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Annual Progress & Services Report

June 2016

Maine Department of Health and Human Services
Office of Child and Family Services

State Agency Administering the Programs

The Maine Department of Health and Human Services (DHHS), Office of Child and Family Services (OCFS), will administer IVB programs under the 2015-2019 CFSP.

The OCFS is a member of the larger Maine community working toward a system of care that is child-centered and family-focused, with the needs of the family and child dictating the array of services.

The organizational unit responsible for programmatic implementation of the CFSP is the Child Welfare Services, overseen by Associate Director Bobbi Johnson. The organizational unit responsible for the administrative support of CFSP implementation, for the development and submission of the CFSP, and for the development and submission of Annual Progress and Services Report (APSR) and all required reporting is the OCFS Operations Unit, overseen by Associate Director Robert Blanchard.

Practice Model

Articulated in our Practice Model is the philosophy of OCFS in providing child and family services and developing a coordinated service delivery system. The Practice Model can be found at the following link: http://maine.gov/dhhs/ocfs/cw/policy/

Consultation and Coordination

The Community Partnership for Protecting Children (CPPC): Based on a national model, the CPPC model in Maine is a network of people who live, work, and serve in our communities to support families experiencing high levels of stress. Guided by the Early Intervention and Prevention Services Unit's strategic goal to improve stability, health, wellbeing and quality permanent connections of individuals and families, CPPC strives to reduce abuse and neglect by developing tangible and sustainable strategies to strengthen families, neighborhoods and the child welfare system. By transforming the relationship between Child Protective Services (CPS) and communities through the development of a child-welfare Continuum of Care related to child safety, vulnerable families and their children will be less likely to experience abuse and neglect. At its essence, CPPC is a Collective Impact model, designed with the understanding that the traditional child welfare system cannot, and should not, be the sole structure responsible for keeping children safe.

CPPC is an approach grounded in child safety which involves all CPPC state and local partners (including CPS) joining together to understand varying perspective and approaches, while sharing unique visions and solution-building strategies, to improve their communities' abilities to reduce child maltreatment rates. Using this flexible, family-centered, multi-system, community response to vulnerable children and families allows for an understanding of shared definitions of safety, risk and danger. Additionally, it also encourages the use of strategies and resource sharing that builds protective and promotive factors and strengthens families at intervention points along the continuum of care and involved in, or at risk of, child welfare intervention.

CPPC is based on the premise that keeping children safe is everyone's responsibility and that no single person, organization or government agency alone has the capacity to protect all children and strengthen all families. The Community Partnerships work in Maine began as a successful pilot program in 2005 and expanded over the next eight (8) years to include six (6) additional communities and neighborhoods. Beginning in the summer of 2016, CPPC will expand in Maine from separate community models to an 8 district model.

The CPPC model, as a continuum of care, will provide services for families who are identified as at risk for child welfare involvement due to concerns of child abuse/neglect at secondary or tertiary intervention points. Families who access CPPC services will demonstrate an increase in protective and promotive family attributes to maintain child safety and wellbeing, as evidenced by a reduction in the incidents of child maltreatment findings as compared to the State trend by:

1. Increased protective and promotive family attributes of families at risk for experiencing child maltreatment through participation in the Preventative Family Team Meeting process and as measured by the Preventative Family Team Meeting Plan and the Self-Sufficiency Matrix;
2. Increased access to, and use of, community support services for families at risk for experiencing child maltreatment; and
3. Increased protective and promotive family attributes of families who have experienced, or are at risk of experiencing, child maltreatment by participation in the Parents as Partners program.

Maine Childrens Trust Serves as administrator for the CAN Councils network, which will deliver quality parent programming for DHHS. MCT promotes parent access to evidence based parent education. MCT also serves as project coordinator in the development and implementation of the Maine Parents Place Project virtual learning center. MCT is leading the development of this training delivery option in partnership with the State, with the initial pilot group of parents to include parents the state has mandated to take parent education. MCT serves as project administrator in the development and implementation of a Community Based Physician Educational Project. The key areas will be Mandated Report Training, prevention training including Safe Sleep strategies for infants and the Period of PURPLE crying. For the Mandated Reporter Training (MRT) MCT intends to utilize a peer-to-peer training model. MCT is coordinating the development of a training syllabus for the MRT and an educational program for the prevention programs and is utilizing a small network of physicians who are interested in providing peer training. MCT recently announced the 2015-2016 rounds of child abuse and neglect prevention grants. The identified priorities for this round are programs that promote protective factors: Parental Resilience, Social Connections, Knowledge of Parenting & Child Development, Concrete Support in Times of Need and Health Social & Emotional Development.

In the fall of 2015 the decision was made to restructure the various panels and committees facilitated by the OCFS to increase efficiencies and to enhance the overall quality of conversations and planning within the stakeholder groups. In December, OCFS facilitation of the Child Welfare Steering Committee and the Citizen's Review Panel were ended. The members of both of those groups were encouraged to continue involvement by participating in either the Child Death and Serious Injury Panel and the State Multidisciplinary Task Force (Child Abuse Action Network). The work of this group related to stakeholder involvement in the CFSP is anticipated to be the same as was the Child Welfare Steering Committee involvement. The OCFS Associate Directors for Child Welfare and Early Intervention and Prevention Services participate in this Steering Committee and facilitate the process of sharing and gathering feedback from this group related to the work of OCFS.

Assessment of Performance

Data used in this Assessment of Performance was pulled from the most recent ACF Summary Data-CFSR 3 Statewide Data Indicators (May 2015); OCFS Management Reports; and Me.-CFSR data from 2009-2015:

- Round 1 11/2009-10/2010
- Round 2 11/2010-10/2011
- Round 3 11/2011-10/2012
- Round 4 11/2012-10/2013
- Round 5 11/2013-10/2014
- Round 6 11/2014-10/2015

Child and Family Outcomes

Safety Outcomes:

Safety outcome 1 includes timeliness of initiating investigations of reports of child maltreatment **(Item 1- Timeliness of initiating investigations of reports of maltreatment)**. This item was assigned a rating of Area Needing Improvement in the 2009 CFSR.

The negotiated PIP goal for Item 1 was 80% and Maine was able to exceed that goal at 84% within the first PIP quarter, the method of measurement was through the OCFS Management Report. Since that time the data would indicate that OCFS caseworkers have had more difficulty in initiating timely investigation as evidenced by the following data:

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
69%	73%	76%	79%	82%	85%
Actuals					
CFSR	76%	-	-	-	
Management Report	75%	-	-	-	-

While evident that OCFS met the Year 1 goal in this measurement, there needs to be continued focus on making improvements and sustaining these improvements over the course of time.

Trends that were highlighted through the case review indicated that barriers to meeting this timeframe included:

- Not making concerted efforts to see all alleged victims within the required timeframe.
- Lack of coordination between OOH worker and case carrying worker to ensure that there is an appropriate response to the situation within 72 hours.
- DHHS caseworkers do not plan to go out until the last day of the 72 hours (the due date) and then there is something that delays the visit.
- Assessment not assigned to worker in a timely manner leaving them little time to meet 72 hours. This includes times when a supervisor initially assigns an assessment to one worker and then reassigns the assessment to another worker, often very close to or even past the 72 hour timeframe.
- Lack of documentation regarding reasonable efforts made within 72 hours to locate families to initiate the assessment.

In the past, factors that impacted the capacity for timely assessments were the significant staff vacancy for direct line caseworkers coupled with an increase in the number of children remaining in foster care which has diverted resource and staff time. In the past year these two factors did not seem to play a large role in this challenge as the vacancy rate leveled off.

In the past, OCFS conducted its own assessment related to work workload and staff allocation. Given the continued challenges in making progress in this area, combined with the ongoing feedback related to the workload being unmanageable, OCFS contracted with an outside consultant to assess the staff allocation and workload assignments. Within six months OCFS will review and implement recommendations from the consultant once this process is complete.

District management needs to be focused on this area and utilize the tools available to them to monitor performance. In 2016 OCFS reinstituted the Assignment Activity worksheet that is required to be completed with the supervisor and the caseworker before the caseworker responds to the report. This will help focus the work for both the caseworker and the supervisor and should lead to more effective utilization of time and workload management. Additional barriers that have been identified are lack of timely decision making and

transferring of cases to other program areas from the assessment units. In many districts there is a bottle neck between an assessment that should be moving on towards a service case however the service case/permanency units not being able to accept new cases. Management will focus on this area and assess the key factors leading to these delays.

This issue has also been identified in the DHHS Strategic Plan so is the focus of both OCFS and the larger DHHS management team.

Safety outcome 2 includes services to family to protect child(ren) in the home and prevent removal or reentry into foster care **(Item 2- Services to prevent removal)** and risk assessment and safety management **(Item 3- Risk and safety management**). Both of these items were assigned a rating of Area Needing Improvement in the 2009 CFSR.

The negotiated PIP goal for Item 2 was 58.5% the method of measurement being the quality case reviews; OCFS exceeded the goal reaching 61% in PIP Quarter 4. Since that time the case review data reflects that in general, there is ongoing progress made in this area although a drop in performance in the latest round of reviews:

Me.-CFSR Round	Item 2
Round 1: 11/2009-10/2010	49%
Round 2: 11/2010-10/2011	61%
Round 3: 11/2011-10/2012	79%
Round 4: 11/2012-10/2013	87%
Round 5: 11/2013-10/2014	89%
Round 6: 11/2014-10/2015	81%
6-Year Average	**74%**

Incorporated into Item 2 is re-entry into foster care, formerly Item 5, a standalone item to review in the previous CFSR cycles.

Re-entry into foster care was not determined to be problematic for Maine in the 2009 CFSR as 100% of the cases reviewed were strength in this area.

The ACF Summary Data- CFSR Round 3 Statewide Data Indicators (May 2015) reflect that Maine falls within the appropriate range in relationship to meeting this standard. The national standard is 8.3%, Maine's observed performance is 4.4%. Based on this data, Maine meets the standard and would not be required to address this issue through the PIP process.

It is anticipated that the goals and strategies identified in the CFSP will continue to support progress in this area.

The negotiated PIP goal for Item 3 was 50.5%, the method of measurement being the quality case reviews. This was a difficult goal to meet but OCFS exceed the goal reaching 53% in the PIP rolling Quarter 5.

This area continues to be a challenge for OCFS and the data from the last six rounds of the qualitative case reviews bears this out, however the data also indicates that incremental progress is being made:

Me.-CFSR Round	Item 3
Round 1: 11/2009-10/2010	40%
Round 2: 11/2010-10/2011	34%
Round 3: 11/2011-10/2012	41%
Round 4: 11/2012-10/2013	48%

Round 5: 11/2013-10/2014	45%
Round 6: 11/2014-10/2015	52%
6-Year Average	**43%**

Trends that were highlighted through the case review indicated that barriers to meeting this timeframe included:

- Ongoing risk concerns noted throughout the period under review (PUR) that are either minimally or not addressed, particularly when new safety issues arise during the open case.
- One or more people living in the home that are not assessed or seen (i.e. significant others of parents).
- Lack of appropriately addressing of safety issues, particularly around substance abuse and domestic violence.
- Lack of documentation that agency approved informal support supervisors have been assessed and understand their role related to the need for the supervised visits.
- Visits starting out unsupervised with a parent who hasn't had contact with the youth for a period of time. Often this is seen with older youth in residential placements where the providers see the benefit of the youth having this connection however the parent situation has not been fully assessed by DHHS.
- Out of home parents not assessed despite the child having contact.
- Lack of assessment of children who do not live in the home full time but do have routine visits with their parent and/or siblings.
- Focused assessment on one child in the family who has been either identified as having problematic behavior or child has been removed but others remain in the home and are not assessed.

This is clearly an area OCFS needs to be focused on. The CFSP includes various strategies that we believe will impact this area which includes strengthening policy, supporting training and coaching opportunities and streamlining work flow so staff can focus on what is most critical. The ongoing qualitative case review process will continue to measure and monitor this area and provide ongoing feedback to districts and management as to the how we are ensuring that risk and safety of children is being addressed. In the last year Maine has put a staffing structure in place to fully implement the Eckerd Rapid Safety Feedback (ERSF) model, with implementation of the process on 3/7/16. This structure includes a manager of the program as well as shifting of work from the current Quality Assurance unit to other resources in order for 3 (2 primary, 1 backup) of the QA Specialists to have reasonability for ERSF.

Incorporated into Item 3 is recurring maltreatment/recurring safety concerns, formerly Item 2, a standalone item to review in the previous CFSR cycles.

The ACF Summary Data- CFSR Round 3 Statewide Data Indicators (May 2015) reflect that Maine no longer meets the national standard related to recurrence of maltreatment. The national standard is 9.1%, Maine's observed performance is 11.2%. Based on this data Maine would be required to address this through the PIP process. It is anticipated that the adoption of the ERSF process will positively impact the challenges we face related to recurrence of maltreatment.

The 2015-2019 CFSP includes strategies that should support continued improvement in this area, specifically the expectation of district action plans for districts that are struggling in this area.

Permanency Outcomes 1 and 2

Permanency outcome 1 includes the following:

- Item 4- Stability of placement;
- Item 5- Permanency goal for child;
- Item 6- Achieving reunification, guardianship, or permanent placement with relatives; and

- Item 7- Placement with siblings.

Item 4 (Stability of placement) was assigned a rating of Area Needing Improvement in the 2009 CFSR. Due to there being significant improvement in this area between the review and the final approval of the PIP Maine was not required to specifically address this area in the PIP.

The ACF Summary Data- CFSR Round 3 Statewide Data Indicators (May 2015) reflect that Maine continues to meet the national standards in this measure. The national standard is 4.12 moves (per 1,000 days in care), Maine's observed performance is 2.65 moves, within the acceptable range. Based on this data, Maine meets the national standard and would not be required to address this issue through the PIP process.

The data collected through the case review process, although pulled from a significantly smaller sample of cases found that Maine does fall below the federal case review 95% threshold, and has fluctuated between 67% in Round 2 to 89% in Round 4- meeting a 6-Year Average of 78%:

Me.-CFSR Round	Item 4
Round 1: 11/2009-10/2010	78%
Round 2: 11/2010-10/2011	67%
Round 3: 11/2011-10/2012	77%
Round 4: 11/2012-10/2013	89%
Round 5: 11/2013-10/2014	77%
Round 6: 11/2014-10/2015	82%
6-Year Average	**78%**

We anticipate being able to drill down into the CFSR data to determine what the challenges are specifically related to this area once the case review process is captured through OMS.

Item 5 (Permanency goal for child) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The PIP negotiated goal for this item was 89%, the method of measurement being the quality case reviews. Maine met that goal at 89% in the PIP Quarter 6 submission.

The quality case review data indicates a fluctuation in performance over the course of 6 review cycles but taking a notable drop in Round 6:

Me.-CFSR Round	Item 5
Round 1: 11/2009-10/2010	78%
Round 2: 11/2010-10/2011	62%
Round 3: 11/2011-10/2012	80%
Round 4: 11/2012-10/2013	89%
Round 5: 11/2013-10/2014	76%
Round 6: 11/2014-10/2015	59%
6-Year Average	**74%**

Trends that were highlighted through the case review indicated that barriers to meeting this timeframe included:

- It's not usually clear from the record as to the delay in changing case goals. Sometimes reunification goes significantly beyond the 12/15 month mark before the TPR (caseworkers and the court trying to give the parents additional opportunities to reunify).
- This item also speaks to whether or not a goal is appropriate to the case. There are times when it does not appear that the parents are involved in reunification at all (or just minimally) but the Department is not making any efforts to move towards a TPR when it appears that would be appropriate (even though earlier than the 12 month mark).

- Lack of documentation related to concurrent planning.

In Round 6 QA was able to extract data related to the specific questions incorporated in Item 5 in order to identify where the challenges are in relation to timely establishing of appropriate permanency goals. This data reflect that Maine does a great job in identifying the permanency goals in the cases, meeting this in 100% of the cases review during that period. In most cases, 87%, the permanency goal was established timely and, in 92% of the cases reviewed, the goals were appropriate to meet the child's needs for permanency and to the circumstances of the case. The data reflects that the challenge may be around when the agency files a TPR and whether this is done timely; in this same cohort of case reviews this was found in only 76% of the cases reviewed with only 61% of those including an exception to the requirement to file the TPR.

Key strategies in the CFSP that will address this, and have been carried over from last year are streamlining caseworker workflow, strengthening the Family Team meeting process, implementing effective Permanency Review Teams, Child Specific Recruitment activities (including the Heart Gallery) and Family Share Meetings all of which will require caseworker attention and time to adequately document these activities. Three additional strategies are anticipated to be implemented in 2016 and should impact children's permanency goals and timeframes related to meeting those goals and include:

- Bi-weekly data planning calls to include District Program Administrators. Specific youth who have been in custody for a period of time and monitor the progression being made toward achieving permanency. This is a similar model used by the Eckerd agency in Florida and includes an interactive questioning approach specific to the actions being taken on the child level to achieve permanency for the children being reviewed. It is expected that district staff will have updates related to steps taken to achieve permanency and that there is follow up by management to ensure those steps are moving the case towards timely permanency goal achievement.
- Developing a process where all youth in care 0-9 months will be reviewed to identify any barriers to reaching timely permanency and strategizing ways to mitigate those barriers.
- All children in foster care with a TPR will be reviewed, with the goal of having each district develop a recruitment plan for each applicable child. Each adoption supervisor will have a tool to track recruitment for every child in their unit. All of our TPR'd children without an identified adoptive family will have a Heart Gallery photo, and an Adoptuskids listing. We will also be working with our contracted recruitment agency, Kidspeace to do other types of child specific recruitment such as print media and community recruitment

The strategies related to strengthening the Family Share Meeting are in the process of being implemented. Family Share policy was updated and disseminated in August 2015. While implemented in each district the data indicates that they are not being consistently used in each district however there has been steady improvement in utilizing these meetings.

Throughout the past year the QA unit has conducted quarterly reviews to determine if the policy is being followed in relation to utilization of Family Share meetings. Districts are provided with the overall summary that is the quantitative pull. A smaller subset of cases are reviewed by QA to determine if the meetings are being held within 5 days of child entry into foster care (the August 2015 policy change was 5 business days), whether meetings are being held when there has been a placement change without caregiver agreement and how well exceptions are documented. While the quantitative data would indicate that districts are completing a high number of Family Share meetings, the qualitative data would indicate that the meetings are not occurring as consistently as expected. As specific data has been shared over the course of the year there has been improvement in terms of how the work is being documented that would better allow for a clean quantitative pull of data, i.e. caseworkers using the correct MACWIS narrative drop down headers. In addition, the QA reviews found that many Family Share meetings were being held in the context of a Family Team Meeting which is not the appropriate forum for these meetings. Based on this information, the revised August 2015 policy clarified that the Family Share meetings need to be standalone meetings, not held in

context of the FTM. In the spring of 2016 the decision was made to incorporate the goals and strategies of the SMT Accountability Plan into the broader 24-month Child Welfare Strategic Plan. It is anticipated that this working pan will be updated routinely and modified based on implementation of identified strategies and data measurements.

Family Share Meetings:

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
12%	16%	21%	28%	37%	50%
Actuals:					
	CCY 2015 Quantitative 65% Qualitative 63%				

Item 6 (Achieving Reunification, Permanency Guardianship, Adoption, Other Planned Permanent Living Arrangement) This new item is a consolidated item to determine if the identified permanency goals have been achieved: reunifications, guardianship, adoption or other planned permanency living arrangement.

In the 2009 CFSR the item rating how well the agency performed in achieving timely goal of reunification/guardianship (Item 8) was assigned a rating of Area Needing Improvement. The data supported significant improvement in this area between the review and the final approval of the PIP so Maine was not required to specifically address this area in the PIP.

The revised data measures in the permanency areas are broken down into three distinct periods. The table below depicts that breakdown as well as the Maine data reflected within the ACF Summary Data- CFSR 3 Statewide Data Indicators (May 2015):

ACF Data Indicator	National Standard (NS)	Maine Data
Permanency in 12 months for children entering foster care	40.4%	25.3 NS not met
Permanency in 12 months for children in care 12-23 months	43.6%	41.5% NS not met
Permanency in 12 months for children in care 24+ months	30.3%	27.5% NS met

The data reflects Maine not meeting two of the three data measurements which would require action through a PIP process. The data reflects that, within the risk adjustment formula process, Maine meets the measurement related to children in care 24+ months achieving permanency and would not be required to address this in a PIP process.

In December 2015 a study of children that did not meet the adoption timeframes during the period of November 2014-September 2015 was conducted. A total of 218 children were reviewed who did not meet the timeframe of adoption within 24 months of the child's entry into foster care.

In summary:

- The following was found in looking at the timeframes between child entering foster and achieving the goal of adoption:
    - 38% of the children reviewed were adopted between 25-30 months of entry into foster care; 54% of those were between 25-27 months.
    - 25% of the children reviewed were adopted between 31-36 months of entry into foster care; 37% of those were at 36 months.
    - 21% of the children reviewed were adopted between 37-42 months of entry into foster care; 29% of those were at 42 months.
    - 7% of the children reviewed were adopted between 43-48 months of entry into foster care; 40% of those were at 44 months.
    - 6% of the children reviewed were adopted between 49-60 months of entry into foster care.
    - 1 child was adopted at 69 months of entry into foster care and 1 child was adopted at 129 months of entering foster care.

- The following was found when looking for a date in documentation regarding the filing of the TPR being discussed with either parent and then looking at the timeframe from that date to the date the TPR was filed.
    - In 15% of the cases reviewed it could not be determined when the parents were spoken to regarding the filing of the TPR.
    - In 6% of the cases reviewed the date of TPR filing could not be determined.
    - In 28% of the cases reviewed these conversations with the parents took place the same month of the filing.
    - In 18% of the cases reviewed these conversation with the parents took place 1 month prior to the filing.
    - In 20% of the cases reviewed these conversations took place 2 months prior to the filing.
    - In 8% of the cases reviewed these conversations took place 3 months prior to the filing.
    - In 5% of the cases reviewed these conversations took place 4 months prior to the filing.
    - In 1 case review these conversations took place 8 months prior to the filing; and in 1 case the conversations took place 13 months prior to the filing.

- The following was found when looking at how many months from the date the TPR was filed until the court hearing. In many cases the parents had different TPR's dates.
    - In 6% of the cases reviewed the court hearing was in the same month as the TPR filing.
    - In 75% of the cases reviewed the court hearing was held between 1-6 months of the filing; in 64% of those cases the time frame ranged from 2-4 months.
    - In 19% of the cases reviewed the court hearing was held between 7-15 months of the filing.

- Of those TPR'd, 30 were appealed by the parents, in 80% of those it took 9-10 months for the appeal decision to be made and relayed back to district staff.

Trends that were highlighted through the Me.-CFSR process indicated that barriers to meeting these timeframe included:

- Not thoroughly assessing the needs of the parents to know what services would be the most beneficial for them in alleviating jeopardy.
- Not speaking to service providers to assess the parents' participation, progress and case goals.
- Not meeting with the parents and or significant others or having other forms of contact frequently enough to discuss reunification goals and progress (ex. A caseworker might have seen the father 2 times during the PUR and the mother 4 times during that same period).
- It is unclear, outside of visitation, what services are being provided to demonstrate reunification is the goal.

- The goal of reunification was in place for a long time without achievement, concurrent plan or change in goal despite concerted efforts. Sometimes parents did poorly for months and then right before twelve months they would have a good month and begin services again leading caseworkers and courts to continue with reunification. There seems to be a belief, held by some OCFS staff as well as the legal community, that reunification efforts must be pursued for 12 months prior to the agency seeking a TPR, regardless of what is happening in the case.
- Concerted efforts were attempted with one parent for a long time without success and then it was only at that point that effort begins with the other parent (usually fathers); lack of concurrent goals and planning.
- Changes in caseworkers would impact cases when one would be going in one direction such as a TPR and then another one would pick the case up and begin efforts again.
- When cases transfer between workers and units, delays in making referrals for services can occur.
- Workers placing the expectation for referrals to providers on parents who may not be capable of following through with the referral process.
- Lack of consistent meetings such as FTMs all along the way to check on progress and change goal if necessary.
- Services not being arranged in a timely manner, including issues with CANEP/CODE evaluations, despite being ordered by the court, and the results of the evaluation not being provided to the Department in a timely manner.

Strategies developed that should positively impact Maine's performance in these areas include:

- ✓ In 2015 the OCFS Deputy Director and OCFS Adoption Program Manager began reviewing all the youth who are TPRd (577) to assess barriers and effectively plan to reduce those barriers. In the first phase three districts with the longest timeframes to permanency were reviewed, District 2 (Portland), District 5 (Augusta/Skowhegan) and District 8 (Houlton/Caribou/Ft. Kent). Following each review the Adoption Program Manager met with the adoption supervisor and either the PA or APA or both. Those meetings included a discussion on the outcome of the review, questions related to the reviews and the adoption program manager making suggestions for improving timeframes. The districts were receptive to this feedback and process and we anticipate we will start seeing signs of improvement in this area.

  In the second phase of this work, all children in districts with a TPR will be reviewed, with the goal of having each district develop a recruitment plan for each applicable child. Each adoption supervisor will have a tool to track recruitment for every child in their unit. All of our children whose parents parental rights have been terminated without an identified adoptive family will have a Heart Gallery photo, and an Adoptuskids listing. We will also be working with our contracted recruitment agency, Kidspeace to do other types of child specific recruitment such as print media and community recruitment.

- ✓ In 2014 OCFS returned to our former practice of dedicating a unit in each district office to adoption. This decision was made to increase the number of adoptions and improve our timeframes to adoption. As part of this effort it was important for OCFS to reestablish our relationship with Probate Judges and share our vision, but even more importantly, we wanted to hear what the Probate Judges needed from OCFS.

- ✓ In early 2015 the OCFS Deputy Director and Adoption Program Manager requested to join the Probate Assembly at their quarterly meeting to discuss these topics. They met with the assembly twice. They also met with three Probate Judges individually to discuss current strengths and challenges specific to that court and OCFS office. This effort was successful in improving communication and trust between OCFS and Probate Judges. It also led to a decrease in the time between filing adoption petitions and getting a date for legalization.

- ✓ Home Court Legislation- *Summary of PL460, "An Act to Ensure a Continuing Home Court for Cases Involving Children"*- Traditionally Maine's Probate Courts maintained exclusive jurisdiction over guardianships, adoptions, and changes of name. This law transfers exclusive jurisdiction over these matters to Maine's District Courts in any case where there is already a pending case regarding custody and/or parental rights in the District Court and becomes effective 7/19/16.

  This law on the Department's work is multifaceted. When the parental rights of parents are terminated it will no longer be necessary to transfer that case to probate court in order to complete the child's adoption, which will allow the judge who has overseen the case from its inception to make the best decision about the child's future and will eliminate the time the Department's staff spent familiarizing the Probate Court judge with the case. In cases where there is a pending protective custody case, any further court action (such as the filing for guardianship by a relative) must take place in the District Court, which eliminates complexity for Department staff, as well as the Attorney General's staff. The possibilities for the improvement in efficiency and outcomes for children are enormous, from the work of parent's attorneys and guardians, to the continuity and consistency that one single court's handling of the case can provide.

- ✓ Given the challenges OCFS has in terms of achieving timely permanency goals for children in foster care and the inconsistency in utilizing the Permanency Review Teams (PRT) in each district, the decision was made to replace the PRT process with bi-weekly permanency planning calls with district management and executive management staff. This is a similar model used by the Eckerd agency in Florida and includes an interactive questioning approach specific to the actions being taken on the child level to achieve permanency for the children being reviewed. The targeted population will be children in foster care between 0-9 months. It is expected that district staff will have bi-weekly updates related to steps taken to achieve permanency and that there is follow up by management to ensure those steps are moving the case towards timely permanency goal achievement.

- ✓ Redevelopment of the Family Reunification Program. The agency remains committed to redeveloping the Family Reunification Program with an anticipated contract start in January 2017.

- ✓ There are also expectations related to supervisory oversight in terms of developing a formal supervisory review protocol of child and family plans. Family Team Meetings will be held prior to the development of child and family plans and will include youth and family voice.

Maine is proud of its work related to achieving permanency for older youth and ensuring that they are prepared when they age out of the child welfare system. While the data supports the good work and practice in this area we will continue to remain focused in this area and the CFSP supports that work.

Item 7 (**Placement with siblings)** was assigned a rating of Area Needing Improvement in the 2009 CFSR. The item was rated a strength in 87% of the cases reviewed, but was just shy of the 90% goal for the review. The policies and practice in place at the time of the 2009 CFSR have remained in place.

The ongoing quality case review data reflects that OCFS has demonstrated improvement in this area with the exception of the Round 2 and, most recently Round 6. The data has ranged from 86%-100%, with the 6-year average reaching 94% as evidenced in the table below:

Me.-CFSR Round	Item 7
Round 1: 11/2009-10/2010	100%
Round 2: 11/2010-10/2011	86%

Round 3: 11/2011-10/2012	100%
Round 4: 11/2012-10/2013	94%
Round 5: 11/2013-10/2014	95%
Round 6: 11/2014-10/2015	90%
6-Year Average	**94%**

Permanency outcome 2 includes the following:

- Item 8- Visiting with parents and siblings in foster care;
- Item 9- Preserving connections;
- Item 10- Relative Placements; and
- Item 11- Relationship of child in care with parents.

Item 8 (Visiting with parents and siblings in foster care) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The item was rated a strength in 71% of the cases reviewed, below the 90% goal for the review.

The ongoing quality case review data reflects that, while OCFS remained challenged in this area for Rounds 1 & 2, there had been steady improvement in Rounds 3, 4 & 5 but did drop in Round 6. The data has ranged from 63%-85%, with the 6-year statewide average reaching 76% as evidenced in the table below:

Me.-CFSR Round	Item 8
Round 1: 11/2009-10/2010	70%
Round 2: 11/2010-10/2011	63%
Round 3: 11/2011-10/2012	78%
Round 4: 11/2012-10/2013	84%
Round 5: 11/2013-10/2014	85%
Round 6: 11/2014-10/2015	77%
6-Year Average	**76%**

The CFSP will support this work and includes the increased funding for supported visitation. We also need to continue to reach out to fathers and the paternal sides of the family and the work in the CFSP related to fatherhood initiative will support these efforts. This works included a potential collaboration with the Maine Coalition to End Domestic Violence (MCEDV) to enhance the collaboration in this area between OCFS and MCEDV. OCFS has also taken steps to embed specific questions related to fathers participation in the FFTM process which can be measured through the FFTM database. These areas of practice will continue to be of focus in the upcoming 24-month Child Welfare Strategic Plan.

Item 9 (Preserving connections) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The item was rated a strength in 84% of the cases reviewed, below the 90% goal for the review.

The ongoing quality case review data reflects that OCFS had made steady improvement in this area however has experienced a drop in performance in the last two rounds as evidenced in the table below:

Me.-CFSR Round	Item 9
Round 1: 11/2009-10/2010	70%
Round 2: 11/2010-10/2011	73%
Round 3: 11/2011-10/2012	88%
Round 4: 11/2012-10/2013	98%
Round 5: 11/2013-10/2014	88%
Round 6: 11/2014-10/2015	86%
6-Year Average	**84%**

There have been policy and practice changes since the 2009 review and include the Indian Child Welfare Policy. This policy clearly lays out the co-case management roles between state child welfare caseworkers and tribal child welfare caseworkers. The most recent update to the ICWA Policy, effective February 1, 2016, was revised in collaboration with the ICWA Workgroup which includes representatives from the Indian Child Welfare communities and the legal community. Several changes were incorporated into the ICWA policy in order for OCFS to be in compliance with the updated guidelines that was provided to State Courts and Child Welfare Agencies implementing the Indian Child Welfare Act. This update was done due to changes made by the Bureau of Indian Affairs *Guidelines for State Courts in Indian Child Custody Proceedings.*

Throughout 2015/spring of 2016 the work continued towards strengthening the Family Team Meeting and Facilitated Family Team Meeting processes to ensure that formal and informal supports are identified and invited to participate in these meetings. These team members are most likely family members' who can support connections being preserved for children if/when they enter foster care.

Timely relative notification when children enter foster care is key in ensuring that the agency is involved with their family and provides an opportunity for grandparents and other adult relatives to engage with the agency to ensure that connections are preserved. The QA unit has conducted several quarterly reviews on the level of compliance in providing written notification to all grandparents and all known adult relatives. The data supports that the agency does a good job in relative exploration with the family within 35 days of the assessment and documenting that exploration. However the data indicates that we are challenged in providing written notification to <u>all</u> grandparents and <u>all</u> known adult relatives. There is evidence that notifications are provided to some relatives however not to the extent that we should be to meet the law. Given the importance of engaging with all families, OCFS included this practice in the CFSP to monitor and measure related to our goal of increasing safety and nurturing family relationship and family/community connections. In the spring of 2016 the tenants of the SMT Accountability Plan (eff. 2/2015) related to compliance on relative notifications will be reviewed again as the data would indicate a lack of significant progress in providing all grandparents and all known relatives with notification of children entering foster care. The Lexis Nexis search engine has been available to child welfare staff for 6 months however the data indicates that staff are not fully utilizing this resource. In the spring of 2016 a survey was conducted with all child welfare staff to identify the barriers to using this search engine, 77 staff responded to the survey. A major barrier was the lack of awareness of the resource. The results of the survey reflect a need to provide additional education/training. Next steps include creating a training webinar to be available to staff at least quarterly as well as an instruction sheet. A training/review of the resource will be provided at an upcoming statewide supervisors meeting.

