in their own parenting style. Authoritative practices include: display of affection towards child; sharing feelings and experiences with child; respect/encourage child's independence; supervision of child; and establishment of family rules and responsibilities. There are no statistical differences between groups on these outcomes.

- **Family Adaptability and Cohesion:** Family Cohesion is defined as the emotional bonding that family members have towards one another. Family Adaptability is defined as the extent to which a family system is flexible and able to change. For Cohesion (scores in the range of 51 to 70 are considered balanced and healthy), at 6 months, Guided = 68.80 and Standard = 68.97; at 12 months, Guided = 67.63 and Standard = 67.44; at 18 months, Guided = 67.16 and Standard = 68.12. For the Adaptability measure (scores in the range of 40 to 54 are considered balanced and healthy), at 6 months, Guided = 48.59 and Standard = 53.68; at 12 months, Guided = 48.04 and Standard = 45.87. At 18 months, Guided = 47.59 and Standard = 47.96. For both groups on both measures, their overall scores were within the moderate/normal ranges.

- **Family Attachment to Child:** Both groups of caregivers rate family members attachment to the child as very attached. At 6 months, the Guided Services mean score is 1.97 and Standard Services mean score is 2.01. At 12 months Guided Services mean score is 1.92 and Standard Services mean score is 1.70; At 18 months Guided Services mean score is 1.79 and Standard Services mean score is 2.31. The scale used is 1=Very Attached and 4=Not at All Attached. There are no statistical differences between groups on these outcomes.

- **Percent of Caregivers Who Trust Child:** Caregivers are asked if they trust their child, Yes or No. At Baseline, there were no statistical differences between groups. At 6 months, 73% of Guided and 61% of Standard report

trusting their child. At 12 months, 69% of Guided and 52% of Standard report trusting their child. At 18 months, 71% of Guided and 41% of Standard report trusting their child. At 18 months there is a statistically significant difference between groups. The Pearson's Chi Square value for 18 months is 8.947, df=1 and p=.003.

- **Parent and Child Communication:** Both groups of caregivers rate their overall level of communication with their child as very positive. At 6 months for Guided Services the rating = 1.73 and for Standard Services = 1.77; At 12 months for Guided Services the rating = 1.71 and for Standard Services = 1.96; At 18 months for Guided Services the rating = 1.71 and for Standard Services = 1.96. The scale is 1=Excellent to 4=Poor. There are no statistical differences between groups on these outcomes.

- **Frequency of Parent and Child Disagreements:** Both groups of caregivers appear to experience very low levels of parent-child disagreements. There are no statistical differences between groups on these outcomes.

- **Frequency of Parent to Child Positive Care giving Behaviors:** Both groups of caregivers appear to demonstrate high levels of positive care giving behaviors. There are no statistical differences between groups on these outcomes.

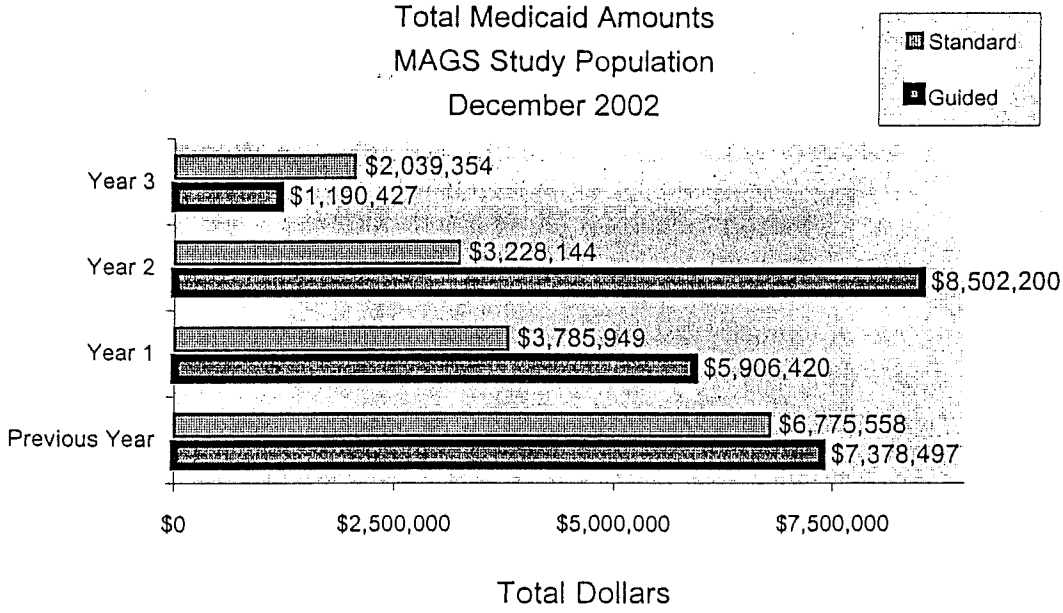
- **Overall Quality of Home Life:** Both groups of caregivers rate their overall quality of home life as positive. There are no statistical differences between groups on these outcomes.