<u>Item 10</u> (Relative placement) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The item was rated a strength in 74% of the cases reviewed, below the 90% goal.

The OCFS Management Report provides monthly tracking for OCFS management to monitor the level of relative placements. For calendar year 2015 the average relative placements ranged from 30%-35%, averaging out at 32%.

The ongoing quality case review data reflects that OCFS had made steady improvement in this area however experienced a drop in performance in the review period 11/2013-10/2014 with just a slight improvement in the last round:

Me.-CFSR Round	Item 10
Round 1: 11/2009-10/2010	55%
Round 2: 11/2010-10/2011	65%
Round 3: 11/2011-10/2012	73%
Round 4: 11/2012-10/2013	85%
Round 5: 11/2013-10/2014	70%
Round 6: 11/2014-10/2015	72%

6-Year Average	**70%**

Trends that were highlighted through the case reviews indicated that barriers to meeting this timeframe included:

- If the child is not placed with a relative and there was no clear information provided to support that both maternal and paternal relatives were explored and assessed for placement options.
- Not updating relative resources (simply ruling people out based on old information).
- Ruling relatives out on assumption they cannot manage the child's behavior or if they live far away or out of state.
- Not contacting incarcerated parents or parents living out of state.
- Not talking to children/youth about who they consider a safe resource.
- Not responding to relatives when they reach out to DHHS.
- Discounting relatives because of age or their own previous dealings with DHHS from many years ago without re-assessing a relative's current circumstances.
- Discounting a relative completely because they are not a placement option.

Maine has also strengthened policy to reflect expectations that will comply with Fostering Connections around relative notifications. The data and challenges related to this were highlighted in the previous item. Maine has also collaborated with outside agencies to provide supports to kinship placements as well as modified its rate structure to provide financial support to kinship providers and encouraging providers to apply for foster care licensing.

Despite the work done in this area and the data that suggests improvement has been made, Maine will continue to explore ways to support relative placements. The CFSP will support this work and includes the increased funding for supported visitation. We also need to continue to reach out to fathers and the paternal sides of the family and the work in the CFSP related to fatherhood initiative will support these efforts. This works included a potential collaboration with the Maine Coalition to End Domestic Violence (MCEDV) to enhance the collaboration in this area between OCFS and MCEDV. OCFS has also taken steps to embed specific questions related to fathers participation in the FFTM process which can be measured through the FFTM database. The data is clear that we need to strengthen the consistency related to providing relative notification letters to all known relatives. These areas of practice will continue to be of focus in the upcoming 24-month Child Welfare Strategic Plan.

Item 11 (Relationship of children with parents) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The item was rated an area needing improvement in 60% of the cases reviewed, below the 90% goal.

The ongoing quality case review data reflects that OCFS has made some improvement in this area, trending up as for the first four rounds of review, maintaining at 70% for Rounds 4 & 5 and bumping up to 77% in Round 6:

Me.-CFSR Round	Item 11
Round 1: 11/2009-10/2010	64%
Round 2: 11/2010-10/2011	51%
Round 3: 11/2011-10/2012	66%
Round 4: 11/2012-10/2013	70%
Round 5: 11/2013-10/2014	70%
Round 6: 11/2014-10/2015	77%
6-Year Average	**66%**

Trends that were highlighted through the case review indicate that barriers to meeting this standard include:

- Parents not being notified or invited to activities outside of visitation and services such as medical and dental appointments, school events (sports, Parent Teacher Conference) or other important events in the child's life.
- If above not offered/invited documentation to reflect why this would not be appropriate, is often not documented nor is it reassessed.
- Lack of efforts to promote a relationship with both parents beyond visitation (usually it is fathers).
- Discomfort by caregivers (relatives and foster parents) in having parents attend the child's appointments and events nor did this appear to be addressed by the worker.
- Parent incarcerated or out of state and efforts are not made at all (such as phone conference for the parent at the child's school or clinical meeting, or a letter to the parent informing them of how the child is doing).

The data supports the need to continue work in this area. The CFSP will support this work specifically through the fatherhood work strengthening the FTM process. In the past year there has been work to strengthen the FTM process by recommitting to the Facilitated Family Team Meeting process, which includes caseworkers being identified for this role who will not carry other cases as well as provide specialized training and coaching. OCFS has continued to work with Strategic Consultants, Casey Family Services to develop training on the FTM process. By the spring of 2017 all staff will be trained and/or re-trained on FTMs.

Please the Review of Goals for 2015-2016 (starting on page 54) for the update.

Family Share Meetings have also been identified as a key strategy to strengthen the relations between children and their parents through building a relationship between the parents and resource parents. Family Share Meeting Policy was developed and implemented in August 2015 outlines the expectations for when these meetings should occur and who should be involved. The following table demonstrates staff improvement in the implementation of these meetings:

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
12%	16%	21%	28%	37%	50%
Actuals:					
	CCY 2015 Quantitative 65% Qualitative 63%				

Throughout the past year the QA unit has conducted quarterly reviews to determine if the policy is being followed in relation to utilization of Family Share meetings. Districts are provided with the overall summary that is the quantitative pull. A smaller subset of cases are reviewed by QA to determine if the meetings are being held within 5 days of child entry into foster care (the August 2015 policy change was 5 business days), whether meetings are being held when there has been a placement change without caregiver agreement and how well exceptions are documented. While the quantitative data would indicate that districts are completing a high number of Family Share meetings, the qualitative data would indicate that the meetings are not occurring as consistently as expected. As specific data has been shared over the course of the year there has been improvement in terms of how the work is being documented that would better allow for a clean quantitative pull of data, i.e. caseworkers using the correct MACWIS narrative drop down headers. In addition, the QA reviews found that many Family Share meetings were being held in the context of a Family Team Meeting which is not the best forum for these meetings. Based on this information, the revised August

2015 policy clarified that the Family Share meetings need to be standalone meetings, not held in context of the FTM. The SMT Accountability Plan also includes steps related to meeting this requirement.

Well-being Outcomes 1, 2 and 3
Well-being outcome 1 includes the following:

- Item 12- Needs and services of child, parents, and foster parents;
- Item 13- Child and family involvement in case planning;
- Item 14- Caseworker visits with child; and
- Item 15- Caseworker visits with parent(s).

Item 12 (Needs assessment and services to children, parents, resource parents) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The negotiated PIP goal for this item was 40.1% and Maine was able to exceed that goal at 45% in the fourth PIP quarter, the method of measurement was through the quality case reviews.

The ongoing quality case review data reflects that OCFS has made some improvements in this area. The five year average of CFSR results in item 12 was 48%, OCFS made steady progress between year 1 and year 5. As a result of the change in the OSRI, during Round 6 Maine was able to hone in on areas that provided the most challenge in respect to assessing and address the needs of children, parents and resource parents. The Round 6 reviews found the following:

Me CFSR Round	Item12a (children)	Item 12b (parents)	Item 12c (resource parents)
Round 6: 11/2014-10/2015	93%	49%	83%

In Round 6 QA was able to extract data related to the specific questions incorporated in Items 12a, b and c:

Item 12 Question	Percentage Met
A2. During the period under review, were appropriate services provided to meet the child's identified need?	91%
B3. During the period under review, were appropriate services provided to meet the mother's identified need?	69%
B4. During the period under review, were appropriate services provided to meet the father's identified need?	58%
C2. During the period under review, were the foster or pre-adoptive parents provided with appropriate services to address identified needs that pertained to their capacity to provide appropriate care and supervision of the children in their care?	84%

It is clear that more work needs to be done in this area particularly as related to working with parents. It is believed that the CFSP will support this continued work through strengthening of Family Team Meetings, funding for supported visitation, Fatherhood Work, IV-E Waiver and the Family Reunification Program.

Item 13 (Child and family involvement in case planning) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The PIP goal negotiated for this item was 54.9% and Maine was able to exceed that goal at 62% in the fourth PIP quarter, the method of measurement was through the quality case reviews.

The ongoing quality case review data reflects that OCFS has made some improvements in this area, trending up primarily in Rounds 3 & 4, dropping slightly in Round 5 and having a slight increase in Round 6:

Me.-CFSR Round	Item 13
Round 1: 11/2009-10/2010	43%
Round 2: 11/2010-10/2011	41%
Round 3: 11/2011-10/2012	65%
Round 4: 11/2012-10/2013	70%
Round 5: 11/2013-10/2014	62%
Round 6: 11/2014-10/2015	64%
6-Year Average	**58%**

Trends that were highlighted through the case reviews indicate that barriers to meeting this standard include:

- Dads not being included in the case planning process.
- Age/developmentally appropriate children not being invited to participate in case planning.
- Lack of documentation of FTM for both parents.
- There is often no documentation to reflect why the case is opened, what has to be done for the case to close and for the children return home. It is also clear that many of the parents have no idea what they need to do or why the case is opened.
- There are no efforts made to involve parents who are out of state (such as phone conference for the parent at the meeting).
- While QA noticed progress made in ensuring older youth are invited to participate in the meetings, the challenge remains when youth chose not attend and no documentation was provided regarding how the information from that meeting was shared with the youth at another time.
- Lack of documentation of inviting/encouraging youth to participate in court activity.
- Frequency of FTMs being insufficient based on the facts of the case- FTMs not being held when there are significant changes in the circumstances of the case.

In 2014 the OCFS QA unit conducted a phone survey of 80 randomly selected youth across the state to obtain their feedback and perceptions related to their involvement in case planning as well as the judicial process. As part of the survey, QA staff also interviewed the assigned CASA or GAL to the youth to obtain their feedback related to their experiences working with youth as well as with the Department. The results of this review were disseminated to the Administration of Courts and to OCFS Management Team.

Age Demographics:

Age of Youth	#'s interviewed
12	11
13	14
14	12
15	15
16	14
17	10
18	4

- 62% of youth reported being invited to Family Team Meetings (FTM);
    - 48% of those youth reported having been asked who they wanted to invite to their FTM.
    - 85% of those who attended their FTM found the meetings to be helpful or very helpful.

Youth provided additional feedback as to the FTM process and several reported not being aware of what a FTM is; others reported knowing what the FTM was but not being invited. One youth reported she used to attend but then was told her attendance wasn't necessary so she stopped going. At least one youth reported having historical experiences with FTMs, but not having a FTM 'in years' which was confirmed by the resource parent. One 12 year old reported that she was told she wasn't old enough to attend the FTM.

- 61% of youth reported having been notified of and invited to attend their court hearings.
  - 96% reported knowing that they had either a GAL or a CASA representing them in court, although not all of them remembered his/her name.
  - 89% reported having their GAL or CASA visit them in the last 6 months, the majority of youth reported having had multiple visit during the prior 6 months with their GAL or CASA.
  - 74% reported that these meeting were either helpful or very helpful.

Some youth provided additional feedback related to judicial proceedings, including several who knew about court hearings but reported not being invited to attend them. One reported not finding out until the last minute making it too late for her attend.

In terms of feedback from youth specific to the GALs or CASAs could better support or help them:
- Would like them to have more positive things to say about the birth parents.
- Would like to see them more often.

- 72% of the GALs reported being invited to FTM's; 86% of the CASAs reported being invited.
  - 92% of the GALs reported that these meetings were either helpful or very helpful; 100% of the CASAs reported the meetings to be either helpful or very helpful. Both groups reported feeling that their voice was heard in the meetings and that they were actively engaged in case planning with the family in this forum.

One GAL did report that she/she was not invited to FTMs in her particular case as "there is no reason to have them".

Most GALs and CASAs provided feedback related to the FTM process and included:
- It would be helpful if the social worker had someone other than him/herself take notes during the meeting so he/she could fully participate in the meeting.
- The use of the Confidentiality Sheets that are to be reviewed and signed by participants not being signed consistently even when a supervisor is attending the meeting who would know to use the form.
- If parents are separated, then FTMs should also be separate.
- Scheduling issues- meeting are often scheduled at the time of the last meeting but if that meeting was missed the next date isn't always messaged out to those who were not in attendance. Recommendations were made that the social workers survey the entire team before finalizing the next FTM to ensure all can attend. When meetings are cancelled the entire team needs to be notified and not when they arrive at the office for the meeting.
- There were a number of reports that FTMs were not happening in cases.
- Several reported that they get little information from the agency social worker and often find out case information through the resource parent.
- Several reported a belief that FTMs were not necessary due to there being a termination of parental rights in place.
- Several reported that the meetings seem to occur to 'check them off the list' of things that a social worker must do versus being helpful to move a case along.

- The quality of the meeting varies from social worker to social worker and are better when a skilled facilitator is leading the meeting.

One of the key strategies in the CFSP was strengthening Family Team Meetings and Facilitated Family Team Meetings. In the past year there has been work to strengthen the FTM process by recommitting to the Facilitated Family Team Meeting process, which includes caseworkers being identified for this role who will not carry other cases as well as specialized training. OCFS has continued to work with Strategic Consultants, Casey Family Services to develop training on the FTM process. By the spring of 2017 all staff will be trained and/or re-trained on FTMs.

In January 2016 the DMT reviewed the child case plan document and defined the steps needed to complete he Child's Case Plan:

1. FTM is held with the child to create the initial child plan or update the current child plan.
2. Caseworker fills out the relevant screens in MACWIS with updated information (i.e. medical passport, education).
3. Caseworker will create a new child plan in the child plan module.
4. Caseworker will complete the child plan document in event tracking.
5. Caseworker sends the document for approval in event tracking and then in the child plan module.
6. Supervisor will approve the plan in event tracking and the child plan module once they have reviewed the child's case plan and confirmed that there is a corresponding FTM in the narrative log.

The PAs were provided instructions on how to run their own AFCARS Overdue Case Plans Report so they can monitor the work in the districts. There is also exploration on what tools may be available to district supervisors in order to monitor the timeliness of completing child case plans. The Training Team will also include training related to the development of the child's case plan occurring in a FTM as part of the Foundations Training.

In February 2016 the QA unit reviewed a random sample of 122 children statewide specifically looking at the 2 prior case plans for the identified children. The sample of children was those who had been in care for at least 18 months. The purpose of the review was to assess how well OCFS is doing in completing case plans on time and how we engaged the children, birth parents, resource parents and children's informal supports in the case planning process, including within the FTM.

In summary:

- The last 2 cases plans were completed on time in 27% of the cases reviewed.
- Cases plans were completed at a FTM in 23% of the time cases reviewed. To be clear, reviewers were looking at the timeframe of when a FTM was held in relation to case plan under question and whether or not it could be determined that there was discussion related to case planning.
- Mothers were present at both FTMs related to case planning in 31% of the cases reviews; fathers were present at both FTMs in 14% of the cases reviewed.
- Children 12+ years of age were present for each FTM associated with a case plan in 67% of the cases reviewed.
- Resource parents were present at both FTM's associated with a cases plan in 51% of the cases reviewed.
- Children's informal supports were present at both case planning FTMs in 14% of the cases reviewed.
- Children did not sign any of the case plans reviewed.
- Reviewers found both case plans reviewed in event tracking in 56% of the cases reviewed.

OCFS recognizes the importance of having supervisors actively oversee the case planning process as those plans should be consistent with what needs to occur for a family to successfully reunify with their children and/or maintain care for their children. In the spring of 2016 the DMT finalized a supervisory review

protocol for quarterly review for children in care cases and monthly review for services. This protocol includes a template that supervises use to document the review in MACWIS.

It is clear that more work needs to be done in this area and it is believed that the CFSP will support this through continued work strengthening of Family Team Meetings, Fatherhood Work, continued support and training related to OCFS Fact Finding Protocol and Motivational Interviewing.

Please see the Review of Goals for 2015-2016 (starting on page 54) for the update.

Item 14 (Caseworker visits with child) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The negotiated PIP goal for this item was 68.4% and Maine was able to exceed that goal at 69% in the sixth rolling PIP quarter, the method of measurement was through the quality case reviews.

In January 2015 OCFS modified the 72-hour report to reflect data pulled is for all victims being seen within 72 hours, not just the first victim. During calendar year 2015, this was met 68% of the time. For children in foster care during calendar year 2015, caseworkers met with them face to face every month on average 94% of the time, 90% of the time in the home.

The ongoing quality case review data reflects that OCFS continues to have challenges in meeting this standard as evidenced in the table below:

Me.-CFSR Round	Item 14
Round 1: 11/2009-10/2010	57%
Round 2: 11/2010-10/2011	54%
Round 3: 11/2011-10/2012	59%
Round 4: 11/2012-10/2013	62%
Round 5: 11/2013-10/2014	63%
Round 6: 11/2014-10/2015	79%
6-Year Average	**62%**

Trends that were highlighted through the case review indicate that barriers to meeting this standard include:

- In-home cases – the frequency of seeing the children is not always sufficient. Of particular concern are those situations where a safety plan is developed yet the child(ren) are not seen by the agency for several weeks/months.
- Lack of quality visits with child(ren) with documentation that reflects exploration of safety, permanency and well-being and lack of thorough observation of non-verbal children. No efforts to communicate with small children who may have some speech delays or be at a younger age even if the child is seeming to grow during the period under review and make developmental gains.
- Narrative does not reflect individual face to face contacts with children or that children are seen alone so it is at time difficult to determine the quality of the contact with the children.

Reviewing the data extracted from the OCFS Management Reports along with the case review data, it is apparent the challenge related to contact with children is the quality of the contact versus the frequency of the contact as Maine has consistently met the federal expectations related to frequency as well as that the majority of contact happening in the home.

Since the 2009 review Maine has strengthened policy and the management reporting related to contact made with children who remain in their home. Supervisors and district management have the ability to monitor and track compliance on this issue. Data from Round 6 of the Me.- CFSR's reflects a significant gain has been made in this area indicating that the strategies implemented have been effective. However, this is an area that needs continued focus and the CFSP will support this goal. Continued use of fact finding interviewing,

streamlining caseworker activities and the work done on redesigning documentation methodology and policy should provide support to caseworkers on sharpening skills to obtain the key information to assure child safety, permanency and well-being and, coupled with that, giving caseworkers the opportunity to document that work by streamlining other activities will demonstrate that caseworkers are having quality contacts with children.

Item 15 (Caseworker visits with parents) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The negotiated PIP goal for this item was 40.7% and Maine was able to exceed that goal at 48% in the fifth rolling PIP quarter, the method of measurement was through the quality case reviews.

The ongoing quality case review data reflects that OCFS has continued to have challenges in meeting this standard as evidenced in the table below:

Me.-CFSR Round	Item 15
Round 1: 11/2009-10/2010	30%
Round 2: 11/2010-10/2011	19%
Round 3: 11/2011-10/2012	40%
Round 4: 11/2012-10/2013	35%
Round 5: 11/2013-10/2014	37%
Round 6: 11/2014-10/2015	42%
6-Year Average	**34%**

Trends that were highlighted through the case review indicate that barriers to meeting this standard include:

- Not seeing both parents as frequently as needed.
- Not discussing important issues related to reunification as they come up in a case.
- Minimal efforts made to have face to face contacts.
- When most of the face to face contacts were done in locations that were not conducive to open communication between the worker and the parents.
- When there is limited to no discussion of parents services, time frames, safety, well-being, and permanency of the children.
- When there is suspected DV and mom and dad are not interviewed alone.
- Out of home parents are not met with.

As noted above the issues here are often related to the frequency of contact with fathers which have been an ongoing challenge for Maine. In addition there are some challenges related to the quality of contact with both parents. Policy supports the need to see each parent monthly if the permanency goal is reunification and to see parents involved in service cases monthly.

Although the data from the last three CFSR rounds indicate incremental improvement in this area, there still needs to be a continued focus. The CFSP will support the work needed in this area on enhancing the Fatherhood Work and strengthening and improving on the Family Team Meeting process. The FFTM database will also be able to capture how the agency is involving birth fathers at the onset of a case, or at least at the point of decision making related to removal.

Well-being outcome 2 includes educational needs of child(ren) being met.
Item 16 (Educational needs of child) was assigned a rating of Area Needing Improvement in the 2009 CFSR. The item was rated a strength in 94% of the cases reviewed, below the 95% goal for the review.

The ongoing quality case review data reflects that OCFS was challenged in this area for Rounds 1 & 2; there has been steady improvement in the last 4 rounds of reviews, reaching a 6-year average of 90%. Of note is that the last two review cycles have met the 95th percentile marker for achieving a strength:

Me.-CFSR Round	Item 16
Round 1: 11/2009-10/2010	75%
Round 2: 11/2010-10/2011	82%
Round 3: 11/2011-10/2012	96%
Round 4: 11/2012-10/2013	92%
Round 5: 11/2013-10/2014	96%
Round 6: 11/2014-10/2015	98%
6-Year Average	**90%**

Since the 2009 CFSR Maine sharpened its focus on ensuring educational needs were being assessed and addressed. This work included:

- In 2010 language was added to Maine Statute to meet the Fostering Connections Legislation around educational stability. The final decision on which school the child/youth will attend will be made by OCFS, but done in collaboration with the school district. The law requires that the school abide by the decision made by OCFS with OCFS paying for transportation costs if needed.
- In 2011 the Citizen Review Panel was established an Educational Stability Workgroup to determine how big an issue educational instability was for Maine children in foster care. A survey was distributed to caseworkers statewide. A total of 407 surveys were conducted on new school aged cases opened between 9/1/08-12/31/09, of those 260 (65.7%) changed school. The reasons provided included:
    - No foster placement available. (36.4%).
    - Placement with relative out of the area. (17%).
    - Other reasons, undefined. (14.7%).
    - Unsafe for the child to remain in the same school. (2.5%).
    - Multiple reasons were cited for 9% of the children who changed schools.
- The OCFS Policy Workgroup reviewed the Educational and School Transfer Policies to ensure that the policies reflected the law changes around school attendance. The decision was made to incorporate several different policies related to education into one policy. In March 2012 the finalized Education Policy and PowerPoint were disseminated to district staff.

In Round 6 QA was able to extract data related to the specific questions incorporated in Item 16 in order to identify how well the agency did in engaging in concerted efforts to address the child(ren)'s educational needs through appropriate services. The case review data reflects that Maine has remained strong in this area, meeting this standard in 97% of the cases reviewed.

Well-being outcome 3 includes physical health of child(ren) being met **(Item 17- Physical health needs of the child**) and mental/behavioral health of child(ren) **(Item 18- Mental/behavioral health of the child)** both of which were rated as an Area Needing Improvement in the 2009 CFSR.

Item 17 (**physical health needs of the child)** was rated a strength in 83% of the cases reviewed, below the 90% goal for the review.

Maine has continued its work on full implementation of the Child Health Assessment (CHA) Protocol. In 2015 the Quality Assurance Unit completed a second review of the compliance related to a couple of tenants of the CHA Protocol (an initial review was conducted in 2014):

1. Are initial health exams scheduled within 10 days?
    a. In 59% of the cases reviewed, there was documentation of medical appointments being made within 10 days of the child's entry into care.

2. Does the narrative reflect that the Pediatric Symptom Checklist (PSC) was completed for children between 4-16 years old whenever there is a substantiated finding and/or a child enters custody?
    a. In 25% of the cases reviewed, there was documentation of the PSC being completed.

As a result of the 2015 QA data and proposed legislation the CHA Protocol was updated with the new expectations implemented on 2/1/16. MACWIS drop down choices were developed in order for staff to document their use of the PSC, CDS referral and the medical appointments being scheduled. This will allow for easier tracking of compliance through the MACWIS system. Prior to implementation Program Administrators reviewed the CHA Protocol with their staff.

In SFY 2014 Child Development Services (CDS) reported receiving 99 referrals from the OCFS- child welfare. There were 1,230 referrals generated for children under 3 who were victims in a case of substantiated or indicated child abuse. Only 8% of the referrals to CDS was reportedly received. In 2016 a strategy was implemented to ensure that all children under age of 3, who are victims in a case of substantiated or indicated child abuse or who are a member of that household, get referred to early intervention services. The OCFS Information Services Team generates a report every two weeks of every applicable child that gets sent securely to a central point of contact at CDS. The goals of this strategy are to increase compliance with CAPTA, increase the number of child welfare referrals being sent to CDS and removing this task from staff to reduce administrative burden.

The ongoing quality case review data reflects that OCFS was challenged in this area for Rounds 1 & 2; there has been steady improvement in Rounds 3 & 4, a slight drop in Round 5 but some improvement in Round 6. The data has ranged from 69%-88% as evidenced in the graph below:

Me.-CFSR Round	Item 17
Round 1: 11/2009-10/2010	73%
Round 2: 11/2010-10/2011	69%
Round 3: 11/2011-10/2012	83%
Round 4: 11/2012-10/2013	88%
Round 5: 11/2013-10/2014	81%
Round 6: 11/2014-10/2015	85%
6-Year Average	**80%**

In Round 6 QA was able to extract data related to the specific questions incorporated in Item 17 in order to identify how well the agency has performed in assessing and addressing the physical health needs of children.

The data reflects the following:

Item 17 Question	Percentage Met
B1. For foster care cases, during the period under review, did the agency provide appropriate oversight of prescription medications for physical health issues?	92%
B2. During the period under review, did the agency ensure that appropriate services were provided to the children to address all identified physical health needs?	94%
B3. During the period under review, did the agency ensure that appropriate services were provided to the children to address all identified dental health needs?	84%

Trends that were highlighted through the case review indicate that barriers to meeting this standard include:

- When the dental needs are overlooked.
- When the providers are unknown.

- Systemic issue related to sufficient MaineCare dental providers however lack of documentation of the agency working the resource parents for alternative solutions.
- When there is no documentation to reflect specific updates as the status of the child's medical/dental care.
- Passport Medical Screen is often significantly out of date.

Maine recognizes the need to continue to work on improving health care oversight and coordination and documentation for children in foster care and objectives in the CFSP will support that work.

Item 18 (Mental/behavioral health of the child) was rated a strength in 72% of the cases reviewed, below the 90% goal for the review.

The ongoing quality case review data reflects that OCFS remains challenged in this area but there is evidence of steady improvement. The data has ranged from 67%-84% as evidenced in the graph below:

Me.-CFSR Round	Item 18
Round 1: 11/2009-10/2010	67%
Round 2: 11/2010-10/2011	70%
Round 3: 11/2011-10/2012	76%
Round 4: 11/2012-10/2013	84%
Round 5: 11/2013-10/2014	77%
Round 6: 11/2014-10/2015	79%
6-Year Average	**76%**

In Round 6 QA was able to extract data related to the specific questions incorporated in Item 18 in order to identify how well the agency has performed in assessing and addressing the mental/behavioral health needs of children. The data reflects the following:

Item 18 Question	Percentage Met
B. For foster care cases, during the period under review, did the agency provide appropriate oversight of prescription medications for mental/behavioral health issues?	94%
C. During the period under review, did the agency provide appropriate services to address the children's identified mental/behavioral health needs?	81%

Trends that were highlighted through the case reviews indicate that barriers to meeting this standard include:

- Where an issue has come up for a child/youth, and it's not clear that this is being addressed.
- When the mental health needs of the child are unknown.
- When the child is in mental health treatment and there is no documentation as to who the provider is or how treatment is progressing, particularly those involved in play therapy.
- When there is no discharge planning documented.
- When the child is on mental health medication and when policy with regards to certain medication is not being adhered to.
- Passport Medical Screen is often significantly out of date.

Since the 2009 CFSR Maine had continued to work towards improving the work conducted to assess and address children's mental health needs. The CFSP will support this work related to consistent implementation of policies and procedures.

In 2015 OCFS implemented CBT Plus, an evidence based clinical intervention developed through the Partnering For Success Initiative. Maine is one of 5 implementation sites for Partnering for Success Initiative in the country. In Maine this service is being piloted in two child welfare districts and, as of February 2016, 69 children are receiving CBT Plus intervention. This service provides CBT for anxiety, depression, behavioral health challenges PLUS trauma treatment. In the fall of 2016 it is anticipated that this services will expand to other districts with the goal being to bring in new providers to partner with OCFS in this work.

In three of the eight child welfare districts, an agency is responsible for providing a comprehensive medical and behavioral health assessment for all children entering foster care. The goal is to find a way to leverage MaineCare funding to expand this service statewide.

The 2015 reorganization included the creation of a clear Children's Behavioral Health Team. Children's Behavioral Health services focus on behavioral health treatment and services for children from birth up to their 21st birthday. Services include providing information and assistance with referrals for children and youth with developmental disabilities/delays, intellectual disability, Autism Spectrum Disorders, and mental health disorders.

The Behavioral Health Unit:

- Ensures that any child between the ages of 0-21 and their family identified as needing a behavioral health intervention have access to and receive this service in the most effective, least restrictive setting as possible.
- Ensures that all youth transition successfully to adulthood
- Ensures that all possible employment options are sought for all youth
- Works with the Office of Maine Care in developing and implementing policy related to children's services
- Ensures that children receive evidenced-based practices whenever possible
- Oversees the mental health block grant funding and implementation
- Oversees Homelessness and Transitional Living Programing
- Develops and Implements the Partnering for Success CBT Plus initiative
- Directs and oversees the Now Is The Time (NITT) Moving Forward Grant
- Provides Program expertise for all contracts, ie respite, Autism Society, BHP training, deaf services, etc.
- Oversees and reviews of youth receiving residential treatment in state and out of State
- Works closely with the Office of Quality Improvement and OCFS Quality team
- Reviews and Follows up on reportable events Community Agency reviews
- Collaborates and consults with on child welfare cases for youth with behavioral health needs
- Follows up on grievances and complaints
- Collaborates with other state agencies.

Resource Coordination: Three Resource Coordinators are responsible for developing and maintaining a comprehensive array of behavioral health resources for children with Autism, Intellectual Disabilities, and mental health problems. They are the primary contact for agencies seeking to provide behavioral health services for children, and for agencies seeking information and/or technical assistance from the Department. They organize regular provider meetings to ensure clear communication between the Department and the children's services providers, and disseminate information regarding Department policies and legal requirements. They develop resources to meet needs in underserved areas. Other responsibilities will include providing technical assistance to agencies regarding Plans of Correction that result from QA monitoring by other OCFS staff. They may address constituent complaints and will monitor data and reports regarding children's behavioral health services, and bring summary information and trends to OCFS management.

Policy Coordination: Policy Coordinator and appropriate staff:

- Works closely with the Office of Maine Care to write and implement Maine Care Policies that govern services for children in need of behavioral health treatment.
- Create and implement standards of care for Treatment Services
- Ensure that Evidenced-Based Practices are used as much as possible and works to increase the use of EBP in children's behavioral health service.
- Create Performance Measures for children's behavioral health services
- Work closely with APS Health care.
- Review and analyze children's behavioral health data

Program Coordination: Ten Children's Behavioral Health Program Coordinators are responsible for ensuring that youth emotional and behavioral challenges receive the most effective services in the least restrictive environment. They are responsible for providing behavioral health education and resources to Child Welfare Staff and the community. They provide on-call coverage on a rotation schedule for out of state hospitalization. They are part of a statewide team of professionals keeping abreast of promising and evidenced-based practice models, informing policy and practice, and maintain consistency across districts.

Care Coordination: Five Care Specialists are responsible for ensuring that youth in treatment services are receiving effective, quality treatment, and are safe within their treatment environment. Specific areas of focus are Residential Treatment, Crisis Services, and Children with Special Health Care needs. Tasks include:

- Review and Follow up on Reportable Events.
- Grievance and Complaint Follow-up.
- Three-Person Committee Participation.
- Residential Reviews.
- Challenging Youth Placement Work.
- Behavioral Health Training.

In collaboration with the CBH Team a plan was developed to lower the usage of psychotropic medication for youth in foster care. In calendar year 2015 23% of youth in foster care were on or more psychotropic medications. The goal for OCFS is that by the end of 2017 this number will drop 5% to 17% of youth being on one or more psychotropic medications. The strategies involved include having Care Specialists (RNs) review quarterly data received from OMS and share that data with OCFS Management staff, Behavioral health Program Coordinators and other Care Specialist. It is expected that Program Administrators will share that report data with district Supervisors within 5 working days who will then use it with their workers in supervision. It is expected that caseworkers will follow the policy related to the use of anti-psychotropic medications and having ongoing oversight over this use in collaboration with the youth's community providers as well as utilizing the Care Specialists for consults related to specific case questions.

Systemic Factors:

Systemic Factors includes the following:

- Information Services (Item 19)
- Case Review System (Items 20, 21, 22, 23, & 24)
- Quality Assurance System (Items 25)
- Staff and Provider Training (Items 26, 27, & 28)
- Service Array and Resource Development (Items 29, 30)
- Agency Responsiveness to the Community (Items 31 & 32)
- Foster and Adoptive Parent Licensing, Recruitment and Retention (Items 33, 34, 35, 36)

Information Services:

Item 19 (Information Services): How well is the statewide information system functioning to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for placement of every child who is in foster care?