- **Family Empowerment - Caseworker Family Centeredness:** In families that are receiving regular case management services, caregivers are asked to assess the family centeredness of those services. Supports are provided based on the family needs and not based solely on the adopted child's needs or professional provider recommendations. Caregivers in both groups rate their caseworkers as functioning in a family-centered fashion. At 6 months Guided Services casework = 4.5 and Standard Services casework = 4.52; At 12 months, Guided Services casework = 4.52 and Standard Services casework = 4.56; At 18 months Guided Services casework = 4.64 and Standard Services casework = 4.57. The scale used is 1=Very Low Levels of Family Centeredness to 5=Very High Levels of Family Centeredness. Scores of 3 or below are considered negative results. There are no statistical differences between groups on these outcomes.

6. What are the costs involved in caring for children after legalization?

The evaluators are working with program and state agency staff in order to better define the kinds of costs that are involved with implementing this model. The following information only describes some of the cost data reviewed to date. Additional analyses will be conducted and a more thorough presentation of the results of a cost analysis will be presented in the June 2003 project evaluation report.

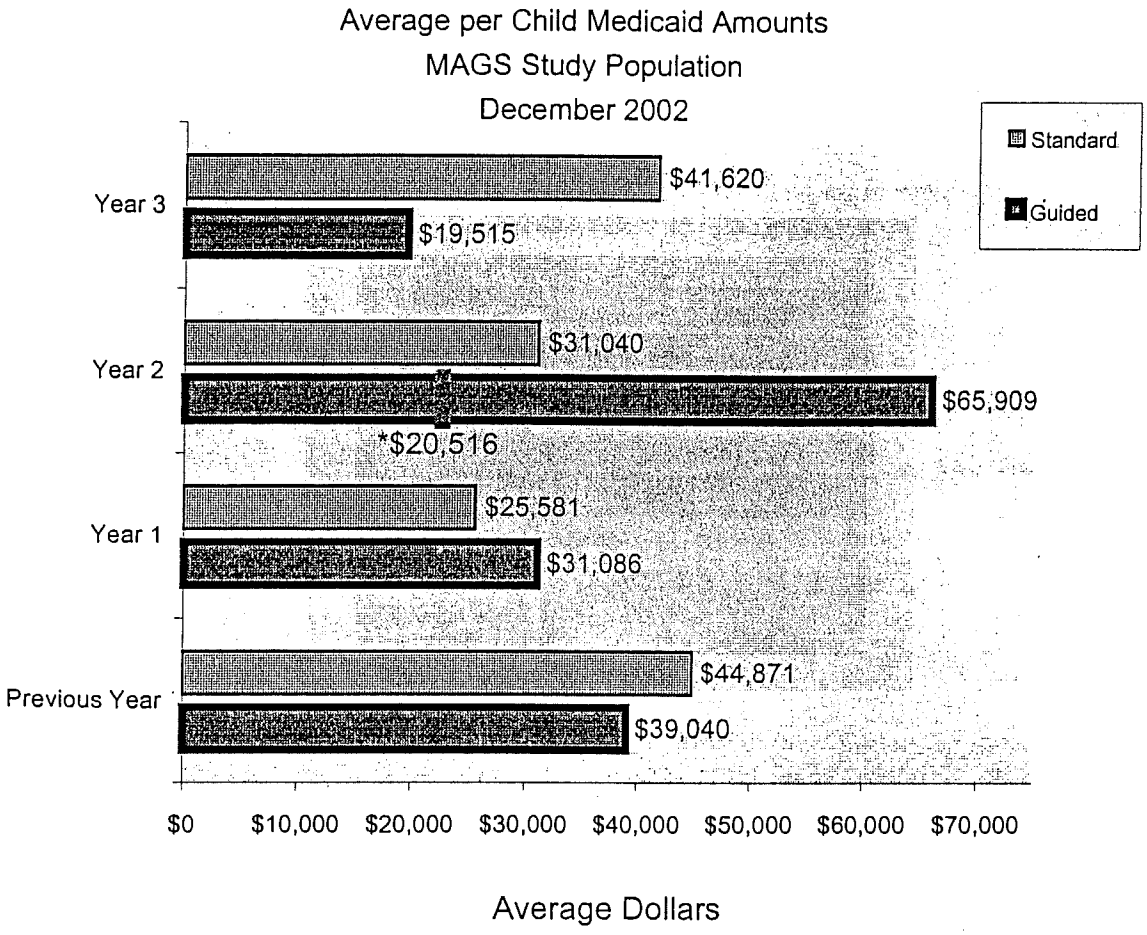
The following Medicaid cost data is provided from the state Department of Human Services, Bureau of Medical Services – Medicaid program. This data is presented in order to begin to describe the kinds of Medicaid related costs that adopted children accrue before and after legalization.



The total amount of Medicaid dollars spent on this population (n=340) of children in foster care the year previous to study entry was $14, 154, 055. For those children (n=338) who are one year into the study, after approximately 90% are legally adopted, the total amount decreases to $9, 692, 369; a difference of nearly $4.5 million dollars.

The explanation provided for this sharp decrease in this first year is the fact that costs related to providing therapeutic foster care are no longer accrued as these children are now legally adopted.

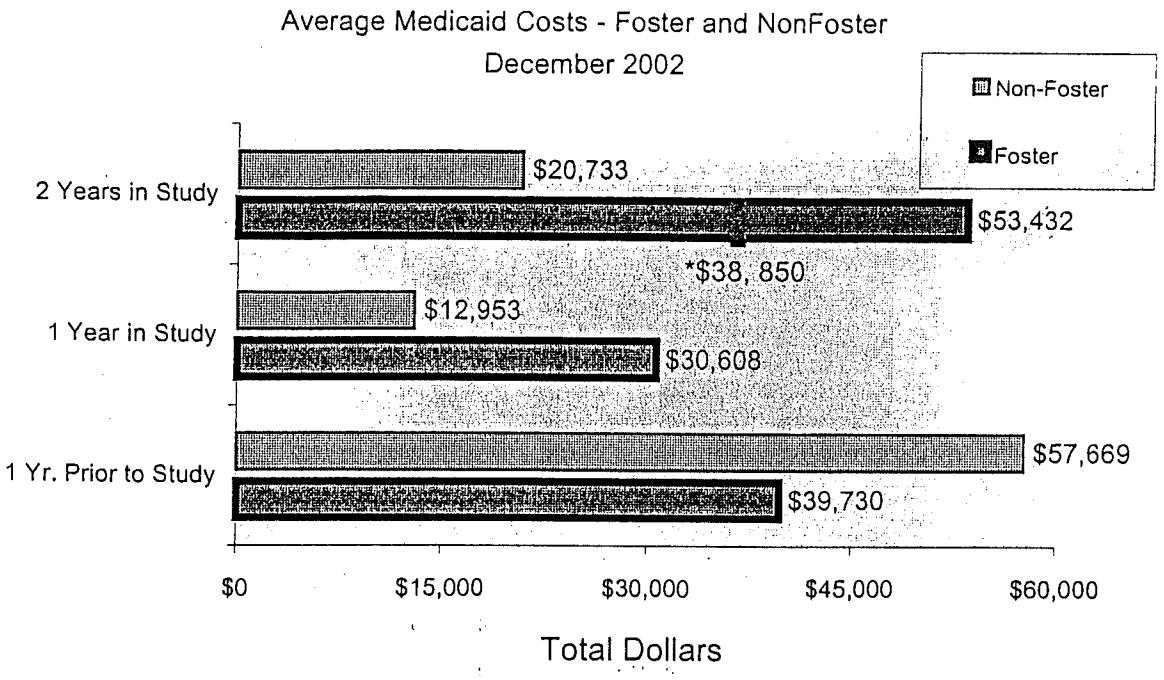
Total costs for those children (n = 233) in the study for two years are approximately $11, 730, 344. For Year 2, there were three children with a total of $7, 011, 618 in costs primarily for medical related services. Removing costs associated for these three provides a revised Year 2 total of approximately $4, 718, 726. For those children in the study for three years (n = 110) the total Medicaid costs are $3, 229, 871.



For these results, average Medicaid costs per child, there are no differences between the two study groups at baseline. At baseline the Guided Services results are; n=189, mean = $39, 040 and SD = $41, 123. At baseline Standard Services n=151, mean = $44, 871 and SD = $61, 408.

As mentioned previously, just three children in the Guided Services group account for almost 60% of the total costs for all children in Year 2. Results for the Guided Group for Year 2 excluding these three children results in an average of approximately $20, 516 per child. Using this revised average amount, note line on bar, there is a decrease in average costs per child over time for both the Guided and Standard Services groups. Average costs per child are slightly lower for Guided Services children than for those children in the Standard Services (control) group. There does appear to be a decreasing trend of lower costs over time for the Guided Services group.