MACWIS has maintained the assigned rating of Strength since 2009. OCFS MACWIS continues to readily identify the status, demographic characteristics, location, and goals for every child in foster care. The system continues to gather reliable data which is entered in a timely manner. During the past 6 years Maine has continued to sustain a high functioning Information Services Program. The Information Services team along with the Quality Assurance and IV-E Programs maintain their collaborative, qualitative and quantitative work to produce a comprehensive data program that supports all of OCFS business processes and users. MACWIS maintains the ability to produce and extract an array of queries and standardized reports informing and supporting the work functions of internal and external stakeholders.

Maine DHHS continues to maintain a federally-compliant SACWIS system. MACWIS remains functionally stable. Throughout the year the MACWIS system receives ongoing maintenance. During 2015, 7 certified release deployments were committed, continuing to improve the support of all new federal requirements.

One of the 7 certified releases which OCFS committed this past year was also the largest in MACWIS history. It entailed the redesign of business processes and recoding of PowerBuilder programming converting the existing current multiple resources into one Family Resource. This Central Resource can now be tracked in the provision of licensed and unlicensed services. OCFS Information Services has continued its work with OCFS management, internal business users, other DHHS partners, and community representatives as well as Office of Information and Technology (OIT) MACWIS for the incorporation of requirements from the Fostering Connections to Success and Increasing Adoption Act of 2008. During the spring of 2015 Information Services along with the OCFS Policy and Training Unit and a committee of internal state and community members met for the development and implementation of the requirements for The Preventing Sex Trafficking and Strengthening Families Act. This functionality was released July 2015.

OCFS continues their contract for the 9th year with the University of Kansas for use of the Result Oriented Management (ROM) system to provide CFSR outcome data down to a worker level through a web-based portal. During 2015 ROM upgraded Maine's ROM Reports Service Model. This model now provides OCFS technology updates, enhanced reporting functionality and allows for a range of new administrative tools for staff customizations. Maine OCFS Information Services staffs continue to work with the ROM Director and University of Kansas team in replacing, modifying, eliminating and or phasing out reports from the ROM Core Model to successfully align with the changing CSFR Round 3 outcome measures.

APS Healthcare continues to have the contract with the State of Maine's DHHS to provide a Behavioral Health Utilization Management System for services currently purchased through the State's Office of Maine Care Services and administered by the CBHS of OCFS.

As part of the Maine ASO Behavioral Health Utilization Review Program, APS HealthCare continues to provide eligibility verification and utilization management services that include: prior authorization, utilization review, and retrospective review for behavioral health services through their Web based authorization system Care Connection. This system in collaboration with the State of Maine Web based Enterprise Information System collects, tracks and produces data associated with children's behavioral health assessment, treatment, transitional services and reportable events that supports the continuum of care and services for children not in foster care as well as those who are in foster care .

Additional activities that have been completed or are upcoming for the Informational Services team include:

- Comprehensive Child Welfare Information System (CCWIS) Notice of Proposed Rule Making reviewed by OCFS Information Services (IS) and OIT staff.
- OCFS IS and OIT staff attendance at CCWIS Information Sessions for State Agencies and Other Stakeholders.
- IS Manager attendance at the following Child Welfare Information Technology Systems Managers and Staff webinars:
    - From Waterfall to Agile Managing Cultural Change and Impacts Across Stakeholder Groups
    - Estimation For Social Services Information Systems , Lessons Learned From the Trenches
    - Challenges and Benefits of Modular System Development
- OCFS IS and OIT Unit Collaborative Agile training with contracted National Agile Coach, Karen Spencer between 11/1/2015-1/15/2016.
- FEi Systems Gap Analysis-Services IT Plan completed and submitted to OCFS, 3/2016. Potential technological solutions in the plan are aligned with the future CCWIS requirements. IS and OIT review.
- Internal OCFS CCWIS Committee began meeting May 5, 2016 to review and identify existing strengths, barriers of attaining CCWIS proposed requirements.

Case Review System

Item 20 (Written Case Plan): (How well is the case review system functioning statewide to ensure that each child has a written case plan that is developed jointly with the child's parent(s) and includes the required provisions) was assigned a rating of Area Needing Improvement in the 2009 CFSR. Although Maine had a process to ensure that each child has a written case plan that is routinely reviewed, the Statewide Assessment indicated that parents are not routinely involved in case planning. The onsite review also found this to be a challenge for Maine.

As highlighted in Item 13, Maine continues to be challenged in this area particularly with parents with the qualitative case review finding fluctuation between rounds in respect to performance.

Trends that were highlighted through the case reviews indicate that barriers to meeting this standard include:

- Dads not being included in the case planning process.
- Age/developmentally appropriate children not being invited to participate in case planning.
- Lack of documentation of FTM for both parents.
- If there is no documentation to reflect why the case is opened, what has to be done for the case to close and the children return home, and it is very clear from documentation that the parents have no idea what they need to do or why the case is opened.
- There are no efforts made to involve parents who are out of state (such as phone conference for the parent at the meeting).
- While QA noticed progress made in ensuring older youth are invited to participate in the meetings, the challenge remains when youth chose not attend and no documentation was provided regarding how the information from that meeting was shared with the youth at another time.
- Lack of documentation of inviting/encouraging youth to participate in court activity.
- Frequency of FTMs being insufficient based on the facts of the case- FTMs not being held when there are significant changes in the circumstances of the case

In January 2016 the DMT reviewed the child case plan document and defined the steps needed to complete he Child's Case Plan:

1. FTM is held with the child to create the initial child plan or update the current child plan.
2. Caseworker fills out the relevant screens in MACWIS with updated information (i.e. medical passport, education).
3. Caseworker will create a new child plan in the child plan module.

4. Caseworker will complete the child plan document in event tracking.
5. Caseworker sends the document for approval in event tracking and then in the child plan module.
6. Supervisor will approve the plan in event tracking and the child plan module once they have reviewed the child's case plan and confirmed that there is a corresponding FTM in the narrative log.

The PAs were provided instructions on how to run their own AFCARS Overdue Case Plans Report so they can monitor the work in the districts. There is also exploration on what tools may be available to district supervisors in order to monitor the timeliness of completing child case plans. The Training Team will also include training related to the development of the child's case plan occurring in a FTM as part of the Foundations Training.

In February 2016 the QA unit reviewed a random sample of 122 children statewide specifically looking at the 2 prior case plans for the identified children. The sample of children was those who had been in care for at least 18 months. The purpose of the review was to assess how well OCFS is doing in completing case plans on time and how we engaged the children, birth parents, resource parents and children's informal supports in the case planning process, including within the FTM.

In summary:

- The last 2 cases plans were completed on time in 27% of the cases reviewed.
- Cases plans were completed at a FTM in 23% of the cases reviewed. To be clear, reviewers were looking at the timeframe of when a FTM was held in relation to case plan under question and whether or not it could be determined that there was discussion related to case planning.
- Mothers were present at both FTMs related to case planning in 31% of the cases reviews; fathers were present at both FTMs in 14% of the cases reviewed.
- Children 12+ years of age were present for each FTM associated with a case plan in 67% of the cases reviewed.
- Resource parents were present at both FTM's associated with a cases plan in 51% of the cases reviewed.
- Children's informal supports were parent at both case planning FTMs in 14% of the cases reviewed.
- Children did not sign any of the case plans reviewed.
- Reviewers found both case plans reviewed in event tracking in 56% of the cases reviewed.

One of the key strategies in the CFSP was strengthening Family Team Meetings and Facilitated Family Team Meetings. In the past year there has been work to strengthen the FTM process by recommitting to the Facilitated Family Team Meeting process, which includes caseworkers being identified for this role who will not carry other cases as well as training. OCFS has continued to work with Strategic Consultants, Casey Family Services to develop training on the FTM process. By the spring of 2017 all staff will be trained and/or re-trained on FTMs.

OCFS recognizes the importance of having supervisors actively oversee the case planning process as those plans should be consistent with what needs to occur for a family to successfully reunify with their children and/or maintain care for their children. In the spring of 2016 the DMT finalized a supervisory review protocol for quarterly review for children in care cases and monthly review for services. This protocol includes a template that supervises use to document the review in MACWIS.

Please see the Review of Goals for 2015-2016 (starting on page 54) for the update.

It is clear that more work needs to be done in this area and it is believed that the CFSP will support this through continued work strengthening of Family Team Meetings, Fatherhood Work, continued support and training related to OCFS Fact Finding Protocol and Motivational Interviewing.

Item 21 (**Periodic Reviews):** (How well is the case review system functioning statewide to ensure that a periodic review for each child occurs no less frequently than once every 6 months, either by a court or by administrative review) was assigned a rating of Strength in the 2009 CFSR as Maine provides periodic reviews for each child in foster care and they are generally held in a timely manner. The process in place at the time of the 2009 review remains, children in foster care are reviewed by the court at least once every 6 months.

A March 2014 poll of Child Protective Assistant Attorney Generals, District Program Administrators and Assistant Program Administrators confirmed that Judicial Reviews are consistently occurring every 5-6 months or sooner depending on the issues in the case or if the court requests more frequent oversight.

The May 2013 ACF IV-E Audit also found that of the cases reviewed all were found to have the required judicial determinations explicitly documented and within the required timeframes. "The court orders reviewed typically detailed the basis for the findings and made reference to supporting affidavits and petitions, which provided additional case history and context". It was also noted that the "case records examined for the review provided evidence of Maine's emphasis on family engagement; concerted efforts to prevent removal; and efforts to achieve permanency through reunification, permanent placement with relatives, and adoptions" (*Title IV-E foster Care Eligibility Primary Review Report of Findings").*

On an annual basis the OCFS IV-E Financial Review Eligibility Specialists conduct a review to ensure that case records contain the appropriate court documentation demonstrating that permanency review hearings occur within 12 months from the date the child entered foster care and no less frequently than every 12 month thereafter. Based on these annual reviews as well as the results of the previously described federal and state audits, it is evident that Maine continues to meet this item.

In March 2015 OCFS was notified that the state audit of foster care and adoption assistance were completed, there were no audit findings. ACF will conduct Maine's 2016 IV-E Audit in June 2016.

A recent MACWIS query found that Maine seems to be challenged in having the first hearing within the first 6 months of children entering custody. However, following that hearing Maine does very well in insuring that periodic reviews are occurring within 6 months. Further assessment will be needed to determine what the barriers are to having a timely first hearing.

CALENDAR YEAR	TOTAL NUMBER OF REMOVALS	# REMOVALS LASTING MORE THAN 6 MONTHS	# 1ST REVIEW HEARING WITHIN 6 MONTHS OF REMOVAL	% 1ST REVIEW HEARING WITHIN 6 MONTHS	AVG MONTHS BETWEEN REVIEW HEARINGS
2012	945	830	288	35%	4.9
2013	1002	848	351	41%	4.8
2014	926	787	292	37%	4.4
2015	871	615	280	46%	3.8

Item 22 (**Permanency Hearings):** (How well is the case review system functioning statewide to ensure that, for each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 month) was assigned a rating of strength in the 2009 CFSR as information obtained confirmed that permanency hearings are held within 12 months of a child's entry into foster care and usually every 6 months thereafter. Maine continued to utilize the same system to ensure these hearings are taking place within this same timeframe. Since 2009

Maine has undergone two Title IV-E Foster Care Eligibility Reviews, 2010 and 2013, and a state audit in 2015, passing all three. The state audit included an audit of the adoption assistance system.

On an annual basis the OCFS IV-E Financial Review Eligibility Specialists conduct a review to ensure that case records contain the appropriate court documentation demonstrating that permanency review hearings occur within 12 months from the date the child entered foster care and no less frequently than every 12 month thereafter. Based on these annual reviews as well as the results of the previously described federal and state audits, it is evident that Maine continues to meet this item.

Item 23 (**Termination of Parental Rights):** (How well is the case review system functioning to ensure that the filing of termination of parental (TPR) proceedings occurs in accordance with required provisions) was assigned a rating of Strength in the 2009 CFSR as it was evident that Maine had a process for filing a petition for TPR in accordance with ASFA.

In the Me.- CFSR Round 6 data was able to be extracted related to the specific questions incorporated in Item 5 (appropriate and timely establishment of permanency goals) in order to identify where the challenges are in relation to timely establishing of appropriate permanency goals. This data reflect that Maine does a great job in identifying the permanency goals in the cases, meeting this in 100% of the cases review during that period. In most cases, 87%, the permanency goal was established timely and, in 92% of the cases reviewed, the goals were appropriate to meet the child's needs for permanency and to the circumstances of the case. The data reflects that the challenge may be around when the agency files a TPR and whether this is done timely; in this same cohort of case reviews this was found in only 76% of the cases reviewed with only 61% of those including an exception to the requirement to file the TPR.

Trends that were highlighted through the case review indicated that barriers to meeting this timeframe included:

- It's not usually clear from the record as to the delay in changing case goals. Sometimes reunification goes significantly beyond the 12/15 month mark before the TPR (caseworkers and the court trying to give the parents additional opportunities to reunify).
- This item also speaks to whether or not a goal is appropriate to the case. There are times when it does not appear that the parents are involved in reunification at all (or just minimally) but the Department is not making any efforts to move towards a TPR when it appears that would be appropriate (even though earlier than the 12 month mark).
- Lack of documentation related to concurrent planning.

In December 2015 a study of children that did not meet the adoption timeframes during the period of November 2014-September 2015 was conducted. A total of 218 children were reviewed who did not meet the timeframe of adoption within 24 months of the child's entry into foster care.

In summary:

- The following was found when looking for a date in documentation regarding the filing of the TPR being discussed with either parent and then looking at the timeframe from that date to the date the TPR was filed.
    - In 15% of the cases reviewed it could not be determined when the parents were spoken to regarding the filing of the TPR.
    - In 6% of the cases reviewed the date of TPR filing could not be determined.
    - In 28% of the cases reviewed these conversations with the parents took place the same month of the filing.
    - In 18% of the cases reviewed these conversation with the parents took place 1 month prior to the filing.

- In 20% of the cases reviewed these conversations took place 2 months prior to the filing.
- In 8% of the cases reviewed these conversations took place 3 months prior to the filing.
- In 5% of the cases reviewed these conversations took place 4 months prior to the filing.
- In 1 case review these conversations took place 8 months prior to the filing; and in 1 case the conversations took place 13 months prior to the filing.

- The following was found when looking at how many months from the date the TPR was filed until the court hearing. In many cases the parents had different TPR's dates.
  - In 6% of the cases reviewed the court hearing was in the same month as the TPR filing.
  - In 75% of the cases reviewed the court hearing was held between 1-6 months of the filing; in 64% of those cases the time frame ranged from 2-4 months.
  - In 19% of the cases reviewed the court hearing was held between 7-15 months of the filing.

- Of those TPR'd, 30 were appealed by the parents, in 80% of those it took 9-10 months for the appeal decision to be made and relayed back to district staff.

Three strategies that are anticipated to be implemented in 2016 should impact children's permanency goals and timeframes related to meeting those goals and include:

- Bi-weekly data planning calls to include District Program Administrators. Specific youth who have been in custody for a period of time and monitor the progression being made toward achieving permanency.
- Developing a process where all youth in care 0-9 months will be reviewed to identify any barriers to reaching timely permanency and strategizing ways around those barriers.
- All children in foster care whose parents parental rights have been terminated will be reviewed, with the goal of having each district develop a recruitment plan for each applicable child. Each adoption supervisor will have a toll to track recruitment for every child in their unit. All of the children whose parents parental rights have been terminated without an identified adoptive family will have a Heart Gallery photo and an Adoptuskids listing. We will also be working with our contracted recruitment agency, KidsPeace, to do other types of child specific recruitment such as print media and community recruitment.

Both of these strategies will allow for ongoing review of child's immediate permanency goals and needs which should support staff in making timelier decisions related to filing for termination of parental rights as soon as it is determined to be appropriate.

Item 24 (**Notice of Hearings and Reviews to Caregivers):** (How well is the case review system functioning to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of, and have a right to heard in, any review or hearing held with respect to the child) was assigned a rating of Area Needing Improvement in the 2009 CFSR.

In October 2015 QA conducted a review of a random sample of 252 foster care cases and looked at the most recent court activity (Judicial Review, Permanency Hearing or Jeopardy Hearing) to determine if written notification to the foster care providers were being consistently provided. The following was found and reported to the DMT for follow up:

District	Written Notification Found
1	82%
2	30%

3	63%
4	81%
5	73%
6	88%
7	36%
8	87%
Total	**69%**

Barriers identified by caseworkers and supervisors related to ensuring timely notification includes:

- Timeliness in receiving court orders that specify the next court date.
- Trailing docket scheduling changes and/or late notification of when the hearing is scheduled.
- Staff being unaware of the need for the notifications and/or what the district process is for ensuring the notices are provided timely.
- Changes in court dates and times not being communicated to the staff responsible for sending notifications to foster parents.

District staff will develop strategies to address the barriers unique to their district and the District Management Team will create a uniform process to ensure that notifications are consistent and timely.

Quality Assurance System:

Item 25 **(Quality Assurance System)** (How well is the quality assurance system functioning to ensure that it is (1) operating the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identified strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures.)

1. Historically, the OCFS has recognized the need for strong quality assurance oversight and has dedicated staff to that activity. OCFS maintains its unit of staff dedicated to Quality Assurance (QA) with one QA Specialist housed in each of the eight Districts and supervised by the central office QA Program Manager. This unit is the core team conducting the CFSR-style site review process which was developed as the means for Maine to measure progress in its PIP and continued following Maine's completion of the PIP as a means to conduct quality case reviews. Specific activities have included monthly case reviews, reviews of client recipients appealing substantiated findings of child abuse and neglect, as well as special projects to provide senior management with qualitative data on areas of concern. The work of this group has also expanded through the restructure to include quality assurance functions that are needed for the entire OCFS.
2. Maine has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of children. The structures in place at the time of the 2009 CFSR have remained in place. The 2015-2019 CFSP included strategies to support ongoing work to ensure that quality services are available to protect children.
3. The OCFS Data Team and QA Unit utilize a consistent process to collect and extract accurate quantitative and qualitative data across the state. Data reports are tested for accuracy through a sampling audit. QA staff is routinely conducting case reviews which could be comprehensive case reviews using the ACF review instrument or focused reviews based on agency need for data.
4. District staff have access to reports provided by the Data and QA Teams although it does seem apparent that not all staff have the same level of access. This is likely based on district staff preferences.

In 2015 OCFS continued the debriefing meeting protocol following each of the districts CFSR. This is an opportunity for all staff to be informed of the outcome of their review and engage in a dialogue with the QA

Program Manager and the Regional Associate Director of Child Welfare. The feedback in the district has been that these meetings have been informative and helpful for direct line staff and their supervisors.

The OCFS Senior Management Team targeted several key practice areas that require focus including quarterly QA reviews and reporting out, three of which are included as measurements for several of the CFSP strategies. These include:

- Conducting Family Share Meetings at the time children are placed in foster care as well as when there has been a change in placement;
- Relative Notification- insuring that all grandparents and known adult relatives have been notified of a child's entry into foster within 30 days;
- Insuring that voice recordings of child forensic interviews are downloaded into the MACWIS system; and
- Reducing the number of findings of abuse/neglect that are overturned upon paper review.

In the February 2015 SMT meeting, the statewide SMT Accountability Plan was developed, looking at each of the goals, identifying steps needing to be taken and resources available/needed in order for success. The Accountability Plan has been used to outline the steps DMT is going to take/areas we are going to focus on. As the quarterly QA reports have been disseminated areas of continued need to improve have been identified and, as a result some of these will stay on the strategic plan for the next 18 months as strategies to focus on.

OCFS has conducted an assessment of how its QA system currently meets the five key components of a sound QA/CQI system as laid out in the ACF IM. Overall Maine believes it has the basic structures in place.

1. Foundational Administrative Structure:

    a. Maine has dedicated staff housed in each district office and supervised centrally.
    b. QA staff is historically those who have worked within the child welfare program either as a direct care caseworker and/or supervisory staff who promote or demote to the QA team. QA staff is trained in the child welfare system, knows policy and can easily navigate the MACWIS system. The QA team meets on a monthly basis. Conference calls are also utilized to allow the team an opportunity for peer group contact to discuss or plan upcoming projects or challenges faced by the team.
    c. OCFS has created job manuals for all positions, including QA.
    d. Training, formally or informally based on the project need, is provided to QA staff prior to conducting a specific project. This ensures that staff are familiar with the tool and/or process so that all staff use the tool consistently. The QA unit has access to the OMS system through the federal CFSR Portal and has moved to using that system to conduct the individual case reviews. The unit has also completed the Onsite Review Instrument (OSRI) Item Specific training modules to ensure they are meeting the requirements for maintaining the integrity of the tool during case review and have received certificates verifying this completion. As new QA staff are hired, they are trained in this process through teaming with their peers as well as reviewing the training modules on the OMS system.
    e. An informal inter-rater reliability process is utilized on most projects and combines peer to peer consults, pairing in teams and/or consulting with the QA Program Manager as an anchor point for any project/study.
    f. In the past year the QA unit has continued to utilize the Questions & Answer database for the CFSR and finding appeals. Both of these tools are updated each time a new question is asked and appropriately answered. This system should allow for consistency in conducting both review processes.

2. Quality Data Collection:

a. Maine is one of a few states with an ACF certified SACWIS program, certified in May 2009.
b. Maine has dedicated staff housed in each district office and supervised centrally.
c. Maine has utilized the ACF OSRI as a review tool which provides clear instruction and guidelines on its use. The QA unit has also consulted with the Boston ACF region to Ensure that the integrity of the federal tool is followed. The assessment from ACF was that the Maine team consistently uses the tool with integrity. The ACF Boston regional staff and the JBS consultants meet with the OCFS QA staff annually to discuss the OSRI and provide feedback to questions asked by the QA Unit.
d. The 2012 OCFS restructure created the Accountability and Information Services Team which includes QA, Title IV-E and the SACWIS/Information Services. This group is supervised by the Associate Director of Operations which allows for increased collaboration between the teams, sharing of data and support from each team to collect relevant data based on Office need. In 2015 there was further realignment which resulted in an expansion of this group to being the Operation Unit. The goal of this realignment is increase fiscal accountability and increase effective and efficient services through appropriate quality assurance programs. Between these systems Maine is able to collect quantitative and qualitative data to address key issues.
e. The OCFS Data team and QA Unit utilize a consistent process to collect and extract accurate quantitative and qualitative data across the state. Data reports are tested for accuracy through a sampling audit.
f. Maine has the systems and resources in place to utilize and monitor AFCARS data, NCANDS data, CFSR, ACF CFSR 3 Statewide Data Indicators and NYTD.

3. Case review data and process:

a. QA staff is routinely conducting case reviews which could be comprehensive case reviews using the ACF review instrument or focused reviews based on agency need for data.
b. The current case review schedule that was established to meet the needs of the PIP allows for stratification of cases as well as including the largest metropolitan area in the state to be reflected in the rolling quarter data that is submitted to ACF. Each district office is reviewed annually, 16 cases per district (128 cases per year), using the federal format and includes interviews with all key participants in the case. The sample includes 4 service cases and 12 foster care cases with permanency goals of Family Reunification, Adoption and OPPLA.
c. In late 2015/early 2016 work was completed to strengthen this process in terms of developing a defined sampling methodology.
d. The case review process includes the QA Program Manager as being the person responsible for providing QA on each of the tools which assures for inter-rater reliability as having one person always being the anchor.

4. Analysis and dissemination of quality data:

a. OCFS utilizes monthly management reports, Kids in Care reports, annual district CFSR's and has access to the Results Oriented Management System, all combined allows for ongoing tracking of outcomes.
b. OCFS has a data team of qualified staff to aggregate and analyze data that can be broken down by district office.
c. OCFS has various stakeholder groups to provide feedback to the OCFS.
d. OCFS maintains a website with current data related to outcomes.

5. Feedback to stakeholders and decision makers and adjustment of program and process:

a. In the fall of 2015 the decision was made to restructure the various panels and committees facilitated by the OCFS to increase efficiencies to enhance the overall quality of conversations and planning within the stakeholder groups. In December, OCFS facilitation of the Child Welfare Steering Committee and the Citizen's Review Panel were ended. The members of both of those groups were encouraged to continue involvement by participating in either the Child Death and Serious Injury Panel and the State Multidisciplinary Task Force (Child Abuse Action Network).
b. District staff have access to reports provided by the data and QA team. It seems that not all staff have the same level of access and this is likely based on district staff preferences. This is an area that could be strengthened. The Associate Director of Child Welfare has committed to following up with districts related to the need for plans to be developed and implemented in response to the various QA studies that are conducted.
c. OCFS is moving towards a stronger CQI approach and this will automatically involve the policy and training teams when outcomes are reported out that would indicate a need for policy review and/or strengthening of a training element.
d. In the winter of 2014 the Quality Circle process was implemented in every district which allows district staff the opportunity to identify challenges to their work, create and implement strategies to overcome those barriers. Quality Circles are supported by the Governor of Maine and the Commissioner of DHHS. In 2015 the facilitators of these groups began having quarterly meetings with the OCFS Director, Associate and Regional Directors of Child Welfare. The purpose of this contact is to learn about new innovative processes that have been implemented in the district as a result of the Quality Circle work as well as to identify resources and support that would promote implementation of ideas. These meetings also provide an opportunity for members of the OCFS Executive Management Team to identify statewide trends/needs and innovative solutions for statewide implementation.
e. QA staffs continue to be available to provide more district-specific consultation through working on special reviews that could provide the District relevant information for that district in its efforts to improve outcomes.

OCFS has begun implementation of a real time review model to better support the work of district caseworkers and supervisors. In the past year staff have been hired and trained to support the Eckerd Rapid Safety Feedback (ERSF) Model. Staffing consists of Quality Assurance staff overseen by the ERSF Program Manager. All of the QA staff was trained in the model in November 2015 with full implementation of the model rolling out 3/7/16 with 3 reviewers (two primaries, 1 backup) from the QA unit assigned this responsibility. Once trained, ERSF staff participated in weekly 'practice' reviews to become more proficient in the model. Based on a comprehensive review of 5 years of data in MACWIS and other sources, critical case practice issues were identified that, when completed to standard, could reduce the probability of high severity child abuse. Among those case practices were quality safety planning, quality supervisory reviews and the quality and frequency of home visits. Once a case is pulled into the ERSF process a review is completed using a standardized tool. If safety concerns are identified or if the case file does not contain sufficient information to determine if safety concerns are present, an ERSF case staffing is scheduled between the ERSF team (RSF Program Manager and the QA Specialist who reviewed the case) and the caseworker and his/her supervisor.

The goals of the ERSF staffing are:

- Mitigate safety concerns in cases with a high probability of a poor outcome;
- Child Welfare staff to utilize the feedback provided by ERSF staff to allow for case practice change real time; and
- ERSF staff to provide mentoring, coaching and support to child welfare staff.

In service of these goals the ERSF staffing uses a four step process.

1. Debrief any potential safety concerns and/or emerging dangers with the caseworker and caseworker supervisor;
2. Develop a plan to reduce potential threats to the child(ren) if safety concern and/or emerging dangers are identified;
3. Identify who will be responsible for action tasks and assign timeframes for resolution; and
4. Provide positive feedback regarding case strengths, as well as discuss case concerns and opportunities for improvement.

In the first month of implementation of ERSF there were 21 cases assigned for review and 10 staffing's held.

Staff and Provider Training:

Item 26 (Initial Staff Training): (How well is the staff and provider training system functioning statewide to ensure that initial training is provided to all staff who deliver services pursuant to the Child and Family Services Plan (CFSP) that includes basic skills and knowledge required for their positions) was assigned a rating of Strength in the 2009 CFSR as Maine demonstrated providing comprehensive child welfare training to new caseworkers and ensuring that caseworkers are fully trained on relevant issues prior to assuming a caseload.

Since the 2009 CFSR there has been a significant shift in staff training. The cooperative agreement between the OCFS and the University of Southern Maine, Muskie School of Public Services was not renewed for SFY 2013. OCFS developed internal capacity by creating a Policy & Training Team that consists of seven Policy & Training Specialists and one Policy & Training Program Manager. Their role is to provide new caseworker trainings, advanced trainings to more experienced workers and other trainings as deemed necessary to enhance staff's work with families and children. This training is done using a variety of delivery methods including onsite, regional and online modules. This approach allows for new hires to receive training almost immediately, versus having to wait for the quarterly scheduled training program to begin. This approach also allows training needs identified to be addressed immediately instead of waiting for an outside agency to conduct the training. In 2015 there were 6 rounds of New Worker Trainings conducted with 76 new child welfare workers and 19 Alternative Response Program staff participating in the training.

Similar to national workgroup retention rates, Maine has been challenged in keeping staff however is seeing an improvement in this area. Maine changed the way churn over is calculated for 2015 and 2016. Statistics below for 2012 through 2014 include an office to office transfer within OCFS as adding to our churn rate and therefore contributing to our vacancy rate. OCFS determined that that is not accurate and have removed those transfers from our data.

In February 2015 an anonymous survey was disseminated to 93 new workers, those who had been hired since January 1, 2014. The response rate was 55.91% or 52 responses of 93 sent out. Overall the survey reflected that new trainees rated the OCFS training team into the "Somewhat good" category from the 5 categories staff had to choose from (Not at all, Not really, neither +/-, Somewhat, Really good),

In terms of outcome:

1. What skills/training would you recommend be added to the New worker Training curriculum to better prepare new workers in the future? The responses were categorized and grouped according to what was written. Some responses had more than one category depending upon the respondent's answer. The following table reflects the results:

Day to day work	37.5%
Legal training	32.5%
MACWIS training	25%
Documentation	15%
Uncategorized (mentioned by more than one person)	15%
Interviewing	10%
Permanency	10%
Substance abuse	5%

2. At this point in your training experience within OCFS, what further skills/training do you need? The responses were categorized and grouped according to what was written. Some responses had more than one category depending upon the respondent's answer. The following table reflects the results:

Uncategorized (mentioned by more than one person)	33.3%
Documentation	33.3%
Day to day work	25%
Legal	22.2%
MACWIS	19.4%

Supervision	5.6%

The results of the survey have been shared with the OCFS Senior Management Team and will be used in the development of training curriculum which is being redesigned to better match the flow of the casework.

Item 27 (Ongoing Staff Training): (How well is the staff provider training system functioning statewide to ensure that ongoing training is provided for staff that addresses the skills and knowledge need to carry out their duties with regards to services included in the CFSP)

Since the 2009 CFSR the shift occurred as referenced in the above item however the same standards remain as far as requiring caseworkers to attend core trainings on various topics over the following two years post completion of the pre-service training. Additionally, all licensed caseworker staff are required by Maine social worker licensing rules to complete 25 hours of training for licensing renewal every 2 years, including 4 hours of training in Ethics. In order to monitor completion of the ongoing training requirement, the Social Work Licensing Board regularly audits a portion of license renewal applications it receives.

Bringing the pre-service training in house also allows for more direct collaboration with the DHHS Staff Education and Training Unit (SETU), this unit also provides ongoing trainings and tracks those trainings. Ethics Training is provided through SETU.

New supervisors are required to participate in training in employment and labor law in the 4-day *Managing in State Government Training.*

In the Spring/Summer 2015 all child welfare supervisors participated in a 3-day Supervisory Academy Training on administrative, educational and supportive supervision. The evaluation data showed that participants of this training found it to be valuable and increase their supervisory skills and the information provided was easily to be transferred from their learning sessions to their day to day work. Supervisors also found value in this opportunity to learn from their peers. This experience has led to the OCFS to bring the LAMM (Leadership Academy for Middle Managers) and LAS (Leadership Academy for Supervisors) trainings to Maine in the next step for the supervisory leadership team and was rolled out in the spring of 2016.

There have been fluctuations in the number of vacant supervisory positions that are reflected below:

2012	16 lines vacated	4 resign, 5 promote, 5 transfer, 2 demote
2013	4 lines vacated	1 promotes, 3 transfer
2014	9 lines vacated	5 resign, 3 promote, 1 transfer
2015	9 lines vacated	3 resign, 2 promote, 1 transfer, 3 retire
2016 (as of 2/22)	1 line vacated	1 retirement

In addition to new worker trainings, ongoing trainings that were available in 2015 and the number of staff trained include:

TRAININGS	TOTAL STAFF
Advanced Medical Indicators	16
Child Care Subsidy Program MACWIS	8

Child Welfare Trauma Training (2-day training)	41
Children's Behavioral Health in Maine	23
Children's Mental Health Treatment in Maine	49
Drug Identification, Impairment Recognition and Worker Safety	32
Facilitated Family Team Meeting Training	59
Failure to Thrive: Diagnosis, Treatment & Family Support	25
FFTM Facilitator Training	27
Indian Child Welfare Act (ICWA) Working with Native American Tribal Child Welfare	106
Legal Training	46
Legal Training-Mock Trial	8
MACWIS & Technology Overview	91
Mock PPO Case Management	58
OCFS Documentation Training	30
Office of Child & Family Services – New Worker Training	100
Online Period of Purple Crying	73
Permanency Two- Understanding Permanency Options for Children	55
Problematic Sexual Behavior in Youths: Risks & Resilience	36
Psychosocial Assessment	83
Random Moment Time Study for Observers	36
Rights of Recipients of Mental Health Services Who Are Children in Need of Service	170
Special Topics for the 0-4 Population: Abusive Head Trauma and Safe Sleep	201
Supervisor Training Academy- Modules 1,2,3	80
Transition to Independence process (TIP)	18
Working Within OCFS	48

Item 28 (Foster and Adoptive Parent Training): (How well is the staff and provider training system functioning to ensure that training is occurring statewide for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities that care for children receiving foster care or adoptive assistance under title IV-E- that addresses the skills and knowledge needed to carry out their duties with regard to foster and adopted children) was assigned a rating of Strength in the 2009 CFSR as Maine was able to demonstrate providing initial and ongoing training for foster and adoptive parents, including licensed relative caregivers. Since the 2009 CFSR there have been changes to this training component.

The cooperative agreement between the OCFS and the University of Southern Maine, Muskie School of Public Services was not renewed for SFY 2013. OCFS instead developed internal capacity to provide pre-service caseworker, resource family, and core trainings using various training delivery methods including onsite, regional and online modules.

In its current resource family training, OCFS is delivering a training curriculum developed by Muskie as a need was identified to revise and update the curriculum. A workgroup was formed in 2015 for this purpose. The workgroup included district staff who were trainers of the current curriculum. The workgroup met regularly between February 2015 and March 2016 and were prepared to present the revised curriculum to managers for final approval with a recommendation to implement the new curriculum during the summer 2016. The revised curriculum includes six training modules. Among the topics covered during these six

modules are topics relating to why children enter care; why children think they enter care; reunification; supporting birth family connections; adoption and permanency guardianship; policies relating to positive discipline; Family Team Meetings; optimal child development; understanding the impact of abuse and neglect upon brain development; and bonding, attachment and trust. The revised curriculum adds some topics including video presentations which were not previously included, such as the Period of Purple Crying video and the Safe Sleep environment video, both of which are focused upon ensuring safety of infants and babies under the age of one year old.

The workgroup created a PowerPoint presentation to accompany the Trainer and Participant Training Manuals, as well as updated a resource guide for applicants. The workgroup presented the draft curriculum at a statewide meeting of all resource unit staff and all trainers involved in delivery of the training to foster parents. Based upon feedback provided by the participants in the meeting, the workgroup made final edits and revisions to the curriculum. When forwarding this revised curriculum to management at the end of March 2016, the workgroup recommended that at least once annually the group of trainers of this curriculum will meet to review the success of the curriculum in meeting the initial training needs of applicant families. The annual meeting of trainers will be an opportunity to suggest any further need for revision or updates to continually assure that the curriculum is as up-to-date with current information as possible.

The workgroup recognized that due to the amount of information presented to new applicants, this initial training presents more of an overview and orientation rather than in-depth training on any one topic. The workgroup recommended that on-going trainings be available to resource parents to provide more in-depth topical trainings relevant to their role than can be provided during the introductory training.

Between 8/2013-6/2014 a survey was completed with resource parents with two specific questions targeted: 1) Is the current training for Resource Parents meeting your needs?; and 2) what changes would you like to see in training?

In summary:

- Between 8/2013-6/2014 there were 88 surveys completed resource parents.
- 52% (t=46) were with kinship providers; 48% (t=42) were with non-kin providers.
    - Of the kin providers 61% (t=28) reported that the training meet their needs, 39% (t=18) reported a mixed in terms of the training meeting/not meeting their needs and/or no the training did not meet their needs.
    - Of the non-kin providers 67% (t=28) reported that the training met their needs, 33% (t=14) reported being mixed in terms of the training meeting/not meeting their needs and/or no the training did not meet their needs.

In looking the Question 2: "what changes would you like to see in training" similar responses were received from both kin and non-kin providers and they seemed to fall into 2 areas: topic specific requests and resource needs.

Topics that both groups would like to see include: more training related to managing behavioral challenges of children, substance abuse by youth, more training on older youth vs. younger children, training on DABs and what their unique needs are, training on the child welfare system, i.e. court process, permanency process, what happens if family reunification doesn't work, more training on 'real life' situations for foster parents, mandated reporter training, trauma training, secondary trauma training, managing kids after their visits, training on alternative discipline methods. Specific to kin providers: training on role differentiation- being a relative and then becoming the caregiver.

Resources: Training on day to day logistics (mileage reimbursement), what's available for supports, how to obtain resources, more information about what is available for training, need for congruency between training

and the manual, training on differences between resources i.e. HCT & CBT, financial resource available i.e. WIC.

A Resource Family Introductory Training and a Kinship-specific training calendar is regularly updated and circulated amongst district resource units. Resource family applicants are able to participate in training sessions in a neighboring district, if the dates and times of training are more convenient for them than those offered in their home district. Similarly if the applicant misses a session in their home district, then the applicant is invited to participate in that session when it is offered in an adjoining district. Neighboring districts in some parts of the state are collaborating in delivery of kinship training sessions.

The Resource Family Support Services (RFSS) contract added as a new responsibility the requirement that the contractor assist district staff in delivery of the pre-service training of resource parent applicants. In a meeting between the contractor and resource unit supervisors, it was determined that this assistance would be carried out through the contracted agency assuming responsibility for training one specific module of the curriculum whenever it was offered in district training on a statewide basis. The contract agency will also co-train with OCFS district kinship training sessions.

The RFSS contract requires the provider agency to collect data to evaluate the effectiveness of training sessions for which the agency is responsible for delivery or co-delivery. Participants in training complete pre-training as well as a post-training surveys relating to measurements which are key to providing safe and effective parenting. Training objectives as measured on these pre-and post- surveys include the following:

- Trainee will report an ability to identify at least 3 things within personal ecosystem that will change with the addition of a child to the family.
- Trainee will report an ability to name at least 3 developmental responses to grief for children at various ages and developmental stages.
- Trainee will report an ability to name at least 5 allegation prevention strategies that can be implemented within the resource home and family.
- Trainee will report that based upon OCFS policies, trainee can list at list 3 types of discipline that may not be used with a foster child.
- Trainee will report an ability to list at least 3 types of ways in which trainee can support a child's behaviors using resiliency techniques.

Trainee's rate their responses on a scale that ranges from strongly agree to strongly disagree. Data is tracked to measure differences in percentages on meeting training objectives between administration of pre- and post-training surveys.

At this time, there is no similar evaluation process in place for pre-service training delivered to resource families by district OCFS staff. This is identified as a need for OCFS to develop similar evaluative expectations for its own staff-delivered training in 2016.

The RFSS contract includes a requirement of on-going training provided to licensed resource families. The contractor sponsors an annual training conference which brings together speakers on relevant topics, as well as workshops and resource information to support caregivers in fulfilling their role and in enhancing their skills.

A Request for Proposals is currently in process which will require bidders for this service to describe how they will provide topical trainings identified as priorities by foster parent respondents to the OCFS 2015 survey relating to training needs of foster parents.

The contractor throughout the year delivers or arranges for training to be delivered in resource family support group settings. The contractor also maintains a listserve which notifies resource families of trainings delivered by various community partners in various parts of the state. The contractor maintains a lending library of books and video training materials which are available to resource families.

Service Array and Resource Development:

Item 29 (**Array of Services**): (How well is the service array and resource development system functioning to ensure that the follow array of services is accessible in all political jurisdictions covered by the Child & Family Services Plan:

- Services that assess the strengths and needs of children and families and determine other service needs;
- Services that address the needs of families in addition to individual children in order to create a safe home environment;
- Services that enable children to remain safely with their parents when reasonable; and
- Services that help children in foster and adoptive placements achieve permanency.)

This area was assigned a rating of Area Needing Improvement in the 2009 CFSR as it was found through the Statewide Assessment and stakeholder interviews that although Maine had established effective services to promote reunification, the amount of overall services has diminished due to budget cuts and that this has affected the State's ability to achieve permanency for some children.

To address the concerns the PIP included continued utilization of statewide services, a survey to assess service array and decision making related to key services. The action steps were met but, during the PIP period one of those key services identified, Wraparound Maine, was defunded due to budgetary challenges however other systems were in place that would continue to service families. Results from the survey of birth parents and child welfare staff confirmed the two groups as having similar experiences in terms of barriers to many of the services being distance to the service and availability of transportation. Key services were identified through this work and presented to the Steering Committee and OCFS Senior Management Team in August 2012. At that time the restructure of OCFS was being implemented and it was agreed that this provided the Office with an opportunity to further assess and address the needs of children and families in Maine from a more holistic approach, starting with prevention. The CFSP will support this ongoing development work, including foster parent recruitment; ARP increased funding in supervised visitation and ARP, the Fatherhood Group expansion and expansion of the CPPC program.

In 2015 there were a number of services that were developed and began being implemented that will support families and children's needs in Maine and include:

- CBT Plus, an evidence based clinical intervention developed through the Partnering For Success Initiative. Maine is one of 5 implementation sites for Partnering for Success Initiative in the country. In Maine this service is being piloted in two child welfare districts and, as of February 2016, 69 children are receiving CBT Plus intervention. This service provides CBT for anxiety, depression, behavioral health challenges PLUS trauma treatment. In the fall of 2016 it is anticipated that this services will expand to other districts with the goal being to bring in new providers to partner with OCFS in this work.
- Bridging Program- A collaboration between OCFS, Public Health Nursing (PHN) and the Maine Families Home Visiting Program to improve service delivery to families with a child born substance exposed. The purpose of Bridging is to improve outcomes for infants and their families by increasing coping skills, removing barriers and building on strengths utilizing all the needed supports and services within the families' community. A PHN Bridging Liaison is co-located in each child welfare District Office for a set number of hours each week. The Liaison is a resource for OCFS staff and PHN staff to improve understanding of what each agency does and build increased collaboration to serve families more effectively.

- Through the Maine Coalition Against Sexual Assault 400 nurses were trained in forensic interviewing for sexual assault victims. The two training programs consist of 1) to cover 13+ year old victims; and 2) pediatric victims. These interviews take place in the local emergency rooms.
- The Office of Violence Prevention (OVP), housed within OCFS, participated in the expansion of the Child Advocacy Centers (CAC), their work includes supporting the multidisciplinary teams in the CACs. There are currently 3 CACs in the state with others being developed in the remaining parts of the state to ensure adequate access statewide for families. Trained forensic nurses are part of the multi-disciplinary teams.
- Maine Enhanced Parenting Program (IVE Demonstration Project)- Through collaboration with the Office of Substance Abuse and Mental Health Services (SAMHS) and MaineCare, OCFS has designed a child welfare demonstration project that is closely aligned with our mission of ensuring the safety of all Maine youth and aimed at improving outcomes for one of our most vulnerable populations. This services is for parents with substance abuse and parenting challenges which have resulted in a service case with substantiated findings or a child entering state custody. In order to be eligible for this service a family must have at least one child who is between the ages of 0-5 years old and either at risk of entering custody or entered state custody and a recent substance abuse assessment (FASA preferred or an assessment utilizing the American Society of Addiction Medicine (ASAM) criteria) that recommends Intensive Outpatient Service (IOP) as the appropriate level of care for treatment. This service will be available in 5 of the 8 districts with a plan to expand to the other 3 districts.
- C.A.S.E. (Center for Adoption Support and Education): In 2016 Maine OCFS was selected as a pilot state to begin working with the National Adoption Competency Mental Health Training Initiative (NTI) and implementing the C.A.S.E. training to better support the work of adoption and guardianship for those children and families moving towards or achieving the goals of adoption and guardianship.
- Family Reunification Program: OCFS is preparing within the near future to post a Request for Proposals for the Family Reunification Program service. This service will be available on a statewide basis to families in the process of reunification with children in custody of the Department. Maine will be contracting with a provider who can deliver with fidelity to the model an intensive reunification service which was initially developed in Michigan and which was able to demonstrate statistically significant success with reunification.
- Adoptive & Foster Families of Maine (AFFM): provides Resource Family Support Services (RFSS) that provide resource parents (kinship parents, licensed foster parents, adoptive parents, and permanency guardianship parents) with an array of resource assistance to support them in their role of caregivers for children placed in their homes by DHHS. RFSS addresses needs specific to enhancing the caregiver's skills as a resource parent, as well as support the resource parent's increased understanding of the role shared with the Department in promoting timely permanency outcomes (including reunification) for children in care. Additionally, RFSS provides resource parents with an identified, neutral entity with whom they can process their thoughts and feelings surrounding important decisions affecting the lives of children. It also allows them an emotionally-safe setting in which they can discuss how they are personally impacted by the tasks involved in caring for children who are in custody of the Department.
- Judge Baker Children's Center: The Modular Approach to Therapy with Children (MATCH) is a groundbreaking evidence-based psychotherapy recently developed by two child psychologists: Dr. John Weisz at Harvard University and Dr. Bruce Chorpita at UCLA. These two treatment developers, and the child psychologists who work directly with them, are the only MATCH trainers. The only way of therapist can become certified in MATCH is to receive training and consultation by child psychologists in one of these two groups. JBCC provides MATCH training and consultation to clinicians throughout Maine.
- Supported Visitation: Support of family visits shall consist of skilled observation and assessment of parent-child(ren)'s interaction and in modeling/teaching parenting skills by a trained Visitation Support Worker during scheduled visit time(s); for the purpose of providing a safe environment in which children in the care or custody of DHHS can visit with their parents and other important people

in their lives, and the parent/child interaction can be strengthened through facilitating appropriate interactions and parenting techniques.

Item 30 (Individualizing Services): (How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be individualized to meet the unique needs of children and families served by the agency?) was assigned a rating of Area Needing Improvement in the 2009 CFSR as it was determined that services provided by OCFS are not accessible to families and children in all areas of the State. Waiting lists for services such as psychiatric evaluations, dental services, substance abuse treatment and in home services was a barrier in this area.

Similar to 2009, it is noted that there are no measures for effectiveness specifically related to service accessibility. Maine's geography and severe weather can restrict accessibility. Public transportation remains limited and lacking in some areas. Caseworkers often transport or arrange transportation for case members and recently OCFS was able to allocate additional funding to transportation service.

OCFS views itself as a member of the community that works together to assure the families and children in Maine will have their needs attended to appropriately. The CFSP supports development of community programs that will be accessible statewide and include increased funding in supervised visitation and APR, Foster Care Redesign, Fatherhood Group expansion and the expansion of CPPC and/or OCFS support of other active community collaborations.

In the 2009 CFSR Maine was able to demonstrate the ability to individualize services despite the limitations attributable to service availability and accessibility. At that time it was recognized that Maine was able to implement several initiatives that allowed for individualization of services to meet the unique needs of children and families.

Since the 2009 CFSR Maine has continued to work towards implementing services that could meet individualized needs of children and families. In March 2012, a new organizational structure was announced within the OCFS, in order to provide a more streamlined approach to what were formerly four divisions: Child Welfare, Children's Behavioral Health, Early Childhood and Public Services Management. The new structure included four teams focused on Policy & Prevention, Intervention & Coordination of Care, Community Partnerships and Accountability & Information Services. The restructure was functionally implemented in the fall of 2012.

The OCFS 2015 realignment of tasks/scope of work included the creation of a Children's Behavioral Health Team, separate and distinct from its former placement within the Child Welfare Team. The Children's Behavioral Health Services Team will be assisting with policy development, provider engagement, and improvement of all behavioral health services. The team leader will be working closely with the resource coordinators to amend Maine Care policies. The team leader will also work towards developing provider capacity across Maine as well as working closely with other staff within CBHS to increase the integrity of our services. Additionally they will as establish measureable performance outcomes for those involved.

The CFSP will continue to support these ongoing efforts specifically through the Foster Care Redesign, increased funding for supported visitation and APR as well as an expansion of CCPC.

Agency Responsiveness to the Community

Item 31 (State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR): (How well is the agency responsiveness to the community system functioning statewide to ensure that, in implementing the provisions of the Child and Family Services Plan (CFSP) and developing related Annual Progress and Services Reports (APSR), the state engages in ongoing consultation with Tribal representative, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and

family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP) was assigned a rating of strength in the 2009 CFSR as the State was found to be working cooperatively with the many stakeholders to implement the goals of objectives of the CFSP.

OCFS continues to be involved in many of the same groups and forums that promote State engagement as it was in 2009 and includes the following:

- The YLAT
- Maine Child Abuse Action Network
- Maine Child Welfare Advisory Panel (MCWAP)
- Maine Youth Transitions Collaborative
- Moving Forward Initiative
- ICWA Workgroup
- The Community Partnerships for Protecting Children
- The Maine Child Death and Serious Injury Review Panel
- ARP Coalition
- Foster Family-Based Treatment Association- Maine Chapter
- Child Advocacy Center Advisory Board
- CBT Plus Leadership and Initiative Team

OCFS can continue to demonstrate that the federal reports are routinely shared in CAAN Meeting. Tribal representation is being sought to participate in this meeting. The CFSP and associated APSRs and can be found at http://www.maine.gov/dhhs/ocfs/prov_data_reports.shtml available to the public, including state Tribal representatives.

OCFS will continue its work on engaging key partners in development and implementation of goals. The Director and Children's Behavioral Health staff are setting up regular provider calls for an array of internal and external stakeholder groups. The purpose being to ensure consistent communication is occurring.

Item 32 (Coordination of CFSP Services With Other Federal Programs): (How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population) was assigned a rating of Strength in the 2009 CFSR as Maine was able to demonstrate its coordination with other Federal and federally assisted programs.

Since 2009 Maine has continued to work towards coordinating with other federal or federal assisted programs. In March 2012, a new organizational structure was announced within the OCFS, in order to provide a more streamlined approach to what were formerly four divisions: Child Welfare, Children's Behavioral Health, Early Childhood and Public Services Management. The new structure included four teams focused on Policy & Prevention, Intervention & Coordination of Care, Community Partnerships and Accountability & Information Services. The restructure was functionally implemented in the fall of 2012. In February 2015 a realignment of the Community Partnership team was implemented to increase fiscal accountable and to increase effectiveness and efficient services though appropriate quality assurance programs. This realignment created an Operations Team that included a Finance Team, and Contracted Services Quality Assurance Team (CSQA). It also designated a Child Welfare Team, Children's Behavioral Team and an Early Intervention Team.

The Children's Behavioral Health Services Team will be assisting with policy development, provider engagement, and improvement of all behavioral health services. The team leader will be working closely with the resource coordinators to amend Maine Care policies and to develop provider capacity across Maine as well as be working closely with other staff within CBHS to increase the integrity of services as well as to establish measureable performance outcomes.

The Finance Team will be providing management of the financial aspects of OCFS. This work will include contracting, financial analysis, and management of accounts, appropriations, and allocations. OCFS will be clear on the role associated with quality oversight of services and the role of financial coordination.

The CSQA team will lead quality improvement activities that will focus on the review of services across OCFS. This team changed purpose and broadened scope to focus on quality improvement and began a new review process in July 2015. In the first six months, case management was reviewed at 32 agencies and residential reviews have been conducted in at least 6 facilities as the existing residential review process is re-tooled to be reflective of the current process. Outpatient and Home and Community Treatment reviews began in December, with less than six visits on each service type to date. In July, the team conducted a review of Respite Services in advance of a new request for proposals and provided feedback on the efficacy of the service that was used in crafting the new RFP. Once reviews, which incorporate an on-site chart review and discussion with agency staff, along with interviews of service recipients, are complete, a written report is distributed to the Program Expert for that specific service or agency and the program expert follows additional quality improvement efforts. The team has found that generally speaking, providers make many changes based upon the exit interview feedback prior to finalization of the report. Providers have given copious encouraging feedback to the Quality Services Manager with regards to this new review process. They report appreciating the time and feedback and have found consultative comments to be helpful. In the year to come, the Team will continue MaineCare reviews while also incorporating other services purchased or managed by OCFS.

Interagency agreements and policies that facilitate the coordination of services with the following departments, agencies, or groups:

- Department of Corrections
- DHHS Office of Aging and Disability Services
- Office of Public health Nursing
- Department of Education
- Penobscot Indian Nation
- Houlton of Maliseet Indians
- Maine Children's Trust, Inc.
- Local and State Law Enforcement
- Maine Coalition to End Domestic Violence
- Maine State Housing Authority
- Municipal housing authorities
- The Thrive Initiative
- Maine Center for Disease Control
- Office of Substance Abuse and Mental Health Services
- Maine Coalition Against Sexual Assault
- Maine Families Home Visiting Services

Foster and Adoptive Parent Licensing, Recruitment, and Retention:

Item 33 (Standards Applied Equally): (How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that state standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds) was assigned a rating of Strength in the 2009 CFSR as Maine was able to demonstrate having standards for resource family homes and child care institutions that are reflected in the OCFS and DHHS licensing procedures respectively.

The standards in place in 2009 have remained essentially unchanged. While the Resource Family Licensing Standards were revised in 2015 and are in the process of being reviewed prior to becoming finalized policy in 2016, there was no substantive change to the standards outlined in the previous 2008 standards policy. This

latest revision was instead an effort to provide more succinct policy guidance. The revised policy includes newly inserted information about the added requirements for foster parents to apply reasonable and prudent parenting standards. The newly inserted information in the Resource Family Licensing Standards policy is as follows:

Reasonable and Prudent Parenting

Reasonable and prudent parenting standard is defined as the standard characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth, that a caregiver must use when determining whether a child in foster care under the responsibility of the state/Tribe to participate in extracurricular, enrichment, and social activities. These decisions will be based upon ensuring a child's safety while also ensuring the child has the opportunity to participate in normal child and youth activities.

Caregiver (for this purpose only) is a foster parent or designated official at a child care institution. As defined in Title IV-E of the Social Security Act, section 475(10).

A combination of requirements and standards for foster and adoptive homes and institutions are found in Maine statute, foster home licensing rules and OCFS policy. Family foster homes and child care institutions are subject to licensure and are included in the general licensing category of children's homes. The OCFS licenses resource family homes which must meet the uniform standards prior to approval. Once approved for a resource family license, the licensee can choose from an array of service provision, including foster care, adoption, permanency guardianship or respite. The approval of resource homes, as opposed to our former practice of separately licensing foster homes and approving adoptive homes, allows the licensee to seamlessly transition amongst various types of service provision during the term of the license without encountering previous barriers relating to a need for submitting a new application or need to repeat background checks when one chooses to provide a different service type. The Maine DHHS Division of Licensing and Regulatory Services licenses children's residential care facilities, child placement agency, emergency shelters and shelters for homeless children.

The Resource Family Licensing Standards policy describes the inquiry, informational, application, and home study components in the process related to becoming licensed. These standards include requirements relating to age, health/functioning, background checks (including criminal history), and physical plant (including a fire inspection and water test).

The home study includes a review of various life domains, including the applicant's life experiences, family relationships, support systems, family beliefs and values. The home study also includes an assessment of applicant's ability to parent safely and successfully and meet the needs of the children served by OCFS, as well as the applicant's ability to collaborate as a team partner with OCFS and service providers. Foster and adoptive parents are required to attend an initial 18-hour Resource Family Introductory Training (RFIT) and to participate in ongoing training as a condition of license renewal. While this initial 18- hour initial training is frequently waived for kinship families who are carrying for a relative child placed in their home, the kinship family is required as part of the process for becoming licensed to participate in an alternative 6- hour kinship-specific introductory training.

Resource family licenses are issued for a two-year term. Licenses for facilities and programs last 2 years, with the exception of child-placing agencies, which are licensed for 1 year. District Resource Unit licensing supervisors are responsible for approving licensing recommendations and for assuring that licensing standards and policies are followed.

While Maine doesn't have any specific quantitative or qualitative data related to standards being applied equally, if we license a home, then the license itself is evidence that the home met standards, perhaps with a waiver for a specific non-safety standard for a specific kinship home. As we license all of our approved homes, we regard every licensed home as meeting uniform standards.

Resource Unit Supervisors meet as a group monthly with the Resource Parent Program Manager for the purpose of ensuring consistent statewide licensing practice. Through review of policy and practice, as well as through discussion of complicated licensing scenarios, the Resource Unit staff strive to reach consensus regarding consistent practice relating to application of specific licensing standards.

Maine DHHS, OCFS, MACWIS Information Services	
Foster Home Application & Approval Data 3/1/2014 thru 3/1/2015	
Initial Applications	342
Renewal Applications	117
Approved Renewal Applications	419
Approved Initial Applications	250

Item 34 (Requirements for Criminal Background Checks): (How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children) was assigned a rating of Strength in the 2009 CFSR and Maine was able to demonstrate that it provides for background checks and fingerprinting as a component for all licensed foster and adoptive placements, including relatives and child care institution staff.

Maine requires all applicants for resource family licensing to complete fingerprint-based background checks through national crime information databases. DHHS Resource Family Licensing Standards policy additionally requires in-state background checks, including State Bureau of Investigation criminal background checks, Bureau of Motor Vehicle background checks and OCFS Child Protective Services background checks. If the applicant has resided out of state in the past five years, then out of state child abuse registries are also checked.

All adult household members and individuals who routinely frequent the resource home property also must have complete background checks. These background checks consist of in-state background checks, unless the adult household member has resided out of state in the past five years, in which circumstance, the adult household member must also complete fingerprint-based background checks. In order for a resource family license to be approved the home study and supporting documentation must verify that the federally required background checks were completed.

DHHS policy Relative Placement and Kinship Care, Including Fictive Kin requires in-state criminal background checks and OCFS CPS background checks must be initiated at the time of placement of any child in a home that has not yet been licensed. OCFS practice requires within 30 days of placement of a child in an unlicensed home, the caregiver must apply for a resource family license and is expected to complete as part of the application process fingerprint-based background checks of national criminal databases.

Maine requires employees to conduct criminal background checks on all child care institution staff and to keep the results of those checks on file.

Item 35 (Diligent Recruitment of Foster and Adoptive Homes): (How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the

diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed) was assigned a rating of strength in the 2009 CFSR as Maine was able to demonstrate that concerted efforts are being made in various locations to recruit resource families that reflect the ethnicity and race of these children.

During 2010-2014, there was a cultural shift in the way in which the Department looked at recruitment of resource families who could meet the specific ethnic and cultural needs of children in care. Rather than the Department assuming internal responsibility for recruitment, there was recognition that diligent recruitment of families needed to be an effort shared with youth in care, resource families, community members and organizations, including faith-based organizations. Partnerships were built with community members and organizations. Some of these partnerships were formalized into community partnerships and others were more informal in structure.

Youth were invited to participate in various workgroups and meetings, including panel participation during district resource family informational meetings and pre-service training for prospective resource families. Hearing the youth voice has been described by both Department staff and by community members as very instrumental in educating the community about the need for families in the community who are compatible in their interest and capacity to meet a youth developmental cultural needs.

For a period of time, the Department collaborated with Casey Family Services in providing Extreme Recruitment services. This proactive approach to recruitment involved preparing youth for permanency; diligent search for potential permanency kinship resource families; and stressing the importance of youth having connections to their extended family members to increase their awareness of their cultural heritage and their identity with their biological family and community.

While Extreme Recruitment did not continue as an ongoing recruitment program, the tenets of the effort are incorporated into the Department's current Permanency Review Teams (PRT) in which a team convenes to review past efforts to promote permanency for child who has typically been in care for more than six months. The team reviews what has been successful and what has not been successful with these past efforts and develops strategies towards identifying recruitment efforts which will be successful in supporting permanency.

During the summer of 2015, OCFS initiated a new contract service focused upon recruitment of foster families who can provide temporary care to children in foster care as well as recruitment of adoptive homes for children in care who are waiting for an identified adoptive family. The following is excerpted from the contracted agency's mission statement:

"A Family for ME is an initiative contracted by the Maine Department of Health and Human Services (DHHS) and the private, non-profit agency KidsPeace. The centerpiece of the initiative is a widespread and coordinated awareness campaign to inform and educate the public about the urgent need for foster and adoptive families to meet placement and permanency needs of children in care of DHHS. A Family for ME is partnering with other agencies, community members, and interested parties to reach prospective foster and adoptive families throughout Maine.

OCFS is seeking families who can provide a safe, nurturing, and stable family setting for children who temporarily cannot reside with their birth families, or youth who need a forever home.

- ***Foster families** care for children whose parents are trying to resolve the problems which led to the removal of their children. During the period in which birth families work toward resolving the problems in their homes, foster families provide children with a stable, nurturing, and safe environment while supporting the reunification process. Foster families are active partners with DHHS in maintaining contact between children and their birth families. There are many ways in*

which foster families support birth families in their reunification efforts, including the transportation of children to visits with their birth families, participating in meetings with the Department and/or providers that support the reunification plan, as well as to ensure that birth families are aware of their children's school and community activities. When reunification is successful, foster parents assist in a child's transition home to their birth family.

- *In the event that reunification cannot occur in a timeframe that meets the child's needs for permanency, other options are explored, the most desirable of which is adoption.* ***Adoptive families*** *provide a permanent home for children once the court has determined that they cannot return to their birth family.*
- *Homes are especially needed for teenagers with trauma histories that can present as challenging behaviors, for infants who are born drug-affected, and for sibling pairs and groups (to prevent siblings from being separated when brought into care).*
- *For families that would like to participate, but cannot commit full-time, the option of becoming a* ***Respite*** *home is available. Families that provide Respite will care for children for a small period of time (a few hours during the day, overnight, for a week, etc) in order to relieve foster homes of their responsibility when necessary. Respite families go through the same process to license their home as do foster and adoptive families."*

In the period since the service was implemented in August 2015 to March 2016, the contracted agency has been successful in eliciting 224 inquiries about foster and adoptive services in Maine and has supported 61 individuals in attending OCFS informational meetings to learn more about the need for foster and adoptive parents and to learn more about the licensing process. Of those interested individuals recruited by the contract agency, 13 have submitted an application and several individuals remain in inquiry status. There is a plan to follow- up with those individuals to encourage them to submit applications if they remain interested in providing foster and adoptive services.

The 2015-2019 CFSP will support Maine's work related to evaluating and redesigning the recruitment and retention of relative and resource homes to include components required to meet the Multi-Ethnic Placement Act.

Maine DHHS OCFS has been challenged during the past year in locating appropriate placements for children in the following groups which are being targeted for special focus of recruitment efforts:

- Youth who are nearing readiness for discharge from residential programs, with no identified step-down placement home in the community.
- Infants who are born drug-affected and who are in the process of reunification with birth family.
- Larger sibling groups.

Accompanying the need to recruit families who can provide placement to these targeted populations is the need to focus upon matching of these children to caregivers who can maintain their connections to their culture, extended family, and community of origin while recognizing and supporting the racial and ethnic diversity of children in foster care in Maine. Among efforts currently underway in Maine are efforts to collaborate with Tribal partners toward enhanced and focused recruitment of Tribal families who can provide placement to children in care who have connections to a Tribe.

Item 36 (**State Use of Cross-Jurisdictional Resources for Permanent Placements**): (How well is the foster and adoptive parent licensing, recruitment and retention system functioning to ensure that the process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanency placements for waiting children) was assigned a rating of Strength in the 2009 CFSR as Maine was able to demonstrate

that it effectively uses cross-jurisdictional adoption exchanges including AdoptUsKids and the Interstate Compact on the Placement of Children (ICPC) to support permanent placements for children.

The OCFS ICPC Program Specialist maintains a spreadsheet to track the ICPC home studies Maine completes for children in the custody of the states. The spreadsheet allows the Program Specialist quick access to determine what studies are pending and is able to have communication with local offices to ensure timely completion of the home studies. The types of home studies completed include parent, relative and adoption.

In 2015, a total of 57 home study requests were received and assigned. Of the 57 studies, 52 (91.23%) were completed within the 60-day timeframe allowed under the Safe and Timely Interstate Placement of Foster Children Act of 2006. Three of the 5 overdue studies were completed within 30 days of the due date under Safe & Timely.

The only available measures of effectiveness are the statistical reports available from the DHHS ICPC manager. Findings from a review of annual ICPC statistical reports indicate that requests for out of state adoption homes studies have been increasing over the last 4 years:

Year	No. of ICPC adoption request for out of state placement
2009	36
2010	9
2011	13
2012	11
2013	12
2014	16
2015	21

The data reflects adoptive placement requests for children in the care of another state being placed in Maine have been declining during the last 2 years:

Year	No. of ICPC adoption requests from other states
2009	16
2010	15
2011	16
2012	13
2013	15
2014	11
2015	9

Review of Goals for 2015 -2016 of the 2015-2019 CFSP

The following is Maine's 5-year CFSP 2015-2019 which reflects the needs of the OCFS and is in line with the Assessment of Performance report.

The established baselines were drawn from the last four cycles of the Me. Child and Family Services Case Reviews utilizing the federal case review instrument, leading up to the CFSP submission in June 2014. OCFS will measure the results, accomplishments, and annual progress towards meeting the goals and strategic targets through data extracted from our SACWIS system including Management Reports and the Results Oriented Management (ROM) system, Quality Assurance data and data received from ACF. The qualitative measurements in each of these items, unless otherwise specified, include reviews completed October 1, 2014 - September 30, 2015.