This is a very intriguing finding in that Guided Services families have access to clinical case management services on a daily basis if necessary and or requested. These results appear to indicate that the Guided Services model results in somewhat lower Medicaid costs over time even while maintaining ready access and utilization of services.



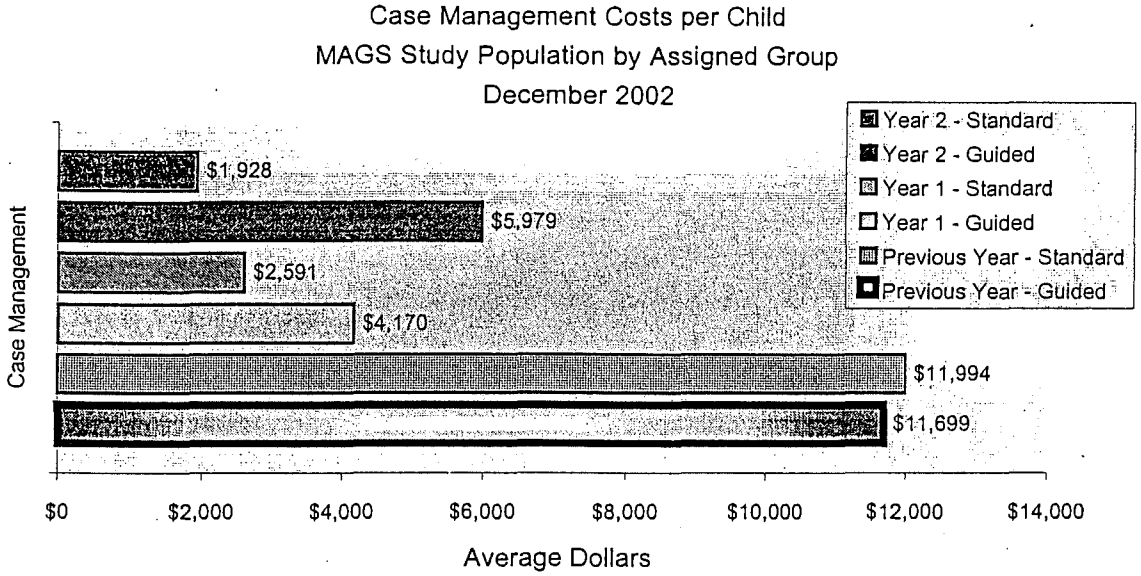
Comparing Medicaid costs by type of adoption indicates that during the year previous to entry to study, while these children were still in the foster care system not yet adopted, average costs for those children who would be adopted by non-foster parents was higher than those who would be adopted by foster parents; $57, 669 to $39, 730 comparatively. However, after legalization, that pattern changes and then foster parent adoptions have higher average costs than non-foster parent adoptions. For Year 1 results only, these differences are found to be statistically significant.

When removing the previously mentioned three children with unusually high costs in Year 2, the average for foster parent adoptions at $38, 850 is still higher than non-foster average at $20, 733; although this difference is not statistically significant. The following table does not include these three high cost children in the results.

Average Medicaid Costs – Foster and Non-Foster
December 2002

	Previous Year – Baseline	Year 1 in Study	Year 2 in Study
Foster Parents:			
N	207	204	208
Mean	$34, 962	$31, 372	$38, 850
SD	$42, 957	$78, 087	$71, 523
NonFoster Parents:			
N	22	22	22
Mean	$45, 501	$15, 648	$20, 733
SD	$35, 468	$20, 697	$64, 884

Of particular interest to this study are Medicaid costs associated with Case Management activities. This is the only Medicaid related cost that Casey Family Services claims for reimbursement for the Guided Services model.