Strategic Goal: Child Safety, first and foremost

Goal #1: OCFS responds to all appropriate child abuse and neglect reports and ensures that children are seen within a timeframe that assures their safety.

Rational for selection of the CFSP goal:

As addressed in the Assessment of Performance section this is an area that Maine has been challenged in sustaining progress in timely initiation of investigating reports of child abuse and neglect. In the APSRs leading up to the development of the CFSP the data indicated that Maine has been timely in initiating investigations of child abuse and neglect ranging between the low of 75.5% in 2010 to the high of 85.5% in 2012. The established OCFS goal in terms of Management Report is 90% which has been difficult to reach which suggests a need for focused work in this area as all children deserve a timely response when it comes to assessing their safety.

Objectives over the next 3 years:

- *Annual, periodic staff allocations among districts.*
- *Annual, periodic staff allocations within each district.*
- *When applicable based on outcome from annual case reviews, written District action plans for timely response will be developed in collaboration with the Associate Director of Child Welfare, Program Administrator, Unit Supervisor and Quality Assurance Specialist.*
- *Creation of policy around response time of Child Advocacy Centers.*

Baseline: Item 1- Timeliness of initiating investigations of reports of child maltreatment within agency established timeframes.

Measurement Methodology: OCFS Management Reports, QA Targeted Project Reports, Qualitative Case Reviews.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
69%	73%	76%	79%	82%	85%
Actuals					

CFSR	76%	-	-	-	
Management Report	75%	-	-	-	-

Progress through May 2016:

- ✓ Districts have been reviewing staffing patterns and case/assessment volume to re-purpose staff into practice areas of great need.
- ✓ The Child Welfare Associate Director will meet with the Operations Associate Director to review the Caseworker Workload Report and then with the District Management Team (DMT) to make any recommendations for adjustments.
- ✓ The DMT will develop a process for periodic staff allocations within each district.
- ✓ OCFS has a history of conducting case reviews and being challenged with having individual district Program Improvement Plans be developed within a timeframe that can allow time for change in practice. In the 2015 discussions with DMT there were plans made to address the ongoing challenges related to safety through the life of the cases, case planning with children and families and frequency and quality of contact with children and parents- similar to the OCFS Strategic Plan & Goals. Historically the expectation has been for districts to develop Program Improvement Plans in response to the outcome report of the Me.-CFSR process. Given the comprehensive nature of the Child Welfare Strategic Plan, many of the areas identified as needing improvement through the Me.-CFSR process will be addressed through the strategies and action steps within that larger plan. However, when there are areas outside of the focus of the CW Strategic Plan identified as a district specific challenge, it is expected that districts will develop a plan to address the unique challenges specific to that district.
- ✓ *The Use of Expert Consultation when Assessing Child Abuse and/or Neglect Policy* was disseminated to staff and effective September 1, 2015. There is clarification that, while it is ideal if the CAC conducts this interview, if a CAC cannot see the alleged victim(s) timely in order to meet the 72-hour timeframe, the OCFS caseworker is expected to conduct the interview.
- ✓ In September 2015 evaluators from Hornby Zeller Associates, Inc. began an assessment of the OCFS child welfare. The goal being to determine if OCFS uses its resources effectively to serve high risk cases, strengthen families and mitigate repeat maltreatment; is structure to engage families in a meaningful way to protect their children; and follows processes and procedures which are efficient, effective and consistent across the state. The assessment is using a variety of qualitative and quantitative research methods to gain a detailed and data informed understanding of operations, processes, and activities that impact child welfare management in Maine. It is anticipated that the report and recommendations will be provided to OCFS Executive Management in July 2016.

Goal #2: Families increase the safety of their children by making and implementing agreed upon plans, supported by services they need. *(CFSR Items 2, 3, 12 &13)*

Rational for selection of the CFSP goal:

Maine has also been challenged in the area of risk assessment and safety management of children. In the four Me.-CFSR cycles leading up to the development of the CFSP strength was noted in this area ranged from a low of 34% in 2010 to a high of 48% in 2013. The last three cycles have indicated an upward swing in this area but the agency is not satisfied that this will be sustained without additional focus on this area.

Objectives over the next 3 years:

- *Continued support and training opportunities of the OCFS Fact Finding Interview protocol.*

- *Training on Family Team Meetings and Facilitated Family Team Meetings.*
- *Develop district repeat maltreatment written action plans based on data standards.*
- *Develop a formal a 90-day supervisory review protocol of child and family plans.*
- *Review/reassess elements needed to strengthen the OCFS Management Reports.*
- *Implement revised policies/procedures. (health screening at entry into foster care; mental health screening of all children in service cases; portable health record regularly updated; current health information and family health history in MACWIS).*
- *Assess current procedures within the Health Care Plan and identify areas that will require strengthening and implement new procedures.*

Baseline: Item 3– Were concerted efforts made to assess risk and safety concerns related to the child in their own home or while in foster care.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
41%	45%	49%	53%	57%	61%
Actuals					
CFSR	56%	-	-	-	

Baseline: Item 17– Agency appropriately addressing the physical health of the child including dental health needs.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
78%	80%	83%	85%	88%	90%
Actuals					
CFSR	83%	-	-	-	

Baseline: Item 18– Agency appropriately addressing the mental/behavioral health of child.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
74%	77%	80%	83%	87%	90%
Actuals					
CFSR	80%	-	-	-	

Measurement Methodology: QA Targeted Project Reviews, Qualitative Case Reviews, Results Oriented Management Data, OCFS Management Reports.

Progress through May 2016:

- ✓ The Family Team Meeting Policy, which includes the Facilitated Family Team Meeting protocol, was reviewed and updated. The training curriculum was completed concurrent to the policy development. Strategic Consultants, Casey Family Services was also consulted with to develop a training on the Family Team Meeting process as it was recognized that the last time all staff were comprehensively trained in this process was in 2005 when FTM's were first implemented within OCFS. By the spring of 2017 all staff will be trained and/or re-trained in FTMs.
- ✓ Pre-service training for all new caseworkers includes the Fact Finding Interviewing Protocol. In 2016 both Fact Finding Interviewing Training and Motivational Interviewing Training will be provided to staff and will continue to be available on a semi-annual basis.
- ✓ The DMT has finalized a supervisor review protocol for quarterly review for children in care cases and monthly review for services cases. This protocol includes a template that supervisors use to document the review in MACWIS.
- ✓ The OCFS Strategic Plan being developed in 2016 will include steps to address concerns related to repeat maltreatment. OCFS understands that its May 2015 ACF data profile indicates a need to develop a PIP around this standard.
- ✓ The work done to update the OCFS Management Report is being re-reviewed by the Associate Director of Child Welfare to ensure the ability to track and monitor the OCFS Strategic Plan elements.
- ✓ In January 2015 the Child Health Assessment (CHA) Protocol was distributed to the District Management Team with the expectation that all staff will be trained on the protocol. A process has been developed to ensure that Child Development Referrals are made in any case with a finding at the end of the child protective assessment. Due to the *Partnering for Success Grant* being implemented in two of the child welfare districts, a decision was made to utilize the PSC -17 statewide

Goal #3: Efficient, effective casework (engagement, assessment, teaming, planning & implementation) is evident in case documentation. *(CFSR Items 2, 3, 12, 13. 14, 15 & Systemic Factor 20-written case plan)*

Rational for selection of the CFSP goal:

An overarching challenge in Maine has been the ability of staff to document their work with families that demonstrate family engagement and inclusiveness in assessment of the issues and development of effective plans that will make a real impact in the families and children. The strategies identified in the CFSP should support improvement in this area.

Objectives over the next 3 years:

- *Increased use of the OCFS Fact Finding Interview protocol supported by annual training which is implemented and monitored.*
- *Explore alternative methods for assessment, i.e. Structured Decision Making.*
- *Annual Family Team Meeting and Facilitated Family Team Meeting trainings for all staff.*
- *Streamline caseworker and supervisor activities.*
- *Training for Supervisors on administrative, educational and supportive supervision.*
- *Evaluate the current Fatherhood projects state wide with a plan to provide state wide leadership through the fatherhood initiative work group. The plan is to employ strategies that have a measurable, consistent, education, support and outreach components that meet the needs of fathers in all parts of our state.*

Measurement Methodology: Qualitative Case Reviews, QA Targeted Project Reviews, Completed Policy

Baseline: Item 3- Were concerted efforts made to assess risk and safety concerns related to the child in their own home or while in foster care.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
41%	45%	49%	53%	57%	61%
Actuals					
CFSR	56%	-	-	-	-

Baseline: Item 14 – Frequency and quality of caseworker visits with child.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
58%	64%	70%	77%	85%	95%
Actuals					
CFSR	80%	-	-	-	-

Baseline: Item 15– Frequency and quality of caseworker visits with parent(s).

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
30%	33%	36%	40%	44%	50%
Actuals					
CFSR	42%	-	-	-	-

Baseline: Voice Recordings of child interviews downloaded in MACWIS.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
65%	100%	100%	100%	100%	100%
Actuals:					
	CY 2015 89%				

Progress through May 2016:

- ✓ Through the past year staff have been positioned and trained to support the Eckerd Rapid Safety Feedback (ERSF) Model. Staffing consists of Quality Assurance staff overseen by the ERSF Program Manager. All of the QA staff were trained in the model in November 2015 with full implementation of the model rolled out on March 7, 2016 with 2 primary and 1 back up reviewer from the QA unit assigned to this responsibility. This group has participated in weekly 'practice' reviews to become more proficient in the model. In the 7 weeks of implementation there have been 40 assigned reviews and 25 staffings.
- ✓ In 2016 OCFS will be implementing Structured Decision Making (SDM) in the Intake process.
- ✓ The Family Team Meeting Policy, which includes the Facilitated Family Team Meeting protocol, was reviewed and updated. The training curriculum was completed concurrent to the policy development. Strategic Consultants, Casey Family Services were also consulted with to develop a training on the Family Team Meeting process as it was recognized that the last time all staff were comprehensively trained in this process was in 2005 when FTM's were first implemented within OCFS. By the spring of 2017 all staff will be trained and/or re-trained in FTMs.
- ✓ Pre-service training for all new caseworkers included the Fact Finding interviewing Protocol. In 2016 both Fact Finding Interviewing Training and Motivational Interviewing Training will be provided to staff and will continue to be available on a semi-annual basis.
- ✓ With the completion of work done related to documentation (policy and training), the next steps in the upcoming year, using the Hornby-Zeller Inc., evaluation results, are to look at supervisory workload and streamline caseworker activities further by looking at administrative tasks that should/could be done elsewhere in our system.
- ✓ Supervisory Training Development: In the Spring/Summer 2015 all child welfare supervisors participated in a 3-part Supervisory Academy Training on administrative, educational and supportive supervision. The evaluation data showed that participants of this training found it to be valuable and increase their supervisory skills and the information provided was easily to be transferred from their learning sessions to their day to day work. Supervisors also found value in this opportunity to learn from their peers. This experience has led the OCFS to bring the LAMM (Leadership Academy for Middle Managers) and LAS (Leadership Academy for Supervisors) trainings to Maine in the next step for the supervisory leadership team and was rolled out in the spring of 2016.
- ✓ The OCFS Deputy Director met with the Director of the Maine Coalition to End Domestic violence to discuss the possibility of enhancing fatherhood through the collaboration between OCFS and MCEDV. OCFS has also taken steps to imbed specific questions related to father's participation in the FFTM process which can be measured through the FFTM database.

Strategic Goal: Parents have the right and responsibility to raise their own children.

Goal #4: Improve OCFS sharing of responsibility with the community to help families protect and nurture their children. *(Systemic Factors 29, 30- Service Array & 31- Agency Responsiveness to Community)*

Rational for selection of the CFSP goal:

OCFS considers itself a member of a community working collaboratively to meet the needs of families and children. The OCFS restructure in 2012 provided opportunity for the agency to streamline its work and resources to better support the work in and of the larger Maine community as OCFS should not be involved in a family for a signification amount of time. OCFS should be one of a continuum of services that the families and children in Maine have access to strengthen the family. To that end the strategies identified in the CFSP will support that goal and vision.

Objectives over the next 3 years:

- *Continued implementation of Mandatory Reporting Training to community stakeholder groups.*
- *Effective training and implementation of the Family Team Meeting Policy and the Facilitated Family Team Meeting Protocol.*
- *Continued expansion of CPPS to other areas in Maine in addition to Biddeford, Portland, Lewiston, Bangor and working with other communities to identify already existing coalitions and offering our support.*
- *Development and dissemination of FAMILY SHARE Policy.*
- *Ensuring FAMILY SHARE Meetings are occurring when children enter custody.*
- *Training for Resource Parents and staff regarding the need for and value of Family Share Meetings.*

Baseline: **While there is no specific data related to the systemic factors 29, 30 - Service Array & 31- Agency Responsiveness to community that will be impacted by these strategies, there are practices that, if consistently implemented, should indicate progress made in this area.**

Those include:
Baseline: Facilitated Family Team Meeting prior to the removal of a child from their home (5 days before or after removal).

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
23%	29%	34%	40%	46%	50%
Actuals:					
	CY 2015 51%				

Baseline: Family Share Meetings after the removal of a child from their home.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
12%	16%	21%	28%	37%	50%
Actuals:					
	CCY 2015				

	Quantitative 65% Qualitative 63%				

Measurement Methodology: QA Targeted Project Reviews.

Progress through May 2016:

- The Family Team Meeting Policy, which includes the Facilitated Family Team Meeting protocol, was reviewed and updated. The training curriculum was completed concurrent to the policy development. Strategic Consultants, Casey Family Services were also consulted with to develop a training on the Family Team Meeting process as it was recognized that the last time all staff were comprehensively trained in this process was in 2005 when FTM's were first implemented within OCFS. By the spring of 2017 all staff will be trained and/or re-trained in FTMs.
- The Request for Proposal for the CPPC expansion has been finalized for seven of the eight districts. In 2016 OCFS, providers and community members will work to establish and/or strengthen the community approach to ensuring child safety. An OCFS Program Specialist has been identified to oversee the CPPC program and develop consistency statewide to develop these services. The Program Specialist will supervise staff dedicated to prevention work.
- Family Share Policy has been was finalized and disseminated to all staff in August 2015. Family Share practice and policy is trained at multiple points during the Foundations training for new workers. In the Resource Parent training they focus on the purpose of the family share meeting and that it is an opportunity for the resource parent to gain specific and pertinent information about the child that will allow them to safely care for and protect that child while placed in their home. They also discuss the hope is that the meeting may help create a mutually supportive and trusting relationship that can foster important communication that will increase the success of the placement, and reunification.
- The QA Unit has implemented a quarterly schedule of reviewing Family Share data, this review process was implemented in January 2014. A baseline was established using data looking at all removals from 7/1/13-12/31/13. Districts have been provided with the raw number of Family Share meetings that are pulled through a query of MACWIS for all removals. In the data pulled for the last quarter of 2014, QA began looking at a smaller sample to provide more of a qualitative review for district staff. The qualitative review includes a review of policy compliance in terms of when the meetings occur. The quantitative query pulls all Family Share Meetings regardless of when they were held the qualitative review looks at if the meeting were held within 5 business days of the child entry into foster and any time a child changes placement. The qualitative review is also looking at documentation for when a meeting isn't held and if the justification is sound.
- Continued implementation of Mandatory Reporting Training to community stakeholder groups. A Process was instituted with a Policy & Training Specialist and Intake Supervisor identified as trainers for train the trainers (referred to as T3s). This duo has continued to train OCFS staff, tribal members from both the Maliseet and Passamaquoddy tribes and Child Advocacy Center staff to provide Mandatory Reporting Training statewide. There has also been two Child Advocacy Center staff trained as T3s that can now train their own staff to become trainers.

Strategic Goal: Children are entitled to live in a safe and nurturing family

Goal #5: Increase stability of placements & permanency. *(CFSR Item 4 & 5)*

Rational for selection of the CFSP goal:

As addressed in the Assessment of Performance section Maine has been challenged in sustaining progress in the area of timely and appropriate permanency goal setting. The data indicates a swing towards progress being made, however it also indicates a need for continued focused in this area given the critical nature of the indicator and the potential lifelong impact it has on children.

Objectives over the next 3 years:

- *Review/revise and strengthen Family Team Meeting Policy and Facilitated Family Team Meeting protocol.*
- *Training on Family Team Meeting and Facilitated Family Team Meeting protocol.*
- *Effective implementation of District Permanency Review Teams.*
- *Develop districts/unit written action plans to improve performance developed in collaboration with the Associate Director of Child Welfare, Program Administrator, Unit Supervisor and Quality Assurance Specialist.*
- *Quality Assurance Review of ROM data related to children who re-enter care with written outcome report disseminated and plans made to address issue.*

Baseline: Item 5– Were appropriate permanency goal for child established in a timely manner.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
77%	80%	82%	85%	87%	90%
Actuals:					
	76%				

Measurement Methodology: OCFS Reports, QA Targeted Project Reviews, Qualitative Case Reviews, Results Oriented Management System Data, ACF Annual Data Profile.

Progress through May 2016:

- The Family Team Meeting Policy, which includes the Facilitated Family Team Meeting protocol, was reviewed and updated. The training curriculum was completed concurrent to the policy development. Strategic Consultants, Casey Family Services were also consulted with to develop a training on the Family Team Meeting process as it was recognized that the last time all staff were comprehensively trained in this process was in 2005 when FTM's were first implemented within OCFS. By the spring of 2017 all staff will be trained and/or re-trained in FTMs.
- The ACF Summary Data Round 3 Statewide Data Indicators Report (May 2015) reflect that Maine falls within the appropriate range in relationship to re-entry into foster care. The national standard is 8.3%, Maine's observed performance is 4.4%. Based on this data Maine would not be required to address this through a PIP. Given this data the decision was made that QA would not conduct a study based on ROM data and re-entry.
- OCFS QA has conducted quarterly studies to determine how well the agency is doing in providing relative notification of children entering foster care. Due to the law being clear that all known grandparents and adult relatives are to be notified, if there was no documentation of all known maternal

and paternal grandparents and adult relatives being notified, the cases would be rated as not met. Typically what is found is that some of the relatives are notified but not all that should be notified are despite the agency being aware of the relatives.

- OCFS has a history of conducting case reviews and being challenged with having individual district Program Improvement Plans be developed within a timeframe that can allow time for change in practice. In the 2015 discussions with the District Management Team there were plans made to address the ongoing challenges related to safety through the life of the cases, case planning with children and families and frequency and quality of contact with children and parents- similar to the OCFS Strategic Plan & Goals. Historically the expectation has been for districts to develop Program Improvement Plans in response to the outcome report of the Me.-CFSR process. Given the comprehensive nature of the Child Welfare Strategic Plan, many of the areas identified as needing improvement through the Me.-CFSR process will be addressed through the strategies and action steps within that larger plan. However, when there are areas outside of the focus of the CW Strategic Plan identified as a district specific challenge, it is expected that districts will develop a plan to address the unique challenges specific to that district.
- Given the challenges OCFS has in terms of achieving timely permanency goals for children in foster care and the inconsistency in utilizing the Permanency Review Teams (PRT) in each district, the decision was made to replace the PRT process with two other targeted permanency review strategies:
    - In 2016 OCFS will implement a bi- weekly permanency planning call with district management and executive management staff. This is a model similar to one used by the Eckerd agency in Florida and includes an interactive questioning approach specific to the actions being taken on the child level to achieve permanency for the children being reviewed. It is expected that district staff will have updates related to steps taken to achieve permanency and that there is follow up by management to ensure those steps are moving the case towards timely permanency goal achievement.
    - All children in foster care with a TPR will be reviewed, with the goal of having each district develop a recruitment plan for each applicable child. Each adoption supervisor will have a tool to track recruitment for every child in their unit. All of our TPR'd children without an identified adoptive family will have a Heart Gallery photo, and an Adoptuskids listing. We will also be working with our contracted recruitment agency, Kidspeace to do other types of child specific recruitment such as print media and community recruitment.

- In 2015 the OCFS Deputy Director and OCFS Adoption Program Manager began reviewing all the youth who are TPRd (577) to assess barriers and effectively plan to reduce those barriers. In the first phase three districts with the longest timeframes to permanency were reviewed, District 2 (Portland), District 5 (Augusta/Skowhegan) and District 8 (Houlton/Caribou/Ft. Kent). Following each review the Adoption Program Manager met with the adoption supervisor and either the PA or APA or both. Those meetings included a discussion on the outcome of the review, questions related to the reviews and the adoption program manager making suggestions for improving timeframes. The districts were receptive to this feedback and process and we anticipate we will start seeing signs of improvement in this area.
- In 2014 OCFS returned to its former practice of dedicating a unit in each district office to adoption. This decision was made to increase the number of adoptions and improve our timeframes to adoption. As part of this effort it was important for OCFS to reestablish our relationship with Probate Judges and share our vision, but even more importantly, we wanted to hear what the Probate Judges needed from OCFS.

  In early 2015 the OCFS Deputy Director and Adoption Program Manager requested to join the Probate Assembly at their quarterly meeting to discuss these topics. They met with the assembly twice. They

also met with three Probate Judges individually to discuss current strengths and challenges specific to that court and OCFS office. This effort was successful in improving communication and trust between OCFS and our Probate Judges. It has also led to a decrease in the time between filing our adoption petitions and getting a date for legalization.

- Home Court Legislation- Summary of PL460, "An Act to Ensure a Continuing Home Court for Cases *Involving Children"*- Traditionally Maine's Probate Courts maintained exclusive jurisdiction over guardianships, adoptions, and changes of name. This law transfers exclusive jurisdiction over these matters to Maine's District Courts in any case where there is already a pending case regarding custody and/or parental rights in the District Court and becomes effective 7/19/16.

  This law on the Department's w**o**rk is multifaceted. When the parental rights of parents are terminated it will no longer be necessary to transfer that case to probate court in order to complete the child's adoption, which will allow the judge who has overseen the case from its inception to make the best decision about the child's future and will eliminate the time the Department's staff spent familiarizing the Probate Court judge with the case. In cases where there is a pending protective custody case, any further court action (such as the filing for guardianship by a relative) must take place in the District Court, which eliminates complexity for Department staff, as well as the Attorney General's staff. The possibilities for the improvement in efficiency and outcomes for children are enormous, from the work of parent's attorneys and guardians, to the continuity and consistency that one single court's handling of the case can provide.

Goal #6: Increase safe and nurturing family relationships and family/community connections. *(CFSR Items 8,9,10,11)*

Rational for selection of the CFSP goal:

As addressed in the Assessment of Performance section Maine has been challenged in promoting relationships with parents and other family connections beyond just visitation. The data indicates a swing towards progress being made, however it also indicates a need for continued focused in this area given the critical nature of the indicator and the potential lifelong impact it has on children.

Objectives over the next 3 years:

- *Foster Care Redesign and Implementation.*
- *Review/revise and strengthen Family Team Meeting Policy and Facilitated Family Team Meeting protocol.*
- *Family Team Meeting and Facilitated Family Team meeting training, monitoring and performance management.*
- *Evaluate the current Fatherhood projects state wide with a plan to provide state wide leadership through the fatherhood initiative work group. The plan is to employ strategies that have a measurable, consistent, education, support and outreach components that meet the needs of fathers in all parts of our state.*
- *Evaluate and redesign the recruitment and retention of relative and resource homes to include components required to meet the Multi-Ethnic Placement Act (MEPA and Inter-Ethnic Placement Act (IEPA).*
- *Develop a written statewide plan to fully implement foster connections statutory requirements that state exercise due diligence to notify all adult relatives when child enters foster care.*

Baseline: Item 11– Were concerted efforts made to promote, support, and/or maintain positive relationship of child in care with parents.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
63%	66%	69%	73%	77%	80%
Actuals:					
	76%				

Baseline: Relative notification letters are evident in MACWIS.

CFSP Year Goal:					
Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
8%	100%	100%	100%	100%	100%
Actuals:					
All grandparents	44%				
All adult relatives	38%				

Measurement Methodology: OCFS Management Reports, QA Targeted Project Reviews, Qualitative Case Reviews, Results Oriented Management System Data.

Progress through May 2016:

- The Family Team Meeting Policy, which includes the Facilitated Family Team Meeting protocol, was reviewed and updated. The training curriculum was completed concurrent to the policy development. Strategic Consultants, Casey Family Services were also consulted with to develop a training on the Family Team Meeting process as it was recognized that the last time all staff were comprehensively trained in this process was in 2005 when FTM's were first implemented within OCFS. By the spring of 2017 all staff will be trained and/or re-trained in FTMs.
- Once the districts are trained in FFTM and FTM, the QA Unit will conduct reviews of the process to determine how consistent the policy is being implemented statewide.
- The OCFS Deputy Director met with the Director of the Maine Coalition to End Domestic violence to discuss the possibility of enhancing fatherhood through the collaboration between OCFS and MCEDV. OCFS has also taken steps to imbed specific questions related to father's participation in the FFTM process which can be measured through the FFTM database.
- In the spring of 2016 the tenants of the SMT Accountability Plan (eff. 2/2015) related to compliance on relative notifications will be reviewed again as the data would indicate a lack of significant progress in providing all grandparents and all known relatives with notification of children entering foster care. The Lexis Nexis search engine has been available to child welfare staff for 6 months however the data indicates that staff are not utilizing this resource. In the spring of 2016 a survey will be conducted with all child welfare staff to identify the barriers to using this search engine. Further steps will be taken once that information is obtained.
- The Foster Care Redesign has undergone a reprioritization in focus in the last year. While the redesign is still underway in terms of ensuring that all families who care for youth get the supports and services needed to care for those youth, OCFS determined a need to strengthen internal capacities in relation to fully supporting structures such as licensing, training and completing the internal processes necessary in

a timely manner. In the spring of 2016 the Request for Proposals for the Clinical Support program was posted. This service was delayed in part due to the agency's procurement process.

- Multi-Ethnic Placement Act- OCFS has contracted with KidsPeace to provide recruitment services for foster and adoptive families. Discussions between OCFS and KidsPeace occur at least monthly and emphasize the need for focused efforts upon recruitment of families who can meet the diverse ethnic and cultural heritage of children in care. This recruitment effort includes targeted, diligent and child-specific recruitment of families who can promote the child's continued involvement and connection with a child's ethnic, religious and cultural history.

Strategic Goal: How we do our work is as important as the work we do.

Rational for selection of the CFSP goal:

The 2012 OCFS restructure brought together the Quality Assurance Team and the Data and Information Services Team. This joining lends itself to strengthening the qualitative and quantitative data collection that then informs senior and district managers as to strengths and challenges within the district practice and outcomes. It is important that the practices involving families and children be measured to determine gaps in practice, policy or services so improvements can be made when identified as necessary.

Goal #7: Further strengthen the OCFS Continuous Quality Improvement program to support district practice and operations as well as the CFSP. *(Systemic Factor 25)*

- *Update and disseminate the OCFS QA/QI Operational Plan on an annual process.*
- *Develop and implement district Quality Circles.*
- *Develop and implement a case record review process that will meet the ACF criteria for the Child and Family Services Review.*

Baseline: Systemic Factor 25 (No baseline data available)

Measurement Methodology: Completed QA/QI Operational Plan, Associate Director Report, Case Review data and report.

Progress through May 2016:

- The QA/QI Operational Plan that was originally developed in 2014 was updated and disseminated in 2015. The revisions made included defining the process that will be used in the federal CFSR. This plan can also be found on http://www.maine.gov/dhhs/ocfs/prov_data_reports.shtml.
- All district offices and central office have established Quality Circles and meet routinely. The OCFS Director, Associate Director of Child Welfare and the Regional Associate Director of Child Welfare have quarterly meetings with the district QA facilitators. The purpose of this contact is to learn about new innovative processes that have been implemented in the district as a result of the QC work as well as to identify resource and support that would promote implementation of ideas. These meetings also provide an opportunity for members of the OCFS Executive Managements Team to identify statewide trends/needs and innovative solutions for statewide implementation.
- Throughout the past year the QA Unit has continued to work on strengthening the review process in order to be in compliance with the ACF criteria for state option CFSR. This has included:
    - Interviewing key participants in 100% of the cases reviewed;
    - Developing and implementing a District CFSR Debriefing Meeting with all district staff following each of the reviews;
    - As a team the QA unit participated in the training of the OSRI through the CFSR Portal made available by ACF;

- Participating in group meetings with ACF Regional Staff;
- In April 2016 OCFS QA started utilizing the OSRI on the Maine CQI Site on the ACF CFSR Portal to complete the review process including the quality assurance process and exchanging the instruments between the primary review teams and the QA Program Manager;
- Developing a Questions & Answer Database related to CFSR items to assist in managing inter-rater aspects of review; and
- Regular phone, in person and email contact between the QA Program Manager who oversees this process, and the Boston Regional ACF representative.

Current Services Supporting the CFSP Goals

The Family Team Meeting (FTM): The FTM has been a cornerstone of Maine Child Welfare practice since 2003. The FTM is a process that brings together (a) family (b) informal supports (i.e. friends, neighbors and community members) and (c) formal resources (such as child welfare, mental health, education, and other agencies). It functions to serve the child and family's achievement of safety, permanency, stability and well-being. The child and family team brings together the wisdom/expertise of family and friends, as well as the resources, experience and expertise of formal supports. Maine is partnering with Casey Family Services and 3P Consulting to develop a curriculum and deliver training to staff to build their skills in both facilitation and using the teaming process to achieve permanency. As part of this process, the OCFS Deputy Director, the Associate Director of Child Welfare Services and members of both the training team and data team are involved in the development of a comprehensive implementation plan to support staff success in this area of practice.

In the spring of 2011, OCFS implemented the expectation that Facilitated Family Team Meetings (FFTM) will occur in all cases prior to removal, with the exception of when there is an after-hours emergency situation. In those cases, an FFTM must occur within five business days of removal. OCFS convenes FFTM Consult meetings for facilitators and their supervisors every other month which focus on building fidelity to the model and skill development.

Maine Children's Trust (MCT): MCT Serves as administrator for the Child Abuse & Neglect Council network, which will deliver quality parent programming for DHHS. MCT promotes parent access to evidence based parent education. MCT also serves as project coordinator in the development and implementation of the Maine Parents Place Project virtual learning center. MCT is leading the development of this training delivery option in partnership with the State, with the initial pilot group of parents to include parents the state has mandated to take parent education. MCT serves as project administrator in the development and implementation of a Community Based Physician Educational Project. The key areas will be Mandated Report Training, prevention training including Safe Sleep strategies for infants and the Period of PURPLE crying. For the Mandated Reporter Training (MRT) MCT intends to utilize a peer-to-peer training model. MCT is coordinating the development of a training syllabus for the MRT and an educational program for the prevention programs and is utilizing a small network of physicians who are interested in providing peer training. MCT recently announced the 2015-2016 rounds of child abuse and neglect prevention grants. The identified priorities for this round are programs that promote protective factors: Parental Resilience, Social Connections, Knowledge of Parenting & Child Development, Concrete Support in Times of Need and Health Social & Emotional Development.

The Community Partnership for Protecting Children (CPPC): Based on a national model, the CPPC model in Maine is a network of people who live, work, and serve in our communities to support families experiencing high levels of stress. Guided by the Early Intervention and Prevention Services Unit's strategic goal to improve stability, health, wellbeing and quality permanent connections of individuals and families, CPPC strives to reduce abuse and neglect by developing tangible and sustainable strategies to strengthen families, neighborhoods and the child welfare system. By transforming the relationship between Child Protective Services (CPS) and communities through the development of a child-welfare continuum of care related to child

safety, vulnerable families and their children will be less likely to experience abuse and neglect. At its essence, CPPC is a Collective Impact model, designed with the understanding that the traditional child welfare system cannot, and should not, be the sole structure responsible for keeping children safe.

CPPC is an approach grounded in child safety which involves all CPPC state and local partners (including CPS) joining together to understand varying perspective and approaches, while sharing unique visions and solution-building strategies, to improve their communities' abilities to reduce child maltreatment rates. Using this flexible, family-centered, multi-system, community response to vulnerable children and families allows for an understanding of shared definitions of safety, risk and danger. Additionally, it also encourages the use of strategies and resource sharing that builds protective and promotive factors and strengthens families at intervention points along the continuum of care and involved in, or at risk of, Child Welfare intervention.

CPPC is based on the premise that keeping children safe is everyone's responsibility and that no single person, organization or government agency alone has the capacity to protect all children and strengthen all families. The Community Partnerships work in Maine began as a successful pilot program in 2005 and expanded over the next eight (8) years to include six (6) additional communities and neighborhoods. Beginning in the summer of 2016, CPPC will expand in Maine from separate community models to an 8 district model.

The CPPC model, as a Continuum of Care, will provide services for families who are identified as at Risk for child welfare involvement due to concerns of child abuse/neglect at secondary or tertiary intervention points. Families who access CPPC services will demonstrate an increase in protective and promotive family attributes to maintain child safety and wellbeing, as evidenced by a reduction in the incidents of child maltreatment findings as compared to the State trend by:

1. Increased protective and promotive family attributes of families at risk for experiencing child maltreatment through participation in the Preventative Family Team Meeting process and as measured by the Preventative Family Team Meeting Plan and the Self-Sufficiency Matrix;
2. Increased access to, and use of, community support services for families at Risk for experiencing child maltreatment; and
3. Increased protective and promotive family attributes of families who have experienced, or are at risk of experiencing, child maltreatment by participation in the Parents as Partners program.

Implement the following four (4) core strategies to meet desired behavioral outcomes:

a. **Family-Centered Practice**: A culturally competent, trauma-informed, and individualized planning approach to support each family's unique strengths and needs based in the following practices and skills:
   i. Strengthening Families five (5) Protective Factors;
   ii. Self-Sufficiency Matrix (SSM);
   iii. Preventive Family Team Meetings (PFTMs); and
   iv. Development of Family Plans.

b. **Policy and Practice Change** by all partners, including CPS, to effectively deliver culturally competent, trauma-informed, family-centered, strengths-based services;

c. **Neighborhood and Community Networks** of local residents and leaders, including public and private agencies and key stakeholders, which may include, *but not be limited to*:

   i. Parent Partners;

ii. Youth, parents, residents;
iii. Child abuse prevention councils;
iv. Home-visiting;
v. Health care services;
vi. Domestic and sexual violence prevention organizations;
vii. Law enforcement agencies;
viii. Child welfare staff;
ix. Mental health/substance abuse treatment and recovery communities;
x. Faith based communities;
xi. Early childhood programs/school staff; and
xii. Businesses.

d. **Shared-Responsibility & Shared Collaborative Decision-Making**, from communities to committees, and with individuals as well as groups, to:
   i. Establish representative decision making;
   ii. Develop leadership to identify area priorities;
   iii. Review effectiveness of strategies;
   iv. Mobilize resources; and
   v. Advance sustainability plans.

One tangible, community based strategy of the CPPC model is to have a central location that brings together services, programs, people, and supports. Designed as a place-based model, the Community Hub brings services to the community it is intended to serve; the co-location is intended to reduce common barriers that contribute to increased risk factors for families. Additionally, Community Hubs create neutral space, allowing for vibrant social networks and strengthening of trust and resource sharing amongst residents. The CPPC Hub model requires partners and communities to work collaboratively, reaching out to those at risk and connecting them to formal and informal supports, with a focus on secondary prevention and early intervention within the target communities.

In order to address identified gaps related to secondary and tertiary intervention services, while maximizing resources within their communities, Communities will establish a Parent Partner Program.

Parent Partners will provide support to and empower parents who are:

a. At risk of involvement in the child welfare system based on an identification of Risk Factors (Early Intervention);
b. Presently involved in the child protective system (Open Case); or
c. Transitioning their case out of the child protective system due to closing assessment, closing service case, reunification, guardianship plan, Termination of Parental Rights (TPR)/Adoption, etc. (Transition Cases).

The overarching goals of the Parent Partner Program are to utilize a peer-support model to:

a. Increase parents' ability to identify, and as a result, decrease individual and family Risk Factors using available resources;
b. Increase parental resilience, social connections, knowledge of parent and child development;
c. Function as integral partners in collaboration with child welfare, to promote time-sensitive family reunification and/or support parents through a timely alternative permanency plan if/when it determined to be in the best interest of the child; and

d. Reduce the likelihood of current or future abuse or neglect by supporting parents as they work to increase their own Protective and Promotive Factors using available resources, which can include but are not limited to, substance abuse and/or mental health treatment, parenting classes, and/or services offered by local Child Abuse and Prevention Councils, case management services, housing, transportation, etc.

These Life-trained, CPPC paraprofessionals can offer a wealth of knowledge and experience in three ways:

a. As ***parent advocates*** the Parent Partners will mentor parents identified in Early Intervention, Open, and Transition Cases. It is expected that Parent Partners will attend PFTMs (Early Intervention), FTMs, and FFTMs (Open and Transition Cases) as a multi-faceted, dynamic systems navigator for the family; and/or
b. As ***parent leaders*** the Parent Partners will act as the "parent's voice" as participants on various committees and workgroups, offer feedback for materials generated by partners, including child welfare, and provide input on policy and program development to ensure programs are family centered; and/or
c. As ***parent coaches*** the Parent Partners will offer weekly, topic-based workshops for parents involved in or at Risk of involvement in the child welfare system, including regular support groups.

Parent Partners and community partners of CPPC will be trained in and offer Preventive Family Team Meetings (PFTM) to identify and decrease Risk Factors while increasing Protective and Promotive Factors for families identified as Vulnerable for child maltreatment.

Overarching Measures of CPPC:

Families in the CPPC Communities will have a reduction in the incidents of child maltreatment findings (including Unsubstantiated, Indicated, and Unsubstantiated) by 15% more than the State trend by July 2020.

80% of families who participate in Preventative Family Team Meetings attain at least 60% of their goals specified in the Individualized Preventative Family Team Meeting Plan by July 2020.

80% of families, who participate in the Preventative Family Team meeting process, score 3 or higher on the domains of the Self-Sufficiency Matrix as identified in the family-specific plan by discharge from CPPC services by July 2020.

Increase number of unduplicated community members who access information and services at the Community Hub by 70% as measured by the Hub Monthly Reporting Form by July 2020.

80% of parents participating in the Parents as Partners Program demonstrate an increase in Protective and Promotive attributes as indicated on the Parents as Partners Assessment Tool by July 2020.

80% of parents participating in the Parents as Partners Program demonstrate an increase of Protective and Promotive attributes as indicated on the Self-Sufficiency Matrix by July 2020.

Signs of Safety (SOS): In early 2014, OCFS leadership and caseworkers identified the key components of the SOS work that will be woven into our training unit. These key areas include:

- Engaging natural and formal supports to address safety goals.
- Quality FTMs and FFTMs.

- Sustainability of family teams through the life of the case.
- Planning for safety through the life of the case.
- Understanding the child welfare planning process with families.
- Sharpening Harm Statements, Danger Statements and Safety Goals that clearly define for families in plain language what is expected from them and us.
- Utilizing strengths/protective capacities to meet safety goals.
- Creating behaviorally specific goals/next steps.
- Using the Questioning Approach in interviews with our families.
- Forensic interviews (refresher).
- Parent interviews.

The key components of Signs of Safety continue to be woven into our practice through our policies and trainings. An example is the use of harm and danger statements for FFTMs to identify the past harm and current safety concerns and the engagement of natural supports in the teaming process. These principles have been the foundation of our organization for many years, including the OCFS Practice Model.

Permanency Review Teams (PRT): OCFS Child Welfare developed a comprehensive Youth Permanency Review Strategy which includes Permanency Review Teaming based on Casey's Permanency Round Table model. This teaming process builds on the Family Team Meeting model and relies on collaborative teaming to ensure that youth's needs for safety, permanency and well-being are met.

Casey Family Program conducted a second training in March 2013 to all members of individual district Permanency Review Teams to ensure that districts are utilizing a consistent approach in these meetings. The four key purposes of the PRT include:

1. To develop a permanent plan for each child/youth that can be realistically implemented over the next six months.
2. To expand thinking about possible permanency options for children and youth and develop a plan for the next steps starting with engaging youth in their own permanency planning process.
3. To stimulate thinking about the pathways to permanency for youth.
4. To identify and address barriers to permanency through professional development, policy change, resource development and the engagement of system partners.

District teams include Program Administrators, Supervisors, Caseworkers, Quality Assurance Specialists, Mental Health Program Coordinators, and Clinical Care Specialists. These teams are reviewing all children that have been in care 6 plus months to ensure the best plans are developed for them early in their foster care experience. In each meeting several plans are developed for the youth to ensure as many supports are built into the child's life. There is a plan to begin a regular review process at the management level in order to ensure a focus on removing barriers to the successful achievement of permanency for youth within expected timeframes (12 months and 24 months). The Family Team Meeting training that will be provided to staff this year will also focus on how to use the teaming process to achieve permanency.

New England Fatherhood Initiative: The goal of this initiative is to develop and implement a unified approach to improving the manner in which OCFS interacts with fathers. A pilot project serving offices involved with the Community Partnerships for Protecting Children (Portland, Biddeford, Lewiston and Bangor) and in collaboration with the father-focused expertise of the Strong Fathers program was developed. Coordination with Casey Family Programs, the community, DHHS and the contracting agency for Strong Fathers, Opportunity Alliance, occurred to plan for orientation for fathers, support groups, outreach to OCFS staff and other educational options. Over the past year the emphasis on this fatherhood work ended due in large part to

the contract that was held by a community provider was not renewed. The OCFS has begun discussions with its partners at Casey to support Maine in developing more internal capacity to coordinate the fatherhood work. The OCFS Deputy Director met with the Director of the Maine Coalition to End Domestic Violence to start a dialogue about how to most effectively work with fathers and other paternal relatives when domestic abuse is a factor impacting child safety. This work will continue as well as additional strategies that will be part of the upcoming OCFS strategic plan. The Child Welfare Associate Director will research various models to identify strategies and next steps for Maine in this work.

"Now is the Time"—Healthy Transitions (NITT-HT) Grant—*The Moving Forward (NITT-HT) Initiative:*
In 2014, OCFS was awarded another five (5) year $5,000,000 "Now is the Time—Healthy Transitions" grant from the Substance Abuse and Mental Health Services Administration.

Under this new grant, *The Moving Forward (NITT-HT) Initiative* will serve youth and young adults, aged 16-25, living in Androscoggin, Cumberland, and Penobscot Counties who have, or are at risk of having, serious mental illness and co-occurring disorder. Many of these youth and young adults will have experienced trauma from domestic violence, child welfare and juvenile justice involvement, and homelessness.

The Moving Forward (NITT-HT) Initiative seeks to improve the outcomes of young people transitioning to adulthood in the areas of: education, housing, employment, relationships, as well as other needs as identified by participating youth and young adults. Please see page 77 for an update.

Adoptive & Foster Families of Maine (AFFM): provides Resource Family Support Services (RFSS) to resource parents (kinship parents, licensed foster parents, adoptive parents, and permanency guardianship parents) including an array of resource assistance to support them in their role of caregivers for children placed in their homes by DHHS. RFSS addresses needs specific to enhancing the caregiver's skills as a resource parent, as well as support the resource parent's increased understanding of the role shared with the Department in promoting timely permanency outcomes (including reunification) for children in care. Additionally, RFSS provides resource parents with an identified, neutral entity with whom they can process their thoughts and feelings surrounding important decisions affecting the lives of children. It also allows them an emotionally-safe setting in which they can discuss how they are personally impacted by the tasks involved in caring for children who are in custody of the Department.

AdoptUsKids**:** Provides a Weblink service that allows for a seamless link between children available for adoption listed by DHHS and families and national resources. Access to this site has resulted in more children being adopted both in Maine and across state borders. This partnership is essential in promoting permanency for children in the child welfare system.

UKR (ROM): ROM Reports is a web-based service that provides outcome reports to OCFS. The reports provide up-to-date performance data on the federal CFSR outcomes and other program improvement measures using information provided by Maine OCFS. ROM measures have been updated to ensure consistency with the Federal CFSR measures. Training has been provided to the District Management Team (DMT) on new reports available.

Judge Baker Children's Center: The Modular Approach to Therapy with Children (MATCH) is a groundbreaking evidence-based psychotherapy recently developed by two child psychologists: Dr. John Weisz at Harvard University and Dr. Bruce Chorpita at UCLA. These two treatment developers, and the child psychologists who work directly with them, are the only MATCH trainers. The only way of therapist can become certified in MATCH is to receive training and consultation by child psychologists in one of these two groups. JBCC provides MATCH training and consultation to clinicians throughout Maine.

Maine Coalition to End Domestic Violence (MCEDV): The MCEDV provides support for domestic violence advocates (DV-CPS Advocates). These DV-CPS advocates are placed in child protective services units in their local Department of Health and Human Services – OCFS District office. The primary intent of the Maine DV-CPS Program is to strengthen the relationship between Maine's Domestic Violence and Child Protective systems in order to enhance early identification, intervention and system collaboration in cases of intimate partner abuse and child protection that will 1) increase the safety of non-offending parents and thereby the safety of children; 2) decrease the short and long term physical and emotional risks to all victims of family violence; 3) minimize separation between them; and 4) hold batterers accountable. The Program serves adult victims of domestic violence who have a co-occurrence of child maltreatment and domestic violence within their family and are determined by the child protective system to be the non-offending parent.

Physical Plant Funding: The OCFS supports relatives who are caring for children in their home meet the standards for licensing through provision of physical plant funding, if needed, to support them in obtaining a satisfactory fire and safety inspection. While certain standards may be waived on a case-per-case basis for relatives to allow them to be approved for licensing, a satisfactory fire and safety inspection is a statutory requirement which cannot be waived. Physical plant funding is most frequently requested for the purpose of assisting with replacing windows in a relative home to allow the windows to meet the egress-sized dimension required by the Life Safety Code. The maximum amount of physical plant assistance which may be provided to any applicant relative family is $5000, although the majority of requests are for far lesser amounts.

Alternative Response Program (ARP): ARP provides community based intervention services to families who have been reported to DHHS with allegations of low to moderate severity child abuse and/or neglect. Also, families considered appropriate referrals for this program are those who are in need of intervention services to enhance child safety and well-being but do not require Child Protective Services. Supporting the OCFS Practice Model which focuses on the family's strengths as well as needs, Alternative Response providers partner with families to provide case management services and in planning for the safety, permanency, and well-being of their child(ren). The Alternative Response Program is a time-limited service aimed at promoting family competence while helping the family develop a network of community resources that will continue to support the family.

Supported Visitation: Support of family visits shall consist of skilled observation and assessment of parent-child(ren)'s interaction and in modeling/teaching parenting skills by a trained Visitation Support Worker during scheduled visit time(s); for the purpose of providing a safe environment in which children in the care or custody of DHHS can visit with their parents and other important people in their lives, and the parent/child interaction can be strengthened through facilitating appropriate interactions and parenting techniques.

Truth and Reconciliation Commission (TRC): The Wabanaki- Maine Child Welfare Truth and Reconciliation Commission aims to create a common understanding of the truth of Maine's Tribal families and their interactions with state child welfare, as well as present recommendations for achieving healing for historical wrongs experienced by Wabanaki Tribes and to move forward in a positive manner.

The Commissioners released their final report with recommendations in June 2015.

Family Reunification Program: OCFS is preparing within the near future to post a Request for Proposals for the Family Reunification Program service. This service will be available on a statewide basis to families in the process of reunification with children in custody of the Department. Maine will be contracting with a provider who can deliver with fidelity to the model an intensive reunification service which was initially developed in Michigan and which was able to demonstrate statistically significant success with reunification.

Although Maine has made progress in its efforts to partner with families to address the Safety, Permanency, and Wellbeing needs of children and families who come to the attention of the Department, Maine has seen an increase in out-of-home placements for children who have entered State custody due to findings of abuse/neglect while in the care of their families. Maine seeks to improve the rate of reuniting families within federally approved timeframes. In 2014, approximately 61% of children returned to the custody of their families within twelve (12) months, compared to the desired national median of 69.9% (*Results Oriented Management*) or better. Through implementation of FRP Services, Maine is focused on bringing the rate of reunification into compliance with federally approved timeframes.

In 1992, Michigan created and pilot tested the Family Reunification Program for families with children placed in out-of-home care. An independent evaluation of the program showed that families who participated in the FRP were more likely to remain reunified than those in the control group who participated in traditional reunification services. At twenty-four (24) months following reunification, 81% of those who exited the FRP service were still reunified compared to only 60% in the control group. (https://www.childwelfare.gov/pubPDFs/family_reunification.pdf)

The goal of FRP Services is to return children to their family's care sooner and safer than would occur during the usual Reunification process by providing the family with an intensive array of social work services to meet the family's individual needs. The basic tenet of FRP is a belief that families can change, which requires a willingness and genuine enthusiasm to support, validate, and recognize the family's progress toward creating a safe environment in which to provide care for children. The FRP Team Leader and Support Worker are collaborators in this effort with the Team Leader partnering with the family to identify goals and strategies to parent safely, and the Support Worker assisting the family with practicing the strategies. The FRP Team's presence in the home during non-traditional work hours is a key component of this service, so that parents are present during natural times for family intervention.

FRP services focus on educating and supporting the family in internalizing behaviors and skills that strengthen the family's ability to provide safety; therefore, preventing further out-of-home placements for the family's child(ren). The FRP Team does not address every dysfunction with which the family may present, but rather focuses on those that are identified as impacting child safety by assisting families who have had their children removed from their care by the Department to learn effective parenting skills, access and utilize needed resources, and develop a supportive, ongoing Natural Support System, to ensure the Safety, Permanency, and Wellbeing of their children. OCFS recognizes the importance of individual choice of service providers and will work with the family to ensure continuity of services that are necessary and important to the family to promote successful Reunification; however, due to the intensive nature of the FRP which will require the family members to be available to participate in family and community activities as supported by the involvement of the FRP team, it may be suggested by the family's support team, including the Department, that the family limit its involvement with outside practitioners during engagement in FRP services, unless there is a medical or mental health necessity for maintaining the service linkage.

While the FRP Team is the primary source of the contact for the family during its work with the FRP, the FRP Team will collaborate with the local district OCFS offices in meeting the program's goals. Fidelity to the model is implemented through ensuring that families referred to the FRP meet eligibility criteria, as determined through review by the OCFS liaisons in the district offices. OCFS will provide the initial training in Michigan Model Family Reunification as specified prior to services starting after the contract has been awarded. OCFS will provide annual training thereafter.

Demonstration Project

The Maine Office of Child and Family Services (OCFS) is pleased to present its approved child welfare demonstration project. The target population for the project is families involved with the child welfare system with children between the ages of 0-5. Over the past five years, this group has represented a growing portion of removals into out-of-home care in Maine and now represents almost two thirds of all removals. This group has significant risk factors, including substance abuse issues among parents, which are reflected in data and corroborated by community input. Substance abuse is identified as a risk factor in more than half of the indicated/substantiated reports of abuse or neglect in households with young children between the ages of 0-5.

OCFS identified a gap in service delivery for families with children between the ages of 0-5, specifically those with concurrent needs for parent education and substance abuse treatment. Families with at least one child between the ages of 0-5, who are at risk of out of home placement, or are already in out of home placement, often present with multiple risk factors, including family stress, social isolation, and ineffective discipline techniques, as well as parental issues associated with substance abuse, domestic violence, and/or mental health.

OCFS is focusing a collocated service array to address the needs of this target population and to reduce the incidence and duration of out-of-home removals for this group. First, OCFS will implement evidence-based parental education and support interventions to build parental capacity and help children to safely remain in or return to their homes. DHHS has chosen Positive Parenting program (Triple P) as the intervention. Second, OCFS partnered with the Office of Substance Abuse and Mental Health Services (SAMHS) to increase parental access to evidence-based substance abuse services in cases where substance abuse is an identified risk factor. DHHS has selected Matrix model IOP as the intervention.

Historically, there has been a tendency to recommend that parents complete substance abuse services prior to participation in parenting education classes. Additionally, there have been accessibility issues for families for both parenting and substance abuse services, particularly in rural areas of the state. Through this demonstration project, OCFS will offer both substance abuse services and parent education classes concurrently, and at the same location, in order to allow parents timely access to services.

While domestic violence and mental health issues were also identified as risk factors for families with children aged 0-5 involved in the child welfare system, there are existing services, including domestic violence initiatives, available to meet those needs. Further, Intensive Outpatient Program (IOP), the selected substance abuse intervention for this demonstration project, is designed to address the co-morbidity of both mental health and substance abuse issues. Successful completion of substance abuse and parenting education classes can reduce domestic violence and have a positive impact on mental health. For these reasons, OCFS designed a demonstration project that focuses on parents with at least one child between the ages of 0-5 with concurrent needs for substance abuse treatment and parent education.

Based on the specific interventions selected for the target population, OCFS expects to see the following short-term outcome improvements:

- Improved competence in managing common child behavior challenges and developmental issues;
- Decreased use of punitive methods to manage children's behavior;
- Decreased parental stress;
- Increased parental confidence; and
- Reduced parental substance abuse during treatment.

Expected long-term outcome improvements include:

- Increased numbers of children who remain safely in their homes;

- Reduced repeat maltreatment;
- Reduced reentry into foster care;
- Increased rates of reunification and timeliness to reunification;
- Improved child and family well-being; and
- Development of recovery skills for longer term recovery from substance abuse.

OCFS's leadership team and resources are committed to the success of this waiver project. OCFS implemented its demonstration project as an opportunity to improve services available to the children and families of Maine. This Demonstration Project service began April 1, 2016. The two contracted provider's staff is trained in both Triple P and Matrix Model IOP.

Technical Assistance

Technical Assistance from the National Resource Center for Organizational Improvement (NRCOI) was completed in September of 2014. This assistance provided facilitation and research on the type of Supervisor curriculum Maine was going to utilize as the stepping stone to the development of the Supervisory Academy. Maine chose the *Putting the Pieces Together Curriculum* and contracted with the Butler Institute, CO to provide train the trainer training, which rolled out to all child welfare supervisor staff in March of 2015.

By utilizing the *Putting the Pieces Together* curriculum we will be able to train supervisors to the four components of supervision (Administration, Educational, Clinical and Supportive) that have been proven to not only retain front line workers, but to also ensure effective, efficient and accountable supervisors. The supervisor's ultimate objective is to deliver to agency clients the best possible service, both quantitatively and qualitatively, in accordance with agency policies and procedures. Supervisors do not directly offer service to the client, but they do indirectly affect the level of service offered through their impact on the direct service supervisees (Kadushin and Harkness 2002). Therefore, teaching supervisors how to understand their management style in relation to the agency's mission and to focus on agency goals and outcomes; understand various learning styles, mentoring techniques, training new employees, and stages of worker development; facilitate quality case practice through many formats; and to improve morale and job satisfaction. This will also be done as a train-the-trainer model which will allow for eventual self-sufficiency in training new supervisors.

OCFS has partnered with Muskie to bring both the Leadership Academy for Middle Managers (LAMM) and the Leadership Academy for Supervisors (LAS) to Maine as a next step in the Supervisory Academy. As part of these trainings, participants will learn the principles of implementation science and develop and implement a change initiative within their scope of responsibility. Coaching will be provided as part of the process.

Evaluation

Moving Forward: Now is the Time—Healthy Transitions (NITT-HT) Initiative

The Moving Forward (NITT-HT) Initiative will continue to address the Department of Health and Human Services' concerns for improved outcomes for transition aged youth in Maine by providing services and supports designed to help youth and young adults with, or at risk of, serious mental illness and co-occurring disorder achieve independence by addressing their education, housing, employment, relationships, personal well-being, and other needs using evidence-based practices.

OCFS serves as the lead agency for this Initiative, and has a Program Manager employed by OCFS, who shares time with DHHS Substance Abuse and Mental Health Services (adult services). The Initiative began accepting referrals for all programming in June, 2015.

- The *Moving Forward Initiative* was present in Cumberland and Androscoggin Counties in the first year (2014). In year two the Transition to Independence Process Model and Youth Support Partner contracting expanded to Penobscot County. There are presently two case management agencies in Androscoggin County Providing TIP, two in Cumberland County, and one in Penobscot County. Other agencies located in other parts of the state continue to be eligible to receive free training in the TIP Model by Maine's Certified TIP Trainer.
- Additionally, in 2015, OCFS trained its Youth Transition Specialists to utilize the TIP Model with older youth in foster care, and in 2016, the Program Manager for *Moving Forward* will meet monthly with the Youth Transition Specialists to provide on-going training.
- The State of Maine is working on building a TIP Training team to build capacity to offer training across the State of Maine in teams, rather than the one site based trainer we currently have. OCFS has committed two (2) OCFS full-time trainers to also become Certified TIP Trainers.
- The *Moving Forward Initiative* contracts with Thrive/Youth MOVE Maine to provide Youth Support Partners to young adults receiving services through this *Initiative* as well as to provide community programming in life domain areas, and help develop and implement a stigma reduction campaign in all three counties.
- The OCFS Program Manager will complete TIP Fidelity Reviews within the *Moving Forward Initiative*. The *Moving Forward Initiative* continues to work with other state agencies to affect state level policy change and work toward program sustainability: the Department of Education, the Department of Adult Services, and the Department of Labor. Discussions focus on improved transition services for youth involved in multiple systems and as they transition from the youth to adult systems of care.
- Young Adults have reported a benefit from receiving TIP case management and participating in activities related to the *Moving Forward: Now is the Time Initiative*. Benefits include additional supports such as improving their own personal well-being, returning to and completing school, finding employment, obtaining housing and making connections.
- Youth engagement is strong. Young adults have been and continue to be actively involved in this *Initiative,* they participate in case management services, peer support and community outreach.
- Agencies report being able to more effectively engage clients who were previously not interested in case management services. One reason is because the TIP model is appealing to youth's independence. Another reason is that agencies are able to serve youth regardless of insurance type.
- In 2015, OCFS hired its Youth Coordinator for this project. This person will ensure youth voice throughout the *Initiative* and will also take the lead in community outreach and stigma reduction.
- OCFS continues to contract with Hornby Zeller Associates, Inc. to serve as the Evaluator for this *Initiative.*

Resource Family Support

OCFS contracts with a provider agency which is responsible for providing training and supportive services to resource families with the desired outcome of retention of skilled and well-supported resource families.

As a result of an RFP process, the current agency providing this service array, known as Resource Family Support Services, is Adoptive and Foster Families of Maine (AFFM). AFFM is responsible for delivery of contracted services on a statewide basis. Included in the services are those which are viewed as priority services to support resource families. Mentoring services are available to any new resource family who requests this service. Experienced resource parents are trained in a curriculum developed by AFFM in collaboration with OCFS.

Ensuring every resource family has access to participate in a peer support group in the county in which the resource family resides is another expectation of the contractor. AFFM is required to either facilitate the

support group meeting or to support the existing support group with whatever administrative or other type of support the group may need. This may include funding or providing child care for those attending support group meetings, as well as arranging for trainers to provide topical trainings during a portion of the support group meeting.

AFFM is also responsible under the terms of the contract for providing a 24 hour a day, 7 day a week warm line service to support resource families. This provides resource families with a neutral entity with which to process any challenges which may arise for resource families.

AFFM is responsible for supporting kinship families in transitioning from their former role as relative to their newly-assumed role of primary caregiver to their relative child. AFFM will work with these families to support them in their unique role as a relative working toward the goal of facilitating positive interaction between the child, the birth parent and the relative caregiver.

As all contracts now have to include performance measurements, these measures are included in the Resource Family Support Services (RFSS) contract. The contractor, AFFM, is required to report the following metrics at designated reporting periods outlined in the Rider A of their contract:

Performance Measures:

Measure 1: 100% of applicant or newly licensed resource families statewide that are assigned and contacted by (email, phone or face-to-face) a trained mentor within 30 days as reported monthly by the provider.

Measure 2: All 16 counties will have a support group that meets needs of resource families in each county.

Measure 3: 80% of surveyed District PAs will report satisfactory collaboration with the provider as reported quarterly through an OCFS delivered survey.

Child and Family Services Continuum

Child abuse and neglect prevention services are provided by the Maine Children's Trust, Inc. and Child Abuse and Neglect Councils, which receive funding and provide services in all 16 counties in Maine. The Maine Children's Trust, Inc. communicates, coordinates, and consults with DHHS Child Welfare Services management in its efforts at prevention of child abuse and neglect. The Trust receives the Community Based Child Abuse Prevention Program federal grant from ACF. In 2015 the Councils offered a combined 139 parenting educations classes, each class consisting of multiple sessions.

OCFS added a Prevention Team to the OCFS in February, 2014. This unit has begun to look at a five-year data set to establish a baseline from which to measure successes and challenges. A few of the many data points being examined include drug affected baby numbers, child deaths and serious injuries, risk factors related to removals, reports deemed inappropriate for intervention, and many others. By working with the community, other state agencies and existing systems and resources, prevention has become a clear focus within the department. Prevention strategies are implemented within policy and practice with a focus on secondary and tertiary prevention. The OCFS Prevention Team seeks to reduce repeat maltreatment rates, child deaths and serious injuries by supporting various initiatives across the spectrum of care. Empowering the community to aid in the important mission of child safety for all Maine children is a priority of the prevention team.

All reports of child abuse and neglect are received and screened by a Statewide Child Protection Intake Unit at OCFS which is staffed 24 hours a day, 365 days a year. The Intake Unit forwards screened reports to child protective supervisors in district offices for assignment. Supervisors assign moderate/high severity CA/N

reports to DHHS child protective caseworkers. Supervisors assign low/moderate severity CA/N reports to contracted Alternative Response Programs (ARP).

The *Child Assessment Policy* was revised in 2007 to include the expectation that, for in home service cases, the frequency and type of caseworker's face to face visit with the child(ren) and family should be appropriate to the family's needs and risk to the child and visits should occur at least once a month in the home. More frequent contact with families helps to establish more effective working relationships, allows for a better assessment of safety and well-being, facilitates monitoring of service delivery, and better enables the caseworker to measure and support the achievement of the agreed upon goals of the family. This policy also guides staff as to the nature and frequency of the reviews to determine if/when the Department's involvement should continue. Despite the policy revision, OCFS still struggled with having frequent, purposeful contacts with families in service cases which was evident in the data collected through the qualitative case reviews. In 2013 the OCFS Management Report was revised to include reporting of contacts made in service cases and has seen a significant uptick in the number of contacts made with children in service cases. In CY 2014 monthly contact with children involved in service cases was met, on average, 60% of the time; in CY 2015 that number was increased to 69%. In January and February 2016 the average was 84% of the time, clearly progress is being made in this area.

The Child Protection Assessment Policy is currently undergoing revisions to incorporate current practice. Due to several key staffing transitions in the fall of 2015, the work has not been completed as of this review date however is anticipated to be finalized in the summer of 2016. The components being reviewed for the revision are:

- A focused understanding of why Child Protection is involved with a family.
- Determining if abuse and neglect are present.
- Concluding through analysis the impact on the child.
- The level, if any of child abuse and neglect.
- Next steps i.e. opening a case, sending to community services or closing.

If a child protection assessment determines that a family is in need of Child Protective Services, the caseworker convenes a Family Team Meeting (FTM) to develop a family plan to increase child safety.

In July 2008 Alternative Response Program contracts were revised to include the expectation that children would be seen in three days, substantially the same response timeframe as a DHHS Child Protection Assessment.

OCFS directly provides, refers, contracts, or otherwise arranges for needed therapeutic, educational, and support services to implement the family plan. Following the FTM, the caseworker makes referrals for services outlined in the agreed upon family plan. DHHS directly pays or contracts with services such as parent education and family support, early intervention services, homemaker services, child care, individual and family counseling services, transportation, supervised visitation and transitional housing services. A full listing of contracted services can be found in the resource module of MACWIS. Families receive, directly or by referral, more intensive services, as needed, from domestic violence, mental health, and substance use treatment specialists.

DHHS caseworkers petition Maine District Court to place children in DHHS custody when a safety assessment has been completed and efforts toward reducing severe abuse/neglect have failed. In Maine, the Department may petition for custody or another disposition to protect the child. The court may order a child placed in DHHS custody upon finding at an ex parte hearing that the child is at immediate risk of serious harm. After

civil court hearing, in non-emergency situations, the court may order that a child is in jeopardy due to abuse or neglect as defined by Maine law.

When children cannot remain in their homes, initial Department social work efforts focus on kinship options. Children can be immediately placed with kin if safe kinship placements can be identified. Kinship assessment begins at the Intake phase and continues throughout our involvement with the child and family. The search for kinship placement options does not stop at removal, if kinship placement cannot be made at that time. Fictive kin placements would be the next preferred placement for the children. For example, child care providers or friends of family can be considered for placement. The next option for placement would be foster care within their home community. If therapeutic foster care is needed, the application process is streamlined state-wide and all agencies receive a detailed application as to the needs, diagnosis, habits, behaviors, likes, and dislikes of the child.

If a child cannot be placed in a family setting, various types of residential care are utilized. Residential programs vary from semi-independent living programs to 24/7 supervision. There is a universal application process in place for residential programs and the OCFS Mental Health Program Coordinators and Clinical Caseworkers are utilized to ensure that residential care is the least restrictive placement needed to provide services for the child.

Maine has a state administered District Court system, which uses standardized court forms. The Jeopardy/Permanency Plan Order documents that a permanency plan has been developed. Within ten days of a child coming into custody, a Family Team Meeting is convened to develop a Family Plan. From the time of assessment, and from the first Court Order, and throughout the period of subsequent court orders, there is dialogue, hearings and documentation in court orders about reunification objectives and times frames.

We consistently file petitions to terminate parental rights for children who have been in care for 15 of the most recent 22 months, unless case-specific information legally exempts a child. Team decision-making is used to determine if a Termination of Parental Rights (TPR) petition should be filed. If the criteria are not met, this is documented in the case record along with a justification for an alternative permanency plan, which is entered into court paperwork.