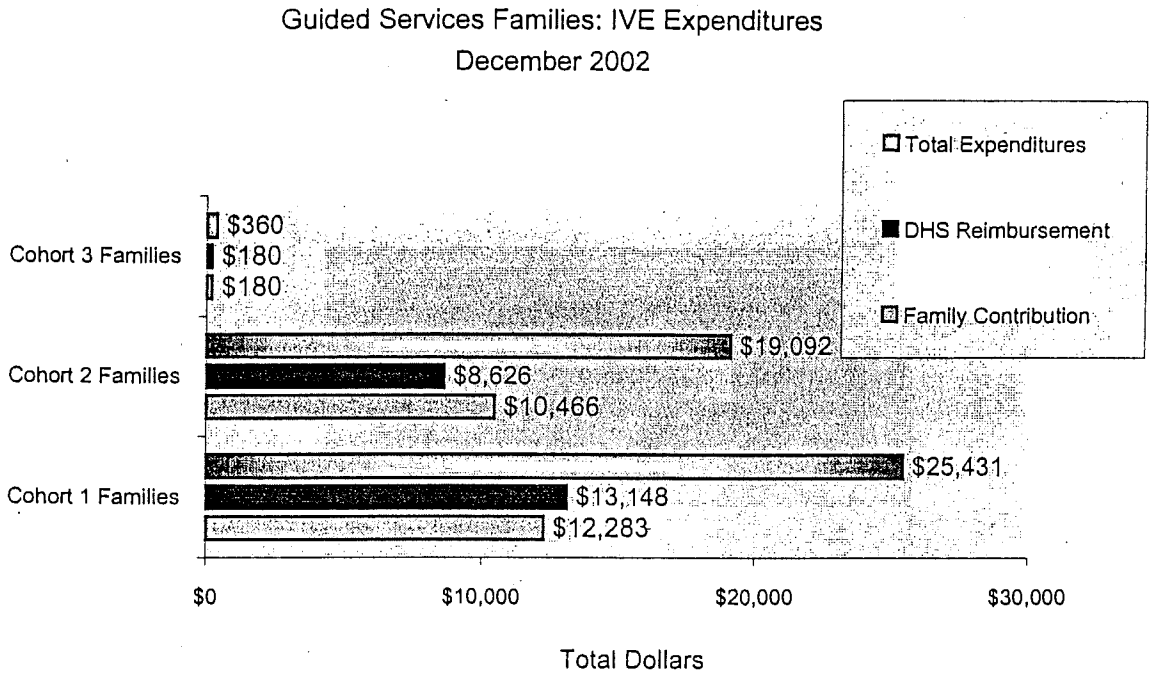


Case Management Costs per Child By Assigned Group
December 2002

	Previous Year – Baseline	Year 1 in Study	Year 2 in Study
Guided Services (E):			
N	173	130	43
Mean	$11,699	$4,170	$5,979
SD	$8,588	$3,087	$3,514
Standard Services (C):			
N	136	77	21
Mean	$11,994	$2,591	$1,928
SD	$8,042	$2,354	$1,130

Although Guided Services per child costs for Case Management are larger than related costs for Standard Services, both groups show significant decreases in costs as compared to the year previous to entry to study. Given such a large difference, efforts should be made to better understand the cost drivers pre-legalization for case management services.

In addition, program staff track the use of IV-E dollars for other types of services not covered by Medicaid or the families insurance carrier.

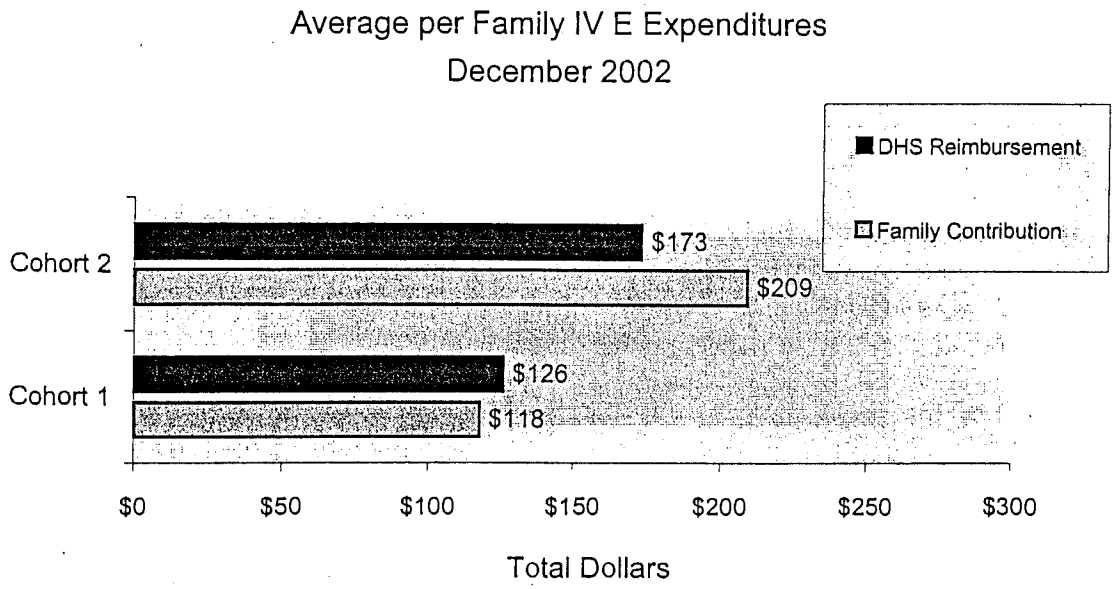


This chart, and the one following, tracks costs that are Title IV-E dollars provided only to Guided Services (E) families. These funds are for services of various types that are not paid for from current options such as Medicaid and/or private insurance carriers. These services include such activities as respite, educational activities and/or special therapeutic activities. The intent is for the family to share equally in the costs of these services. Requests are made to Casey social workers and then approved by the state DHS adoption program manager on a case-by-case basis.