Appointment of a Permanency Guardian is a dispositional alternative in Child Protection cases in Maine District Court. This alternative provides a viable permanency option to children who might otherwise remain in foster care through to the age of majority, including children who express a desire not to be adopted. In order to be considered for permanency guardianship, the child must be in the legal custody of the Department or Tribes; reunification must have been determined to be no longer a permanency option for the child; the child must meet the definition of "special needs"; the adoption option must have been fully explored and ruled out; the permanency guardianship must be determined to be in the best interests of the child; and the family must meet all the required standards to qualify for permanency guardianship. Inherent in permanency guardianship is a respect and value for maintaining connections with family and with the cultural norms of the family. Subsidies are available to families who choose this option, with the rate, which is not to exceed the rate of reimbursement for regular foster care, negotiated with the family, based upon the level of need and the family's resources.

The OCFS has programs in place to help children prepare for a successful transition to adulthood. Youth in care are offered Extended Care (V9) services. A youth in custody who is turning 18 years old can make an agreement to remain in care, in order to accomplish the individual youth's transition goals while still receiving the support of the Department. Individualized agreements are negotiated with the youth to assist in providing specific services to help the youth achieve educational or skills training needed for successful transition to adult

self-sufficiency. If a youth will require assisted living beyond what can be provided through a V9 agreement, then when the youth is age 16 a referral is made to DHHS Adult Behavioral Health Services.

Transitional living services include ongoing training in skills such as money management and consumer skills, educational and career planning, locating and maintaining housing, decision making, developing self-esteem, household living skills, parenting and employment seeking skills among others. Prior to turning 18, the youth is assisted in applying for MaineCare (Maine Medicaid) for health insurance. Under new provisions of the Affordable Care Act, beginning 1/1/14, youth who turned 18 while in foster care will remain eligible for coverage until their 26th birthday.

Maine has no policy that defines "Other Planned Permanent Living Arrangement" as a goal or provides guidance as to when to select it. Maine's Child and Family Services and Child Protective Act, Title 22, Chapter 1071, Section §4003 B states:

> …the District Court may adopt another planned permanent living arrangement as the permanency plan for the child only after the Department has documented a compelling reason for determining that it would not be in the best interests of the child to be returned home, be referred for termination of parental rights or be placed for adoptions, be cared for by a permanency guardian or be placed with a fit and willing relative.

Maine does have policies to prepare children for independent living. All Maine children in foster care, regardless of permanency goals, are required at age 16 to have a life skills strengths/needs assessment and an independent living case plan as part of the Child Plan. The plan should have mandated education and training services as well as mandated "resource listing/training" services.

OCFS policy requires that the following be provided to the youth by the Permanency Caseworker or by the Transitional Living Caseworker: linking with occupational and college prep high school classes; assistance with linking with other educational alternatives; provision of information about financial aid for post-secondary education; information about tutoring and special education services, if needed.

Youth who were adopted or entered Permanency Guardianship after the age of 16, may request Federal Education and Training Voucher (ETV) assistance from OCFS to help meet their post-secondary financial needs, at the same level as youth on Voluntary Extended Care Agreements or who were reunified with parents, up to $5000 per academic school year. Youth whose parent/PG receives a subsidy from DHHS are also eligible to apply for one of the thirty college tuition waiver slots for schools within the University of Maine system.

In 2014, Maine passed legislation, LD 1683: **"An Act to Improve Degree and Career Attainment for Former Foster Children."** This provides funding to youth who aged out Maine's V9 Program at 21, in order to finish their post-secondary education, up to the age of 27. This new program, called the *Alumni Transition Grant Program (ATGP),* also provides grant recipients with Navigator support, and establishes a committee to report outcomes to the Legislature.

In 2011/2012 OCFS developed a comprehensive Youth Permanency Review Strategy which included the Permanency Review Team based on the Casey Family Program Permanency Round Table model. This teaming process built on the Family Team Meeting model and relied on collaborative teaming to ensure that youth's needs for safety, permanency and well-being were met

Casey Family Program conducted a second training in March 2013 to all members of the individual Permanency Review Teams to ensure that districts were utilizing a consistent approach in these meetings.

Going forward the plan is for PRT meetings to be held at least monthly reviewing children who have been in foster care at least six months.

Child Welfare continues its commitment to assist children and youth in out-of-home placement to reside in the most normative setting warranted by the child's safety and well-being circumstances.

OCFS continues to stress the importance of relative and kinship placement as the most desirable type of out-of-home placement when children cannot remain in the homes of their parents. Policy and procedure requires staff to explore the possibility of relative and kinship placements on an on-going basis throughout the period of involvement with the family. In addition to emphasizing the need for relative and kinship resource searches and placement, OCFS is also committed to funding services to help support and maintain kinship placements.

While we have made significant improvements in the percentage of placements with relatives and kin, we continue to view opportunity to improve in this area.

OCFS Visitation Policy implemented in 2005 emphasizes the importance of visitation between children and their family members as a key service provided to assist with reunification efforts. Policy clarifies visitation purposes, visitation procedures, parental/participant responsibilities and the role of the foster parent or relative caregiver.

OCFS visitation contracts went through the State procurement process in 2015. As a result three regional contracts were implemented on July 1, 2015. The contracts emphasize the importance of visitation between children and their family members as a key service provided to assist with reunification efforts. Policy clarifies visitation purposes, visitation procedures, parental/participant responsibilities and the role of the foster parent or relative caregiver. OCFS staff collaborated with providers of contracted supportive visitation services for the purpose of finalizing performance-based measurements for the visitation contract. As a result of this effort, contracted agencies now report data relating to indicators of child safety during the visit. The following are measures put in the new contracts:

Performance Goal and Objectives

Goal: To provide safe and supportive visits between children who are in DHHS custody and their parents (and/or other identified individuals) during the Reunification and rehabilitation process.

A. Objectives:
   1. Children referred by DHHS or federally recognized tribe have a safe and supportive environment for arranged visits with their parents and other identified individuals, as measured by monthly reports (Attachment D).
   2. Parents participating in the program demonstrate improved parenting skills, as measured by monthly reports (Attachment D).

B. Performance Measures

   The Provider shall submit monthly reporting of, but not be limited to, the following:
   1. The number of interventions as defined in the family's Rehabilitation and Reunification plan per visit, in order for DHHS to collect, analyze, and report quarterly data that assesses the performance.

2. The raw score of the Quality of Visitation Scale (adapted from the *California Reunification Assessment Tool*, 2009 per visiting parent, per visit, in order for DHHS to collect, analyze, and report quarterly data that assesses the following performance measure:

C. Internal Quality Control

The Provider shall survey all adult recipients of the service at least once monthly, or a minimum of once during the service period if less than one month, for quality improvement purposes.

Results will be analyzed and reported to the DHHS annually.

The Provider will use client feedback to improve services, as evidenced by quantitative and qualitative data provided to DHHS.

These performance measures are for contracts that provide Supportive Visitation Services for OCFS. These measures work toward maintaining the parent-child relationship in a safe and protected environment. This will assist with the reduction of a child's sense of loss and/or abandonment and promote opportunities for reunification.

Conducting program evaluations is an integral part of OCFS operation and management because it helps to examine whether we are meeting the needs of client base and achieving the overall goals of this program. OCFS is currently working internally and in conjunction with Office of Continuous Quality Improvement on a database for these measures. Data has been and is currently being collected by a program specialist. OCFS is striving to find the best method to review and improve program performance through these measures.

Strategies used will help standardize the service and support the goal of reunification. They will include the following:

Supportive family visits shall consist of skilled observation and assessment of parent-child(ren) interactions and will include modeling/teaching parenting skills during scheduled visit times by a trained Visitation Support Worker (VSW). The parameters of the scheduled supported visits will be determined through the Family Team Meeting process with the family's assigned DHHS caseworker and the family. The Provider's VSW shall participate in Family Team Meetings as requested by DHHS staff according to the family's individualized Rehabilitation and Reunification Plans and court order.

Visitation between children and their parents, siblings, extended family members, or other significant persons serves many purposes. Visitation not only promotes continuity, but may serve additional functions in aiding progress toward permanency goals identified in the family's Rehabilitation and Reunification Plan. Some of these purposes include:

1. To prevent child abuse;
2. To reduce the potential for harm to victims of domestic violence and their children;
3. To enable an ongoing relationship with a strengths-based approach between the non-custodial parent or significant persons and child;
4. To facilitate appropriate child/parent interactions during supervised contact in the least restrictive setting;
5. To help build safe and healthy relationships between the parents and children using a parenting/teaching model;
6. To provide written, objective documentation to DHHS regarding supervised contact with families who are receiving services;

7. To reduce the risk of parental kidnapping; and
8. To facilitate Reunification as ordered by the court.

As visitation support staff are expected to actively engage birth parents during the visit and to facilitate positive interaction between parents and children, one would expect that as visitation support staff respectfully engage parents, informing them of any behaviors of concern which were observed during the visit, and noting positive progress during the visit, the behaviors of concern will decrease over time, and fewer.

Section §4068 of Title 22, gives Courts greater power in Child Protection cases to order sibling visitation if the court finds the visitation is "reasonable, practicable, and in the best interests of the children involved". The court can order the custodians of the children involved to make sure the children are available for visitation with each other. This statute gives the child, or someone acting on his behalf, the right to request visitation with a sibling from whom the child has been separated due to a child protection case.

While the statute does not allow a sibling to request visitation from a sibling who has been adopted, it does require the Department to work with prospective adoptive parents to establish agreements in which the adoptive parent will allow contact between the adopted child and the child's siblings, in circumstances where the contact is in the best interest of the child.

The rights of Maine youth in care are defined in law, in policies, and in statements of belief. A workgroup including youth members was formed to develop a Bill of Rights for Maine Youth in Care. More than a philosophical statement about rights that youth in care deserve, the resulting publication is a resource for youth in care, for their care providers, and for OCFS staff to identify and compile information about these rights, thereby ensuring the rights of youth are understood and upheld in the delivery of services to youth.

School Transfer Policy and Practice for Children in Care provides guidelines and strategies that support positive educational outcomes for children in the custody of the State of Maine. In 2010 language was added to Maine Statute to meet the Fostering Connections Legislation around educational stability. The final decision on which school the child/youth will attend will be made by OCFS, but done in collaboration with the school district. The law requires that the school abide by the decision made by OCFS with OCFS paying for transportation costs if needed.

The OCFS Policy Workgroup that we developed as a strategy to meet PIP needs, reviewed the Educational and School Transfer Policies to ensure that the policies reflected the law changes around school attendance. The decision was made to incorporate several different policies related to education into one policy. In March 2012 the finalized Education Policy and PowerPoint was disseminated to district staff.

Since 2004, Maine youth in care have been able to attend Camp to Belong Maine (CTBM), a summer camp program for siblings who are separated by out of home placement. OCFS has provided significant support to CTBM by providing funding for administrative costs, paying camper fees, allowing OCFS staff to be volunteer counselors without having to use vacation time, helping to plan for camp during the year, and coordinating camper referrals in their Districts. OCFS views that this is a way to increase normalcy between siblings, who otherwise do not see each other on a day-to-day basis.

The 2015 reorganization included the creation of a clear Children's Behavioral Health Team. Children's Behavioral Health services focus on behavioral health treatment and services for children from birth up to their 21st birthday. Services include providing information and assistance with referrals for children and youth with

developmental disabilities/delays, intellectual disability, Autism Spectrum Disorders, and mental health disorders.

The Behavioral Health Unit:

- Ensures that any child between the ages of 0-21 and their family identified as needing a behavioral health intervention have access to and receive this service in the most effective, least restrictive setting as possible.
- Ensures that all youth transition successfully to adulthood.
- Ensures that all possible employment options are sought for all youth.
- Works with the Office of Maine Care in developing and implementing policy related to children's services.
- Ensures that children receive evidenced-based practices whenever possible.
- Oversees the mental health block grant funding and implementation.
- Oversees Homelessness and Transitional Living Programing.
- Develops and Implements the Partnering for Success CBT Plus initiative.
- Directs and oversees the *Now Is The Time (NITT) Moving Forward* Grant
- Provides Program expertise for all contracts, ie respite, Autism Society, BHP training, deaf services, etc.
- Oversees and reviews of youth receiving residential treatment in state and out of State.
- Works closely with the Office of Quality Improvement and OCFS Quality team.
- Reviews and Follows up on reportable events Community Agency reviews.
- Collaborates and consults on child welfare cases for youth with behavioral health need.
- Follows up on grievances and complaints.
- Collaborates with other state agencies.

Resource Coordination: Three Resource Coordinators are responsible for developing and maintaining a comprehensive array of behavioral health resources for children with Autism, Intellectual Disabilities, and mental health problems. They are the primary contact for agencies seeking to provide behavioral health services for children, and for agencies seeking information and/or technical assistance from the Department. They organize regular provider meetings to ensure clear communication between the Department and the children's services providers, and disseminate information regarding Department policies and legal requirements. They develop resources to meet needs in underserved areas. Other responsibilities include providing technical assistance to agencies regarding Plans of Correction that result from QA monitoring by other OCFS staff. They may address constituent complaints and will monitor data and reports regarding children's behavioral health services, and bring summary information and trends to OCFS management.

Policy Coordination: Policy Coordinator and appropriate staff:

- Works closely with the Office of Maine Care to write and implement Maine Care Policies that govern services for children in need of behavioral health treatment.
- Create and implement standards of care for Treatment Services.
- Ensure that Evidenced-Based Practices are used as much as possible and work to increase the use of EBP in children's behavioral health service.
- Create Performance Measures for children's behavioral health services.
- Work closely with APS Health care.
- Review and analyze children's behavioral health data.

Program Coordination: Ten Children Behavioral Health Program Coordinators are responsible for ensuring that youth's emotional and behavioral challenges receive the most effective services in the least restrictive environment. They are responsible for providing behavioral health education and resources to Child Welfare

Staff and the community. They provide on-call coverage on a rotation schedule for out of state hospitalization. They are part of a statewide team of professionals keeping abreast of promising and evidenced-based practice models, informing policy and practice, and maintain consistency across districts.

Care Coordination: Five Care Specialists are responsible for ensuring that youth in treatment services are receiving effective, quality treatment, and are safe within their treatment environment. Specific areas of focus are Residential Treatment, Crisis Services, and Children with Special Health Care needs. Tasks include:

- Review and Follow up on Reportable Events.
- Grievance and Complaint Follow-up.
- Three-Person Committee Participation.
- Residential Reviews.
- Challenging Youth Placement Work.
- Behavioral Health Training.

In January 2015 the new Child Health Assessment (CHA) Protocol was distributed to the District Management Team with the expectation that all staff will be trained on the protocol. The priority of the CHA protocol is to ensure that all staff knows and follows the law regarding medical services (medical, dental, mental health and developmental screening). This includes medical appointments being made for children within 10 days of entry into foster care, children 4 years and younger will be referred to Child Development Services and that the Pediatric Symptom Checklist (PSC) will be used by the caseworker with the parent/caregiver and/or youth to screen children in the 4-16 year old age range for clinically significant behavioral, cognitive, and emotional challenges. The PSC has been validated for use with children and families in the child welfare population. The tool will be administered in the first 30 days of the assessment whenever there is a substantiated finding and/or a child enters care.

In response to Fostering Connections Legislation Maine engaged with several collaborative workgroups to ensure compliance. These efforts continue to address:

- Health screening and follow up screenings.
- How medical information will be updated and shared.
- Steps taken to ensure continuity of care that promote the use of medical homes for each child.
- Oversight of medication which has been addressed by a multi-system workgroup that developed a checklist for reviewing the use of psychotropic medications for youth in foster care.
- How the state consults with medical and non-medical professions on the appropriate treatment of children.

Adoption Incentive

In September 2015 Maine was notified by ACF of a Grant Award of $66,497 for Adoption and Legal Guardianship Incentive Payments. Maine's plan to use the funds includes:

1. A portion of the money will be used to support physical plant funds for fictive kin who are in the process of finalizing a PG or adoption. This will be approved at the discretion of the Licensing or Adoption Program Manager.

2. A portion of the money to provide short term emergency respite for PG or Adoptive families at serious risk of disruption. This will only be approved when all other alternatives have been ruled out. The respite would be used while we work with a Mental Health Program Coordinator and other service providers to establish the services needed to help prevent disruption. This will be at the discretion of the Adoption Program Manager.

Services offered under Title IV-B, Subpart 2- Promoting Safe and Stable Families

OCFS, Child Welfare Services will use IV-B, Subpart 2 funds to provide family preservation services, support reunification efforts, increase and support relative/kin placements, support adoption promotion, and expand services to expedite permanency within acceptable timeframes for children in the care of DHHS. Expenditures are shown on the CFS, Part 1 that follows.

Family Preservation: Approximately 20% of funds will be used for Family Preservation Services.

- Expansion and support of the Community Partnership for Protecting Children (CPPC) program.
- Each county Child Abuse and Neglect Council provides an average of 18 parenting classes/learning sessions per year.
- Kinship Care Services- information and support services to be provided to relatives who are helping care for their grandchildren, nieces and nephews to alleviate the need for those children to enter state foster care.
- Supporting evidence-based parenting skills and supportive visitation.
- Continued use of funds for family preservation services provided by direct staff intervention with families who become known to DHHS, but who, with sufficient support and referral to services, can maintain their children safely in their own homes.

Family Support Services: Approximately 20% of funds will be used for Family Support Services.

- Kinship Care Services-Through contract, information and support services will continue to be provided to relatives who are helping raise their grandchildren, nieces and nephews. These services are available to all families, not just those who are caring for children in the custody of DHHS.
- Support of domestic violence advocates in OCFS district offices.
- Expansion and support of the Community Partnership for Protecting Children (CPPC) program.

Time-Limited Family Reunification Services: Approximately 20% of funds will be used for time-limited family reunification Services.

- Post Permanency Support Program (AFFM)
- Family Reunification Program

Adoption Promotion and Support Services: Approximately 20% of funds will be used for Adoption Promotion and Support Services.

- Recruitment of foster/adoptive homes, support services for potential adoptive families, and child specific adoption promotion efforts.
- Kinship Care Services-Through contract, information and support services will continue to be provided to relatives who are helping raise their grandchildren, nieces and nephews. These services are available to all families, not just those who are caring for children in the custody of DHHS.

Other Service Related Activities: Approximately 10% of funds will be used for Other Services, Related Activities and 10% to administrative costs.

- Other related activities will include continued utilization of research, inter-state communication and sharing of information and technology and training/planning activities, statewide, which are designed to advance the goals and activities set forth in this plan.

Service Decision Making Process for Family Support Services

The Maine Department of Health and Human Services also contains a centralized contracts division. This division is responsible for the integrity of the State's purchased services rules. This division is responsible for all contracts between any office within DHHS and any provider of services. In collaboration with OCFS

program specialists, the contracts division creates and administers the contract, processes payment for services, receives and evaluates required performance reporting, and monitors trends. Performance measures are included in Rider A for all contracts. Service providers must adhere to the CONTRACT/GRANT/PURCHASE GUIDELINES overseen by the Division of Contract Management. The DHHS Contract Management Division receives and analyzes cost data provided monthly or quarterly from service providers and provides analysis to OCFS on the provision and cost of contracted services used by recipients. Contract agencies report and are reviewed on a regular basis by the OCFS Community Partnerships team based on the terms of the contract, and the results are reported to OCFS Management. It is the responsibility of the OCFS senior management team to approve scope and definitions of service, performance measures, payment schedules, approval of the continuation of ongoing contracts, as well as to authorize the funding amount and fund source.

Populations at Greatest Risk of Maltreatment & Services for Children Under Five Years Old

Maine's policies reflect the recognition that very young children are especially vulnerable and are in need of timely intervention and assessment:

- The *Intake Screening and Assignment Policy* provide assignment practice standards for districts to utilize in decision making in terms of assignment reports of child abuse and neglect. One of the factors to be considered is the vulnerability of the alleged child victim, "*Infants and very young children are especially vulnerable".*
- The *Child Protection Assessment Policy* includes criteria to be used in determining whether a family is need of Child Protective Services one being a family with *children under age 6.*
- Policy stipulates that all children under the age of 5 who are have been involved in an assessment resulting in a finding of child abuse and neglect be refereed to Child Development Services for follow up.

Within 3 days of a child entering custody they are to have an appointment scheduled for a medical evaluation in the near future. Follow up to those appointments could be a variety of services when appropriate.

In terms of family foster parent-to-child ratio, Maine's Foster Home Licensing Rules stipulate that "*The total number of children in care may not exceed 6, including the family's legal children under 16 years of age, with no more than 2 of these children under the age of 2. The only exception which may be made to the number of and ages of children is to allow siblings to be kept together".* In terms of therapeutic foster parent-to-child ratio, Maine's Foster Home Licensing Rules stipulate that *"The total number of children in a Specialized Children's Foster Home may not exceed 4, including the family's legal children under 16 years of age, with no more than 2 children under to age of 2." "The only exception, which may be made to the number and ages of children, is to allow siblings to be placed together."*

Maine prioritizes placements of infants and toddler with relatives that support timelier reunification and adoption. Maine recognizes that whether being cared for by their parents, by kinship caregivers, or by child care providers, young children require stability in all areas of their life which has impact on their positive early childhood development. These young children are also a group that would be reviewed through the Permanency Review Teams as the practice in the last year is for all children who have been in care 6 plus months would be reviewed in this forum. Maine has worked to identify and implement practices to support early childhood service delivery that are based on research about child development and the impact of early trauma and adversity. This promotion of evidence based programs for birth to five population and their families is furthered through shared knowledge of the research and collaboration with home visiting and nursing partners.

The data indicates that these efforts have helped as since 2012 the number of children in care age 0-5 has decreased- 2012 (950); 2013 (848); 2014 (763) and 2015 (544).

Maine identifies those populations at greater risk of maltreatment by following the Child Protection Assessment Policy which was revised in 2007 to give specific guidance around child protection assessment decisions as to when families are in need of child protective services. This policy was designed to reduce recurrence of maltreatment by requiring child protective services in event of:

- Signs of danger, with agreed upon safety plan.
- Safety plan failure.
- Findings of maltreatment with specific signs of risk that is likely to result in recurrence of maltreatment.
- Findings of child abuse or neglect within previous 12 months.
- Parental unwillingness to accept services or to change dangerous behaviors or conditions.
- Priority response to children under six who are more vulnerable.

In addition, the state addresses the needs of families affected by substance abuse and domestic violence, key indicators of risk for child abuse and neglect, with in-house consulting staff and statewide coalitions that include caseworkers as participants.

M.R.S.A. 22 §4011 A 7 specifically addresses children under 6 months of age or otherwise non-ambulatory as part of Maine's mandated reporting laws. This law recognizes that there are certain injuries, such as fracture of a bone; substantial bruising or multiple bruises; or subdural hematomas; that when they are occur in children under the age of 6 months or children who are non-ambulatory are more likely to be inflicted.

Preventing Sex Trafficking and Strengthening Families Act P.L. 113-183:

The state of Maine has started the process of implementing H.R 4980, Preventing Human Trafficking and Strengthening Families Act that was enacted in 2014.

The Office of Child and family Services as well as a representative from the Commissioner's Office have assembled a multidisciplinary workgroup to research, discuss and give guidance around implementing the many pieces of this legislation.

Workgroup Members	
Holly Stover	DHHS Commissioner's Office
Jenni Smith	OCFS Policy & Training Specialist
Destie Holman-Sprague	Maine Coalition to End Sexual Assault
Meg Hatch	Maine Coalition to End Sexual Assault
Samantha Durham	Clinical Social Worker, Longcreek Juvenile Detention Center
Leslie Webster	OCFS, Information Services Unit
Kristine Gefvert	Office of the Courts
Linda Brissette	OCFS, Resource Family Program Manager

Kristi Poole	OCFS Title IVE & Adoption Program Manager
Charlene Musgrave	OCFS, Information Services Unit
Karen Dostaler	Assistant Attorney General
Lori Geiger	OCFS, Information Systems Program Manager

The workgroup was tasked with researching current practice, policy and law to identify areas that need to be changed or enhanced due to this legislation, and to recommend appropriate changes to ensure that the state of Maine is compliant with this law in the timeframes given. The group has met twice and will meet monthly to ensure that the process of implementation is a smooth one.

Please see the **Appendix A. - HR 4980 Planning Committee**

Children in State Custody from Failed Inter-Country Adoptions

The state takes responsibility where needed for children adopted from other countries, including activities intended to serve children entering state custody as a result of the disruption of placement for adoption. Maine's private adoption agencies make every effort to replace a child from a disrupted or dissolved adoption into another family within the agency or with another private agency so that the child does not have to enter DHHS custody. The DHHS Office of Vital Statistics report that the number of children adopted from other countries by Maine families during calendar year 2015 was 25.

During 2015, the Maine Department of Health and Human Services did not record any disrupted international adoption involvement.

Consultation and Coordination between States and Tribes

Maine has four federally recognized tribes with five locations: the Penobscot Nation (Indian Island, Penobscot County, District 6), the Aroostook Band of Micmacs, (Aroostook County, District 8) the Houlton Band of Maliseets (Aroostook County, District 8), the Passamaquoddy Tribe (Indian Township and Pleasant Point, Washington County, District 7)

In February 2010, the Governor of Maine signed an Executive Order directing all state agencies to work collaboratively with Native American Tribes. Tribal child welfare representatives were already meeting with state child welfare representatives quarterly or sooner as needed or requested. This group was, referred to as the ICWA Workgroup, first began meeting in 1999. In 2010 this workgroup began to develop the Truth and Reconciliation (TRC) to discover the truths about people's experiences with the state's child welfare agency. This process expanded the current group's membership to include other tribal and non-tribal community members. This became the Convening Group for the TRC. The Convening Group was responsible for developing the TRC's Declaration of Intent, its Mandate, and to help with seating the Commission. Since the Commission was seated this group is now called REACH (Reconciliation, Engagement Advocacy, Change & Healing) Workgroup whose purpose is to supporting community healing and support the TRC process and the recommendations that come from their work. This forum is one of the ways OCFS seeks to assure ICWA compliance. In 2015, with the conclusion of the TRC work, the ICWA workgroup was reestablished with representatives from the state child welfare, tribal child welfare, OCFS Policy & Training representative and the Attorney General's Office. The goal of this group is to having ongoing discussions and develop policies and strategies to continue the work related to building collaborative relationships between state child welfare and

tribal child welfare. In July 2012, a comprehensive *Indian Child Welfare Policy* was finalized. This policy was developed by the ICWA workgroup as a stand-alone policy, rather than having pieces of ICWA interspersed throughout various OCFS policies. This policy provides clear direction to OCFS staff that the tribal child welfare staff is co-managers of the case in every aspect through the life of the case. In the fall of 2015 the ICWA Workgroup modified that policy to include the new BIA Guidelines. OCFS continues its practice of sharing draft policy with the tribal child welfare personnel for comment.

The Department has an agreement with the Penobscot Indian Nation, which was signed in 1987, to work cooperatively toward the goal of protection of children who are suspected to be or are victims of abuse or neglect. The Department also has an agreement with the Houlton Band of Maliseet Indians, which was signed in 2002 to assure that they have maximum participation in determining the disposition of cases involving the Band's children. This maximum participation has since been extended to all federally recognized tribes in Maine.

OCFS caseworkers receive ICWA training during their first six months of employment. This training is conducted by a Native member of the ICWA workgroup and the OCFS ICWA liaison. The training is comprised of: a video of former Native foster children who were in the custody of the State of Maine prior to the passage of ICWA speaking of their experience and feelings of not belonging; the TRC process which also explains the history of what happened to Native Americans in this country and why ICWA was necessary and the Indian Child Welfare Policy. Caseworkers, as part of the Child Protection Intake process and the initial CPS assessment, ask the family if they have any Native American heritage. The district court judges also ask questions regarding Native American heritage at court proceedings. When Native American heritage is known before the first contact with the family and if their Native heritage is from one of the federally recognized tribes in Maine, the tribe is notified and invited to participate in the assessment. If Native American heritage is not known until after the first visit or at any other point in the assessment or case process, the tribe is invited to participate from that point forward. If the tribe is unable to accompany the OCFS caseworker the caseworker is still expected to contact their tribal child welfare counterpart to make joint decisions regarding the assessment/case.

In cases where ICWA applies and children are removed, caseworkers provide written notification to the Native American families and the tribe, informing them of the right to intervene, regardless if the tribe is a Maine tribe or not. OCFS recognizes homes that have been licensed or approved by the tribe as a fully-licensed foster/adoptive home. If the family is a relative or unlicensed placement with a relationship with the child or family, that family is considered for possible placement option, as is the case with all children entering DHHS custody. DHHS works with the tribe and the family to help them become either a tribally approved resource or a State licensed resource. OCFS will accept a home study conducted by the tribe and will coordinate with them as the family moves through the State licensing or Tribal approval process.

OCFS works with Native families, as we work with all families, to prevent the removal of a child from the home. This includes an assessment of the situation and providing services to lower the potential risk of child abuse and/or neglect. In Indian Child Welfare cases the caseworkers also involve the tribe in planning for the family. In the policy the tribe is considered co-managers of the case with OCFS, and joint decision making is the expectation. It is also recognized that the tribe may offer a distinct set of services and supports for families. The services/supports the tribes may be able to offer families does not negate the fact that Native children in state custody are eligible for the array of services offered to all children and families which include, but is not limited to: counseling, substance abuse services, in-home supports, family visitation and parenting classes.

In addition, contract language with services such as the Alternative Response Program and transportation includes tribes, therefore, children in tribal custody may also access state funded contracts.

The Penobscot Nation and the Passamaquoddy Tribe have a tribal court system and are therefore able to take custody of tribal children residing on reservation or tribal territory without the need to have the child enter the custody of the State of Maine. Due to lack of resources, the tribes do not always request a transfer to tribal court when a native child, not living on the reservation, may enter care. The Aroostook Band of Micmacs and the Houlton Band of Maliseets do not have a tribal court system therefore; children from these tribes must enter state custody through the State of Maine District Court system.

In helping the tribes prepare to have their own IV-E plan, Maine's OCFS IV-E Program Manager provided in-person training on three occasions. There have also been numerous email and phone discussions with Tribal staff. The Program Manager has explained our determination process and sent several OCFS policies, training tools, manuals and links to IV-E information. OCFS will continue to work collaboratively with the tribes on issues/initiatives. OCFS recognizes the need to update its agreements with each of the tribes; however there have been challenges in completing this work due to resources limitations.

The final APSR and CFSP documents are also available on line and available to the public on http://www.maine.gov/dhhs/ocfs/provdatareport.shtml.

Many of the above-cited activities are ongoing and will continue through 2016. This includes regular meeting with the DHHS, OCFS – ICWA liaison to ensure compliance with ICW policy and to allow any strengths and challenges to be discussed, training for both new staff and experienced staff. In addition the Indian Child Welfare Policy was updated to include the new federal guidelines.

Tribal Representation	
Tribal Affiliation	**Contact Name**
Houlton Band of Maliseet	Lori Jewell , ICWA Program Director
Aroostook Band of Micmac Indians	Luke Joseph, ICWA Program Coordinator
Passamaquoddy Tribe at Pleasant Point (Sipayik)	Genevieve Doughty, Social Services Director
Passamaquoddy Tribe at Indian Township (Motahkmikuk)	Bea Lily, Social Services Director
Brooke Loring	Penobscot Nation Child Welfare Director
Penobscot Nation	Debi Frances, Human Resources Assistant Director

Monthly Caseworker Visits

Maine has a fully-implemented SACWIS system (MACWIS) which stores all of the data required to track monthly caseworker visits. This data is provided to management and district Program Administrators through the Monthly Management Report. The Associate Director of Child Welfare meets regularly with District Program Administrators to review the data and support full compliance. The requirement for monthly contact is

clearly stated in policy revised in 2008: *Child and Family Services Policy Manual; V.D.-1 Child Assessment and Plan.*

In order to track compliance of the ACF caseworker monthly contact expectation, Maine built a MACWIS report that automatically generates data on caseworker compliance with monthly contact with at least the majority of visits occurring in the child's place of residence. This provides a statewide average, as well as broken down by district. OCFS is working toward the goal of seeing youth in care and in services cases, as well as parent/caregivers every 30 days as opposed to monthly recognizing that more frequent contact is linked with more successful case outcomes.

OCFS will continue to use the caseworker visit funding (section 436(b)(4) of the Act) on enhancing technologies to allow more efficiencies of caseworker time while out of the office, allowing more time in the home of the families they serve. This technology allows caseworkers to have immediate contact with their supervisors while in the field, providing opportunity to consult and make timelier decisions related to the safety, permanency and well-being needs of children and families. When caseworkers feel supported and safe doing this difficult work, the likelihood of caseworker retention is significantly increased.