Cohort 1 (n=18) families are those families accessing these funds that entered the project in the first year, Cohort 2 (n=14) families entered in the second year and Cohort 3 (n=3) in the current or third project year. Therefore, Cohort 1 families have had more time to accumulate costs as they have been in the project longer. Approximately 56% of Cohort 1 families have accessed this funding, 30% of Cohort 2 families and only 11% of Cohort 3 families.

The types of activities paid for from these funds is varied; one arbitrary categorization of these activities is respite related services and all others.

- Cohort 1 Families: 31% Respite and 69% Other Types of Services
- Cohort 2 Families: 38% Respite and 62% Other Types of Services
- Cohort 3 Families: 67% Respite and 33% Other Types of Services



This chart depicts average overall expenses per family for Cohort 1 and Cohort 2 families. This data indicates that the intent of co-equal contributions from families and the Title IVE dollars appears to be evident; there are no statistical differences to report.

Looking closer at costs for types of expenses:

- There were a total of 157 requests for financial support from 35 families to date.
- 54 requests for Respite type services, at an average total (family and DHS combined) cost of $276.00 per request.
- 103 requests for Other types of services, at an average total cost of $289.00.
- Average costs per activity are:
  - Family Contribution: $145.00
  - DHS Contribution: $139.00
  - Total Combined: $284.00
- Minimum Contribution by Family = $12.50
- Minimum Contribution by DHS = $12.50
- Maximum Contribution by Family = $1,800.00
- Maximum Contribution by DHS = $600.00.

One of the goals of the intervention process was to create a shared approach to costs with families for services to meet their child's unique needs. It appears that MAGS social workers are successful at creating this shared approach to paying for unique services.

CONCLUSION

A critical continued finding from this study is the level of need for mental health services for many of these children. Using the Child Behavior Checklist (Achenbach, 1991) as a measure of functioning, anywhere from 45% to 65% of the children (age 6 – 18 years old) in this study are considered in need of clinical mental health services.

Caregivers appear to feel positive about the adoption process and rate the level of attachment of child to family and family to child as positive. Ratings of overall communication with the child and overall quality of home life are also positive. The parenting styles reported, Authoritative, and degree of family Cohesion and Adaptability are all results in favor of healthy family functioning.

For this report, there are 34 separate child and family outcome variables analyzed for group differences over time. Of those, only three outcomes revealed statistical differences over time in favor of the Guided Services model and those are:

- Caregiver Level of Trust with Child;
- Case Manager Develops/Brokers Services
- Case Manager Provides General/Educational Support

Analyses for other group differences over time were not found to be statistically significant.

At this point in the study there are results for most participants who have been in the study for at least 18 months, n = 107 children and n = 54 families. Results to date provide reasons for both concern and optimism. As these results are considered, it is very important to remember that this intervention is being evaluated as it develops. Although the study design is strengthened by the use of random assignment and valid and reliable measures, the fact remains that this research is conducted in a live setting, not in a controlled setting. Questions that need to be explored while considering these results are:

- Fidelity of Implementation of the Intervention - Are all families receiving the same quality and quantity of service/support from their assigned social worker/case manager/Guide?
- Appropriateness of Outcomes – Are the outcomes chosen the best to measure success?
- Sensitivity of Measurement – Are the measures selected sensitive enough to pick up on changes over time?
- Group Differences – Are families/children in the control group (Standard Services) receiving services/supports in such a way that is similar to the experimental group (Guided Services) and therefore minimizes ability to detect between group differences?
- Amount of Intervention – Are children/families who are receiving the Guided Services intervention in fact getting the amount (dosage) of support that they need in order to improve?

- Length of Exposure to Intervention – Are children/families exposed to the Guided Services intervention for a long enough period of time in order to receive benefits?
- Limitations to Case Management Models – A core function of case management models is to refer and/or connect families to other services/supports in the community. What is the quality of the other services families receive and how does that influence outcomes?

For those participants in the study for 18 months, there are few statistically significant differences to report that would lend support to the Guided Services intervention. Even with positive trends on a number of other child and family functioning outcomes, there is little evidence to support effectiveness based on differences between groups on these outcomes at this point in time. This finding needs further interpretation in order to decide how effective this type of case management model is at influencing change for children and families.

Turning to reasons for optimism, it is clear that this intervention model is designed and implemented to meet needs expressed by these adoptive families. The philosophical intent of providing services in a family driven framework appears to be evident. The partnership between the Casey Family Services agency and the state DHS adoption program appears to function in support of this project. Both agencies have demonstrated willingness to collaborate and work through a uniquely difficult process with families at various stages of engagement.

The preliminary results of the descriptive analyses of the financial data, use of Medicaid funds and Title IVE funds, provides another area of focus for potential improvements to the post-adoption system. Medicaid costs drop substantially after legalization and for Guided Services children, on average costs continue to decrease more so than for Standard Services children. At this point in time, it appears evident that Guided Services participants are receiving services in such a way that is not increasing costs to the Medicaid system. Results from analysis of service use appears to indicate that Guided Services families have access to daily, if they should choose, supports from this clinical case management model. This is an important initial finding as most all of these children have access to Medicaid, and the intervention claims against Targeted Case Management funds for reimbursement for service provision. This finding needs to be further studied in order to discern which types of costs are most evident for which types of child/family needs. In addition, the Title IVE funds provided to Guided Services families appear to be utilized in an equitable way amongst families and the state DHS funds are fairly matched by family contributions. This process may provide a model of how to increase flexibility of access to services for children/families in need.

Finally, these results clearly indicate a substantial need for behavioral health services and supports for the majority of children who are adopted from the state child welfare system. The evidence from this study to date, from parents and providers, clearly supports the need for post-adoption services for a majority of the children entering into adoptive families. In the midst of caring for children with substantial needs, caregivers

continue to report overall levels of satisfaction with the adoption, their services from DHS staff, and with the supports they receive from the Guided Services social workers. These results are encouraging and are a testament to the grace exhibited by many of these families.

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EDUCATION AND TRAINING VOUCHER PROGRAM
AMENDMENT TO 2001-2004 CFCIP STATE PLAN
JULY 2003

ETV PROGRAM CONTACT PERSON:

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Older youth in care are well supported by the Chafee Foster Care Independence Program in Maine for pursuit of post-secondary education and specialized vocational technical job training programs. For many years, a considerable amount of Chafee funds have been budgeted and expended for older youth in care in post-secondary education and job skills training programs. These funds have been used to supplement other forms of non-loan federal student aid that are applied for through the Free Application for Federal Student Aid (FAFSA) as well as scholarships from various other resources. For example, each year, at least one of our students has qualified for a full four-year Orphan Foundation Scholarship. Maine also has a foster care tuition waiver for up to 30 freshman students per academic year who are planning to attend one of the state university system schools or one of the state community colleges. This waiver is supported by state funds as these post-secondary schools systems have agreed to absorb the cost of the waiver within their operating budgets. There are more than 15 college campus locations for youth to choose from among these schools. Once a freshman student has qualified for the waiver, they have up to 5 years of waiver eligibility to complete their undergraduate degree provided they remain a student in good academic standing.

In September 2002, there were over 100 older youth in care in Maine who were planning to begin, or continue their post-secondary education. More than half of these students were not attending one of the tuition waiver institutions. Some of these students were attending post-secondary education institutions out of state and some were attending a private post-secondary education institution in state. As a rule, these institutions were more than double the cost of attending a state post-secondary education institution. The availability of ETV funds will be of great assistance to students in the private post-secondary institutions. Our overall plan for the Education and Training Voucher (ETV) program funds is to use the funds for these students, students who may have a remaining financial need who are attending a tuition waiver institution, and any students who might be attending a specialized job skills training program. All students who have a post-secondary education financial need will receive the benefit of the ETV funds including any older youth in care who was adopted after the age of 16. We intend to serve all categories of former youth in care up to age 23. There are no identified statutory, or

administrative barriers that will prevent us from fully implementing the ETV program in Maine.

As the Chafee Independent Living Program Manager, I am aware of each student that is planning to attend a post-secondary education and job skills training program every year. This information is provided to me directly through our Life Skills Educators, individual caseworkers, and information that is contained in the individual youth's automated child welfare record. A central database is maintained by the Independent Living Program Manager, on a yearly basis, to track the progress, financial need, and expenditures of funds for every older youth in care in Maine who is attending a post-secondary education program. The Independent Living Program Manager will make the determination of each youth's eligibility for ETV, make the determination of their ETV allocation need under the guidelines of the ETV program, and track expenditures separately from other expenditures under the CFCIP.

Our specialized Chafee Life Skills Educators are very well connected with any youth who is planning for attending a post-secondary education, or job skills training program. They also have well-established links with secondary education counselors, officials, and other support persons for the benefit of the youth that they work with. Life Skills Educators will continue to provide in-person assistance to the youth for completion of required college applications, tests, and how to complete the various financial aid forms. They also help the youth locate housing, child-care, and tutoring, if needed. We have found that working together face-to-face with the youth to plan for post-secondary education has been the most effective way to enhance their chances of succeeding in making the transition to a post-secondary education program. We recognize the importance of spending a considerable amount of time in planning with the youth before they enter a post-secondary education program and in providing guidance and support particularly during the first year of their post-secondary education program. Our Life Skills Educators provide this type of assistance to all youth who are, or will be attending, a post-secondary education program. They will provide this form of assistance in support of the ETV program.

All of our district management and caseworkers have been fully informed about the availability of ETV funds and what the criteria is for eligibility. This was done to establish a viable link between district staff, the Life Skills Educators located in the district offices, and the Independent Living Program Manager located in the Department's central office. Through this process we expect that all political subdivisions in the state will be served in a uniform and consistent manner. We place a high priority on having our older youth in care fully informed about the post-secondary educational opportunities available to them. Because of this, we know that we can fully inform any youth currently attending a post-secondary education program, or any youth that is planning to attend as a first year student. In addition, we are aware that some of our older youth in care do not attend a post-secondary program directly out of high school and may plan to attend at a later date. We will fully inform these youth of the availability of ETV funds and of the process for applying for these funds if they are accepted into a post-secondary education program at a later time.

The determination for ETV eligibility for funds will follow the same process being used currently for our older youth in care for determining their eligibility for Chafee funds for their post-secondary education program. All youth in care are expected to apply for federal FAFSA funds and for the foster care tuition waiver, if applicable. They also apply for various scholarships as well. Once any of these non-loan forms of financial assistance have been determined to be available for the student, the remaining level of non-loan financial assistance needed is determined. Once this information has been gathered and is available, a determination of the amount of ETV funds to be awarded will be made. As is the case now, we will require that the student maintain a GPA of at least 2.0, or what is considered a satisfactory level of academic performance, in order to remain eligible for ETV funds. In this way, we are able to assure that the total amount of educational assistance to a youth and any other federal assistance program does not exceed the total cost of attendance. It will also avoid duplication of benefits under the ETV program and any other federal assistance program.

Older youth in care in Maine have been and will continue to be directly involved with their Life Skills Educator, caseworker, foster parent, or group care provider, in making plans for attending a post-secondary education program. Individual youth will be consulted with regard to the ETV program as well as members of Maine's Youth Leadership Advisory Team. We feel that it is very important to have our youth's voice contained in the process of overseeing the ETV program. Since we have a well-established framework in place for this, we feel that this level of consultation and support will happen without having to create something new to facilitate the process.

We intend to inform all post-secondary education institutions and financial aid offices in Maine with respect to the ETV program and how it works. We will fully inform and coordinate with other state and federal supported programs such as the Department of Education's Upward Bound program (many of our youth participate in this program every year), the Department of Labor's Workforce Investment programs for out of school youth, and other private sector initiatives. We will also inform and coordinate with any of our state's dropout prevention programs with respect to the ETV program.

Attachment B

STATE CHIEF EXECUTIVE OFFICER'S CERTIFICATION
for the
EDUCATION AND TRAINING VOUCHER PROGRAM
Chafee Foster Care Independence Program

As Chief Executive Officer of the State of Maine, I certify that the State has in effect and is operating a Statewide program relating to Foster Care Independent Living and that the following provisions will be implemented as of September 30, 2003:

(1) The State will comply with the conditions specified in subsection 477(i).

(2) The State has described methods it will use to:

- ensure that the total amount of educational assistance to a youth under this and any other Federal assistance program does not exceed the total cost of attendance; and
- avoid duplication of benefits under this and any other Federal assistance program,

as defined in section 477(3)(b)(J).

Peter E. Walsh

Signature of Chief Executive Officer*

Commissioner, Department of Human Services

8/15/03

Date

* The Human Services Commissioner is authorized by state law to be the Chief Executive Officer's designee for signing this document.

Attachment C

Part II - FY 2003
ETV Program Request for Funds

Federal Funds Requested $ 235,117

State Match Amount $ 58,780

Sources: Third party contributions* (see State Match section of FFY-2001-2004 Application and State Plan on page 26 for explanation)

In-kind*
Tuition Waiver for State University and Community College systems

Request for Re-allotted Funds, (if available) $ 0

I certify that I am authorized to submit for the State of Maine, the FY 2003 and 2004 application for ETV Program funds.

Application submitted by:

Peter E. Walsh *
Name

Commissioner, Department of Human Services
Title

Peter E. Walsh
Signature

August 26, 2003
Date

* The Human Services Commissioner is authorized by state law to be th Chief Executive Officer's designee signing this document.

Approval Date: _____

_____
Signature - ACF Regional Administrator