As evident in the chart below, Maine has been successful in meeting this expectation:

STATE OF MAINE FACE TO FACE CONTACT REPORT FEDERAL FISCAL YEAR 2015 OCTOBER 1, 2014 - SEPTEMBER 30, 2015					
MONTH (FFY2015)	**# SEEN**	**TOTAL IN CARE FOR MONTH**	**% Seen**	**# Seen In Home**	**% In Home**
OCTOBER	1749	1795	97%	1593	89%
NOVEMBER	1719	1779	97%	1543	87%
DECEMBER	1752	1799	97%	1602	89%
JANUARY	1751	1811	97%	1596	88%
FEBRUARY	1746	1817	96%	1583	87%
MARCH	1769	1821	97%	1602	88%
APRIL	1771	1827	97%	1596	87%
MAY	1785	1849	97%	1588	86%
JUNE	1779	1832	97%	1591	87%
JULY	1803	1854	97%	1602	86%
AUGUST	1796	1850	97%	1616	87%
SEPTEMBER	1790	1829	98%	1615	88%
FEDERAL FISCAL YEAR TOTAL	**21210**	**21863**	**97%**	**19127**	**87%**

Targeted Plans within the CFSP

Chafee Foster Care Independence and the Education and Training Voucher Programs -See Appendix B

ETV Funding- See Appendix C

CAPTA Plan- See Appendix D

Foster and Adoptive Parent Diligent Recruitment Plan

For several years, Department staff were responsible for recruitment of new foster homes. However, staff were unable due to competing priorities to effectively meet an identified need for diligent recruitment for foster families to care for children in foster care.

As a result of this identified need for diligent recruitment, the Department issued a Request for Proposals for a recruitment service provider. OCFS contracted with a provider agency, KidsPeace. Active recruitment services were implemented during the summer of 2015. The name selected for this recruitment service is A Family for ME. OCFS managers meet monthly with contracted agency managers and direct service staff who are responsible for delivering A Family for ME to share progress towards full implementation of this statewide-delivered service array. Roll out of this new program was thoughtfully carried out, beginning with development of recruitment materials and progressing to general recruitment efforts. These efforts progressed toward more targeted efforts to recruit families for three specific populations of children in care who are in need of more foster homes:

1. Babies who are born drug-affected who are in the process of reunification with their parents;
2. Children and youth who are ready for discharge from residential treatment programs without an identified placement family; and
3. Larger sibling groups who are in need of caregiver homes who can accommodate placement of the entire sibling group.

During the next contract year of this service, focus will intensify upon child-specific recruitment to support children achieving legal permanency through adoption. This child specific recruitment will involve focus upon Heart Gallery and upon television and other forms of media to increase awareness of permanency needs of children who are awaiting an identified adoptive family in Maine.

This service will greatly enhance our ability to place children in foster care in homes which match the cultures and communities from which they originate.

As part of our renewed focus, we will be identifying children within our population who are in need of diligent recruitment as well identifying resource materials which are culturally and linguistically accessible to those whom we are diligently recruiting as placement families for those identified children.

<u>OCFS Foster & Adoptive Recruitment Plan:</u>

1. A description of the characteristics of children for whom foster and adoptive homes needed:
    - OCFS is recruiting homes for children age birth through age 18.
        - Children currently entering foster care are those younger (0-5) and are frequently a member of a sibling group and are often drug-affected.
        - Children who are in need of placement frequently have significant behavioral challenges requiring more specialized parenting.
        - Older youth who require caregivers who have knowledge and desire to provide support, guidance and/or permanency to youth transitioning to independent living/adulthood.
2. Specific strategies to reach out to all parts of the community:
    - Multi-tiered approach to recruitment that includes general, targeted and child specific recruitment.

- Recognize the diversity of parenting skills that we are seeking and target parents with that particular expertise. With our contracted Recruitment agency provider partner, we will meet with community members, business and civic groups, and with schools and churches to inform them of recruitment needs and to enlist their support as partners in this endeavor.
- OCFS will collaborate with the contracted Recruitment agency provider in also meeting with media partners to develop television, radio and print material for distribution.
- OCFS understands the need to recruit for diverse populations, including religious, LGBTQ, racial, ethnic and cultural groups. We will assure that staff are culturally competent and that translation services are available.
- OCFS needs to work with nursing staff and other professionals who can provide us with guidance towards meeting the care needs of medically-impacted youth.
- Recruitment Services will be supported through a Request for Proposal.
- OCFS will develop strategies to assure that kinship placements are consistently explored as a priority whenever possible.

3. Diverse methods of disseminating both general information about being a foster/adoptive parent and child specific information:
   - Child specific recruitment will occur through the child's community such as church, social activities, school activities. Child profiles will be sent to all district offices when exploring for a particular home. Concurrent planning is considered for all applicable youth. Maine often seeks placement with relatives in other states when no in-state resources are identified.
   - Targeted recruitment identified a population of youth in care with the highlighted need for increased resource families, i.e. teenagers, infants who are drug-affected and sibling groups.
   - General recruitment is through media and educational programing in the community.
4. Strategies for assuring that all prospective foster/adoptive parents have access to agencies that license/approve foster/adoptive parents, including location and hours of services so that the agencies can be accessed by all members of the community:
   - All licensing is completed through the OCFS.
5. Strategies for training staff to work with diverse communities including cultural, racial and socio-economic variations:
   - Training specific to the Indian Child Welfare Act is conducted in pre-service training of all new caseworkers.
   - OCFS recognizes the importance of developing and implementing a culturally competent training unit that will be implemented consistently for all staff. Our intention is to enhance our current training curriculum to reflect increased diversity in our state.
6. Strategies for dealing with linguistic barriers:
   - OCFS recognizes the importance and need of developing and implementing a statewide comprehensive system of translation. We are currently working with our Office of Multicultural Affairs to gain increased information and understanding regarding the details of this plan.
   - OCFS understands the needs to expand services to our deaf and hard of hearing resource family community and to increase usage of interpreter services and TTY devices when this will enhance effective communication.
7. Non-discriminatory fee structures:
   - OCFS does not have fees attached to recruitment and licensing.
8. Procedures for timely search for prospective parents for a child needing an adoptive placement, including the use of exchanges and other interagency efforts, provided that such procedures ensure that placement of a child in an appropriate household is not delayed by the search for a same race or ethnic placement:
   - OCFS believes in concurrent planning for all youth. Kinship placement is the priority choice of placement as such placements most ideally reflect the cultural ethnic diversity of children

entering foster care. OCFS includes fictive kin in its definition of kin in its kinship policy. Fictive kin are recognized and validated as having significant relationships with the child and family which may assume the same characteristics of relative relationships. OCFS recognizes that as Maine becomes an increasingly diverse state we need to continue to expand our policy, procedure and protocols fictive kin in its definition of kin in its kinship policy. OCFS recognizes that as Maine becomes an increasingly diverse state we need to continue to expand our policy, procedure and protocol.

Deliverables and Performance measures for the current contracted service **A Family for Me** include the following:

I. DELIVERABLES

The provider shall:

a. Develop and implement a statewide recruitment plan that will allow for adaptability to meet the Department Office of Child and Family Services (OCFS) District Needs. The provider shall submit a statewide plan which shall be approved by the Department.

   This plan can be adaptable on a district-by-district basis, to meet the placement needs of children currently in foster care and those expected to enter foster care, including sibling groups, adolescents, and children birth to age three, children with medically fragile conditions, children with challenging behaviors or developmental disabilities, and children from birth parent families in the reunification process. This plan must include general recruitment, targeted recruitment and child specific recruitment.

b. Develop a plan to show how they will limit themselves to recruiting only twenty (20%) percent of the Resource and Foster Families for their own program.

c. Utilize the developed timeline for the roll out and in meeting milestones of this contract.

d. Operate a toll free number, 1-844-893-6311 which shall allow any interested party to call to gain further information and knowledgeable about the program and process of becoming licensed.

e. Operate a website http://www.fostercare.com/a-family-for-me/ which will allow for the dissemination of information for interested parties.

f. Develop and gain approval from the department with all marketing materials.

g. Develop a marketing campaign (radio, print and TV) that will allow the provider to reach the largest possible audience statewide and that will allow them to adapt their marketing campaign to Department OCFS District level. The provider shall develop their outreach through five main channels, seeking three contacts in each area per month.
   i. The main channels shall be but are not limited to the following: churches, schools, local media, business, and community events.
   ii. The provider shall utilize the name of A Family for ME for their marketing campaign. The provider shall utilize the marketing method of Thursday's child which showcases a child during specific timeslots through television media.

iii. The provider shall utilize the Heart Gallery. The Heart Gallery should have images which are embedded and don't allow the image to be downloaded or saved to a user's computer.

h. Provide the training curriculum for training workers which will be approved by the Department. This training shall include trauma informed information.

i. Include in all planning and execution, the need to address linguistic barriers, including but not limited to, limited English proficiency, deaf, blind, hard of hearing and intellectual disability.

j. Convene quarterly meetings with community providers, the contracted Resource Family Support Service provider and others as deemed appropriate by the Department.

i. The provider shall have recruiters covering the following four geographic areas of the state
ii. Districts 1 and 2 (York and Cumberland Counties)
iii. Districts 3 and 5 (Androscoggin, Franklin, Oxford, Kennebec and Somerset Counties)
iv. Districts 4 and 7 (Knox, Lincoln, Sagadahoc, Waldo, Hancock and Washington Counties)
v. Districts 6 and 8 (Penobscot, Piscataquis and Aroostook Counties)

k. Develop a work plan in collaboration with appropriate DHHS staff being sure to include at least three successful projects in each of the five identified marketing domains (business, school, community, church and media) each quarter.
i. The provider shall develop seasonal recruiting events (apple picking, truck pulls, snowmobile races, sailing regattas etc.) to provide a variety of materials promoting the message that there are children in every community in Maine in need of Resource and Foster Families.
ii. Messaging materials may include but are not limited to: book protector bags and stick notes, information about the option of a speaking engagement, paycheck inserts, golf tees and pencils etc.)

l. Meet at least quarterly with the Department OCFS District Recruitment Team or as requested by the Department OCFS District Recruitment team.

m. At least twice a year meet with the Department's Youth Leadership Advisory Team (YLAT) and provide the minutes of the meeting to the program administrator in Rider B.

n. Hire staff with the appropriate background and relevant experience and submit a summary of their qualifications to the program administrator in Rider B.

II. PERFORMANCE MEASURES

I. Required Standards:	II. Information Used to Track/Monitor Completion of Column I.:	III. Source of Information of Column II. (e.g. Name of report, on-site visit, data extraction from particular database, Department-obtained report 3rd party (such as APS), etc.):

A. Baseline to be established of unique formal inquiries to the provider, are licensed as family foster homes within nine (9) months of application.	A. The following data will be tracked through a collaborative process with DHHS staff: unique inquiries to the provider, and of those inquiries, the number that attend an informational meeting, the number that apply for licensure, and the subset of those inquiries that are licensed within nine (9) months of application.	A. Data mine database and MACWIS
B. 90% of targets identified within state and district plans have been implemented.	B. State and district plans will be developed within three (3) months of contract award and will be successfully implemented with consistency.	B. Currently in Development
C. The Provider will limit themselves to recruiting only twenty (20%) percent of the Resource and Foster Families for their own program.	C. The provider shall develop the plan and seek approval from the Department.	C. Currently in Development

Health Care Services

The OCFS restructure integrated the Behavioral Health Program Administrator with the Intervention & Coordination of Care Team. This has facilitated more collaboration between OCFS Mental Health Program Coordinators (MHPC's) and child welfare district staff as there are 9 MHCP's and 3 Clinical Caseworkers that are housed across the state. The MHPCs provide consultation to community providers, families, child protective colleagues, Department of Correction, Department of Education etc. on treatment services, mental health resources, developmental disability resources, transition information, evidenced-based practice modalities, and attend team meetings on youth who may need temporary residential treatment. The hope is that in the team meetings those other services can be suggested and utilized versus having the youth have to leave their home to receive effective services. We are currently looking at this role and plan to add additional duties such as, providing trauma informed training to child protective colleagues, and more oversight of community providers of home and community based treatment. MHPC's were trained on Permanency Reviews and have been attending those meetings in all the districts. As we continue to evolve with further integration it is anticipated that there will be more activities within the districts that can be shared by the MHPCs.

In the spring of 2012, in collaboration with Children's Behavioral Health Services (CBHS), a process was implemented to provide consults between child welfare and CBHS psychiatric staff to review situations when a child is prescribed antipsychotic medication. These consults review the appropriateness and need for the medication, as well as anticipated duration for the medication. Staff is also expected to conduct quarterly medication reviews on children prescribed antipsychotic medication.

The OCFS developed a strategic plan to address the issues related to the prevalence of foster children being prescribed psychotropic medication at a higher rate than other children/youth.

Strategic Recommendations for Lowering the Usage of Psychotropic Medication for Youth in Care

Target Goal: For calendar year 2015 23% of foster youth are on one or more psychotropic medications. By the end of 2017 the goal is to decrease by 5% to 17% .

1. Care Specialists (Two RNs) will review quarterly data received from OMS and record the data onto spreadsheets to see the data more easily for "Foster Youth". The data will be forwarded to Central Office, District Program Administrators; Assistant Program Administrators, Behavioral Health Program Coordinators and other Care Specialists. Each district also will receive a list of foster youth who have a Maine Care claim for a psychotropic medication.
2. Within five working days Program Administrators will share the report data with Supervisors who will use it during supervision with the Social Workers.

Social Workers will:

- Follow policy for Antipsychotic medications "*Use of Antipsychotic Medications for Youth in Foster Care"* ; utilize tools: "*Making a Choice: A Guide To Making A Decision About Using Antipsychotics Medications";* and "*State of Maine Medication Management Grid* and *Medication Management Considerations*".
- Ensure that the psychosocial treatment/interventions are being maximized.
- Ensure that the antipsychotic consent checklist is being utilized.
- Continue to weigh the benefits -vs-risks and have these conversations with foster parents.
- Reach out to the Care Specialist (RNs) for any medication related questions.
- Participate in the child's medication management appointment and continually asking questions on the necessity of medication and if there are other therapeutic ways to manage behavior without the use of medication.
- Document in a MACWIS narrative log every six months after participating in the med management appointment unless the child is on an antipsychotic which requires monthly documentation per policy.
- Remember that youth 14 and older must consent for medications unless there is an emergency (Imminent Danger).

Care Specialists (Two RNs) will:

- Monitor the data for any trends of psychotropic medication Maine Care claims. If a significant increase is noted, the Care Specialist (RNs) will advise Central Office. Care Specialist (RNs) will reach out to the PA and APA of that district to explore possible reasons for changes. If appropriate, will work with district staff, Central Office staff, and Medical Director to determine plan of approach.
- Be available to Social Workers to answer questions and help brainstorm on a case by case basis, looking at less intrusive behavioral interventions and offering suggested questions to ask at the medication management appointments.
- Develop work group with OCFS child welfare representation (a couple of PAs or APAs), the Care Specialists (RNs) and Medical Director (currently vacant)

  Goals of work group would be to:

  a. Explore how the data is working now;
  b. How is it being used statewide;
  c. Explore ways to make the data more workable;
  d. How do we keep the conversation of psychotropic medications on the radar, maximize prosocial interventions;

e. Develop a possible tracking grid of children on psychotropic medication to help trigger conversations;
f. Develop trainings for Foster and Adoptive parents in regards to the use of Psychotropic Medications and all alternative interventions available; and
g. Ensure consistency across the state in how districts are monitoring the use of Psychotropic Medications.

Health Care Plan

1. Initial and follow-up health screenings will meet reasonable standards of medical practice.

The Office of Child and Family Services requires in policy that all children have a medical review within 3 days of coming into care.

OCFS currently also requires in policy The Pediatric Screening Checklist (PSC) to be completed for every child in substantiated service cases to identify any behavioral health concerns. Those children that are scored in the high range are then referred for assessment either through our collaboration with Children's Behavioral Health or community providers.

For ongoing care, each child will be assigned a primary care provider and receive coordinated care through use of a medical home and/or behavior health home model or in conjunction with Targeted Case Management when indicated.

2. Health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from the home.

The Health Screening will provide immunization record, growth chart, and immunization schedule, list of other known providers (dentist), immediate treatment needs for identification of monitoring and treatment needs.

The Office of Child and Family Services includes both Child Welfare and Children's Behavioral Health Services working together to meet both the physical and behavioral health of foster children. OCFS believes strongly in the use of a trauma informed care that involves understanding, recognizing, and responding to the effects of trauma.

OCFS currently also requires in policy The Pediatric Screening Checklist (PSC) to be completed for every child in substantiated service cases to identify any behavioral health concerns. Those children that are scored in the high range are then referred for assessment either through our collaboration with Children's Behavioral Health or community providers.

OCFS currently provides a comprehensive health assessment in three largest districts. This assessment is an in depth physical, educational, and mental health evaluation for every child entering foster care. It is a comprehensive interdisciplinary evaluation to address the complex psychological, medical, and neurological problems that affect behavior and emotional adjustment or result in problems functioning in family, school or community. It also includes the collection of all of the child's prior health and education records, so that a full evaluation of the child's current needs can be made.

For those children who have need, targeted case management (TCM) services will be offered to ensure any identified issues are addresses. For those cases without the need of TCM the OCFS caseworker will ensure that any identified issues are addressed.

Maine also utilizes a wide range of evidenced-based treatment for children exposed to trauma such as Multisystemic Treatment (MST), Cognitive Behavioral Therapy and others to address emotional trauma associated with child's maltreatment and removal.

3. Medical information will be updated and appropriately shared.

Routine medical care will be completed in the "medical home" with routine updates provided to the agency caseworker. The State of Maine continues to develop the medical home model and, where it is available, OCFS utilizes this model.

4. Development and implementation of an electronic health record.

Current health information and family health history is currently tracked in MACWIS, and ongoing work has been occurring between OCFS and MaineCare Services (OMS) to ensure transfer of medical information as the new MIHMS system rolls out. OCFS currently has access to the Maine's Electronic Immunization Information system (Immpact) for access to foster children's immunization history and foster children enrolled with a provider currently using Maine EHR will have their information added to the system. OCFS will continue to work with MaineCare towards the use of an electronic health record system to increase the system's use for foster children's medical record information.

5. Steps to ensure continuity of health care services will include establishing a medical home for every child in care.

The State of Maine has a number of Patient Centered Medical Health Homes. The Office of Child and Family Services requires in policy that, at a minimum, every child in foster care is to have an identified medical home and a primary care provider (PCP). It is a requirement that every child's PCP be provided to MaineCare for service authorization and benefits. When appropriate, Targeted Case Managers will organize the most appropriate services to be provided to children based on the information gathered by the assessments completed, information gathered though the comprehensive health evaluation, and the input of a child's current medical and behavior health providers. It is OCFS intent that this group of providers will work together, through coordination with the Case Manager, Caseworker and Foster Parents, to create a plan to meet the needs of each child. This team based medical delivery system would continue to be available based on the child's needs and eligibility after returning home.

6. Oversight of prescription medicines.

Policy states it is crucial to ensure that antipsychotic medications are being used only when clinically indicated, i.e. when the likely benefit from their use would outweigh their very substantial risk. When these medications are used, proper monitoring of their metabolic side effects must take place. The OCFS Consent Worksheet is to be followed when antipsychotic medications are currently prescribed or considered and require that prior to any consideration of medication to address a child's mental health needs the treating provider must be given a full description of the circumstances of the child that is inclusive of all conditions.

The state has promoted informed and shared decision-making through the development of the Youth Guide that allows the youth to give informed consent and assent promotes methods for ongoing communication between the prescriber, the child, his or her caregivers, other healthcare providers, the child welfare worker and other key stakeholders. Effective medication

monitoring at both the client and agency level is well described as a process in the Consent Worksheet.

The Behavioral Health Director and the child welfare Associate Director collaborated to develop a protocol related to youth in foster care being prescribed psychotropic medication. The expectation is that the child welfare staff will use the developed tool and consult with district Critical Care Specialists to ensure the appropriate use of medications.

7. The state actively consults with and involves physicians and other appropriate medical and non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

Collaboration between DHHS and MaineGeneral Medical Center has resulted in the Pediatric Rapid Evaluation Program (PREP). For seven of the 16 Maine counties, this program provides medical examinations and psychosocial screenings of children who have entered foster care. Two additional CHS sites have been developed through the Spurwink Child Abuse Clinic in southern Maine and Penobscot Pediatrics in northern Maine. All of these programs are either developing the medical home for the child or helping to identify a medical home if one is not currently serving the child.

8. The state is taking steps to ensure that components of the transition plan development related to health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

The Department has taken steps to ensure that the transition planning process with young people, age 18-21, includes planning with young people to consider Health Care Proxy or Healthcare Power of Attorney by including this in the health planning section its revised Voluntary Extended Care (V9) Agreement Maine's Youth Transition Policy includes instructions for caseworkers to inform youth, beginning at age 18 about the importance of executing formal documents that define their wishes as to a Health Care Proxy or Healthcare Power of Attorney. OCFS provides young people with a website to download (free of charge) documents they would need to execute such documents. This website also contains valuable information that will help youth make an informed decision in this matter.

Additionally, this information has been made available directly to young people on Maine's Youth Leadership Advisory Team website (www.ylat.org) and OCFS will have printed information available at its annual Teen Conference in June regarding the importance of designating a Health Care Proxy or Healthcare Power of Attorney.

Disaster Plan

The Departments Disaster Plan is contained in C&FS Policy XV H. Emergency Response. This policy is hereby included in its entirety. See **Appendix E**

Training Plan

Training activities are categorized based on the subject of the training, the audience, and/or either a direct or administrative function. Training staff directly enter their workweek hours based on the training work provided. The Maine Time and Attendance Management system then send that information to the Maine

Department of Health and Human Services Costs Allocation Program, so that staff costs are claimed appropriately to all beneficiating programs as required by A-87. For title IV-E training activities, the DHHS Cost Allocation Program applies, as appropriate, all allocation methodologies, penetration rates, and administrative rates as required for Title IV-E claiming. Unallowable costs are billed to state general funds.

Maine anticipates spending $1,090,000 annually for training costs.

See **Appendix F** for training plan.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 permits states to claim Title IV-E training reimbursement for certain short term trainings of current and prospective relative guardians and for court and related personnel who handle child abuse and neglect cases. Maine OCFS has historically included the training of relative guardians in its training program. In terms of training court and related personnel, OCFS currently collaborates in training opportunities with the court but will need to further review any financial opportunities to support training in which we would then make claim through this latest legislation.

Financial Information

PSSF Service Category Disproportionality: Based on State of Maine Purchasing rules no payment for service to a provider greater than $10,000 can be administered without processing through the procurement process. The Procurement process can take upwards of 1 year, once a service has been identified, presented to DHHS management, and approved for Request For Proposal. Funding that was available based on this unplanned barrier were diverted to other eligible program areas from within the grant.

States may not spend more title IV-B, subpart 1 funds for child care, foster care maintenance and adoption assistance payments in FY 2016 than the than the State expended for those purposes in FFY 2005 (Section 424(c) of the Act). For comparison purposes, submit with the CFSP information on the amount of FFY 2005 title IV-B, subpart 1 funds that the State expended for child care, foster care maintenance and adoption assistance payments in FY 2005.

Expenditures in 2005 were $0

The amount of State expenditures of non-Federal funds for foster care maintenance payments that may be used as match for the FY 2016 title IV-B, subpart 1 award may not exceed the amount of such non-Federal expenditures applied as State match for title IV-B, subpart 1 in FY 2005 (Section 424(d) of the Act). For comparison purposes, submit with the CFSP information on the amount of non-Federal funds expended by the State for foster care maintenance payments for FY 2005.

Expenditures in 2005 were $2,408,000

DHHS assures that the state funds expended for FFY 2013 for purposes of Title IV-B, subpart 2, is $19,386,131.66. These expenditures were greater than the FFY 1992 base amount of $15,847,000 which was used to provide Preventive and Supportive Services, including Protective Services. That amount was provided in the annual summary of Child Welfare Services included in the Bureau of Child and Family Services FY '91-93 State Child Welfare Services

Appendix A

HR 4980 Planning Committee
Title IV-E requirements for identifying, reporting and determining services to victims of sex trafficking:

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
471 (a)(9) **Develop policies** and **procedures (including caseworker training)** to identify, document and determine appropriate care for CSEC victims and children at risk of becoming CSEC victims.		• Screening tool to identify victims and at risk children • MDT response protocol for when identified • Protocol for appropriate care • Policy	• MECASA • MDTs • Caseworkers	9/2015	Human Trafficking, Commercial Sexual Exploitation of Children Policy completed. This policy outlines identification, documentation and making appropriate referrals for identified victims, and those at varying risk levels of CSEC. Training is happening in each district office with all staff around the policy and risk factors and dynamics of CSEC and human trafficking.
Demonstrate implementation				9/2016	
471 (a)(34) Report to LE, no later than 24 hours after CSEC victim is identified		• Protocol for LE referral • What happens once LE gets the referral • MDT response protocol	• District Attorneys • LE Agencies	9/2016	Part of the HTCSEC policy
Report Annually to HHS total number of CSEC victims		• Way to capture this number	• DHHS	9/2017	AFCARS screens up and working in our MACWIS system

471 (a)(35) **Develop and implement protocols to:** locate missing foster Children, **determine what factors lead to the child's absence and address this in future placements,** determine if child was a CSEC victim during absence from care		• Develop Protocols • Screening tool • Way to document factors leading to the runaway	• DHHS • MECASA	9/2015	A new policy is drafted in regards to all of the components of this.
Report this information to HHS		• Way to capture this number	• Macwis staff through AFCARS	9/2015	Working with MACWIS staff around this
Develop and implement protocols to report missing or abducted children to law enforcement for entry into the National Crime Information Center		• Develop and implement protocol	• DHHS • LE • NCMEC	9/2016	Law change was necessary in regards to the reporting to the national center and this was passed. This will be addressed in the above drafted policy

Title IV-E requirements related to the reasonable and prudent parent standard and developmentally appropriate activities for children in foster care

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Modifies the existing title IV-E plan requirement at 471(a)(10) requiring state and tribal licensing authorities to: **permit the use of the "reasonable and prudent parenting standard" as defined in**		Policy or rules that permit this	Linda Brissette	9/2015	**Rule changes have been drafted to incorporate the reasonable and prudent parenting language for our foster homes. Residential facilities will be signing an attestation that states that they**

section 475(10)4 4 " Caregiver is a foster parent or designated official at a child care institution, **in their standards for foster family homes and child care institutions; require child care institutions to have an on-site official authorized to apply the reasonable and prudent parent standard;** have **policies** for foster parents and private entities (under contract) applying the reasonable and prudent parent standard to ensure appropriate caregiver liability when approving an activity for a foster youth. Each child care institution's authorized official must have the same **training** on the "reasonable and prudent parent standard" as required under section 471(a)(24) of the Act for foster parents.		Designate an official who is in charge of applying the reasonable and prudent parenting standards Develop Policies, rules or standards Develop training for both Foster parents and child care institution staff who will be designated the reasonable and prudent parent	Stephanie Barrett to join us next workgroup to speak about the residential programs		**will follow these same standards. Training for casework staff, foster homes and residential facilities have happened and is ongoing.**

Adds new title IVE IVB case plan and case review system requirements for youth with a plan of APPLA and children over age 14

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Modifies the title IV E plan at section 471 (a) (16) and title IVB plan at 422 (b) (8) of the act with new requirements for agencies to modify their case review system (in section 475 (5)(c)(i) as follows : •limits APPLA as a permanency plan for youth age 16 and older (section 475 (5)(c) (i)) Requires title IVE agencies to follow additional case review and case plan requirements in sections 475 a, 475 5 B and c I of the act for all children in foster care with a permanency plan of appla including that the title IVE agency must : • **Document** at each permanency hearing the efforts to place a child permanently with a parent, relative, or in a guardianship or adoptive placement. • **Implement** procedures to ensure		Youth transition policy and permanency policy changed to 14		**9/2015**	**Child case plan and the Permanency policy changed to address these.** **The court has been working collaboratively with OCFS to ensure that this happens. Legal summary changed to address this**

that the court or administrative body conducting the permanency hearing asks the child about his/her desired permanency outcome and makes a judicial determination at each permanency hearing that APPLA is the best permanency plan for the child and compelling reasons why it's not in the best interest of the child to be placed permanently with a parent, relative, or in a guardianship or adoptive placement (section 475A (a)(2) of the Act).					**Now in the child case plan.**
•**Document** at the **permanency hearing** and the **6 month periodic review** the steps the agency is taking to ensure that the foster family follows the "**reasonable and prudent parent standard"** and whether the child has regular opportunities to engage in "age or developmentally-appropriate activities" (sections 475(5)(B) 475A(a)(3)of the Act). **For children age 14 and older:**	Legal summary and child case plan addresses this. Youth transition policy addresses this for youth 16 and older, now changed to 14				**In the child case plan, as well as law and policy to start transition planning with the youth.**

The case plan must document the child's education, health, visitation, and court participation rights, the right to receive a credit report annually, and a signed acknowledgement that the child was provided these rights and that they were explained in an age appropriate way (section 475A of the Act), The case plan must be developed in consultation with the child, and at the option of the child, 2 members of the case planning team, who are not the caseworker or foster parent(sections 475(1)(B) and (5)(C)(iv)of the Act), The case plan and permanency hearing must describe the services to help the youth transition to successful adulthood (formerly at age 16) (sections 475(1)(D) and (5)(C)(i) of the Act), The title IV-B/IV-E agency must provide a copy of his/her credit report annually and assistance in fixing any inaccuracies	Youth transition policy addresses this				**Child case plan addresses this as well as training has happened with staff to ensure that this happens.** **Child case plan, youth transition policy and law now address the new age.**

(formerly age 16) (section 475(I) of the Act).					

Providing important documents to youth aging out of foster care

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Agencies must provide a youth aging out of foster care at age 18 (or 19, 20 or 21 as elected by the agency under section 475(8) of the Act) with his/her birth certificate, Social Security card, driver's license or identification card, health insurance information, and medical records. *Children who have been in foster care for less than 6 months are exempt.*		**No new needs to be met**	**Child welfare staff.. again through training**	9/2015	**This is addressed through the youth transition policy and we exceed the requirements**

Relative notification and sibling definition

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Modifies the title IV-E plan requirement in section 471(a)(29) of the Act for relative notification to include notifying parents of the child's siblings**.** **Defines** siblings in section 475(12) of the Act to mean an	This is addressed in the Permanency Policy	Added relatives.	Kristi Poole, Gina, SMT, social workers	Immediately	**Permanency policy and law changed to reflect this addition.** **Sibling definition and**

individual who is considered by state law to be a sibling or who would be considered a sibling under state law is it not were for a disruption in parental rights, such as a termination of parental rights or death of parent.					**expanded notification added to law.**

Successor guardians

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Allows continuation of title IV-E kinship guardianship assistance payments if the relative guardian dies or is incapacitated and a successor legal guardian is named in the agreement (or any amendments to the agreement) (section 473(d)(3)(C) of the Act).	Permanency guardianship policy addresses this.	Changes to the language on pg 6 and 7	Kristi P	**9/29/14**	**Permanency guardianship policy changed as well as agreement paperwork will be changed to add a successor guardian. Staff are also being trained on this.**

New Adoption and Foster Care Analysis and Reporting System (AFCARS) data elements

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Amends section 479 of the Act to require title IV-E agencies to report information on children in foster care who are identified as sex					**Completed and in macwis**

trafficking victims and children who enter foster care after a finalized adoption or legal guardianship					

Annual state child welfare outcomes report (section 479A of the Act)

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Beginning in FY 2016, HHS must **report** state-by-state data on children in foster care who are: *pregnant or parenting. *placed in a child care institution or other non-foster family **home** setting including: the number of children in the placement, their ages, and whether they have a permanency plan of APPLA, their duration in placement and the type of child care institution placed (e.g., group home, residential treatment, shelter, or other congregate care setting), The number of foster children placed in each setting, and any clinically diagnosed special need and the					**Changes made to the AFCARS reporting system**

extent of special education or services provided in the placement. HHS must consult with states and other child welfare-related organizations on other issues and data to report on using AFCARS, NYTD and other data available to HHS					

Appendix B

CHAFEE FOSTER CARE INDEPENDENCE AND EDUCATION AND TRAINING VOUCHERS PROGRAMS

The Maine Department of Health and Human Services, Office of Child and Family Services (OCFS), will continue to administer Maine's Youth Transition Services funded through the Chafee Foster Care Independence Act of 1999, including the Education and Training Voucher Program, and will comply with all required national evaluations.

Youth currently and formerly in foster care are consulted throughout the year regarding the services and supports they receive through Maine's Chafee Foster Care Independence Program. Youth feedback is integrated into this State Plan, as well as used to shape Maine's laws, policies, and practices to support older youth in care.

Section I covers the programs, services, and activities for which Title IV-E of the Social Security Act, Sections 471, 472, 474, 475, and 477 and Title I, Improved Independent Living Program, Public Law 106 - 109, the Chafee Foster Care Independence Act of 1999, were expended for FFY 2016.

Section II summarizes the administration of the Education and Training Voucher fund program for the academic school year 2015-2016.

SECTION I: CHAFEE YOUTH TRANSITION SERVICES

Eligible Population:

For the purposes of Youth Transition Services, the terms "child" and "youth" are used interchangeably to mean an individual up to 21 years old. The Department of Health and Human Services elects the following youth as eligible for services under its Chafee Foster Care Independence Program:

- Youth in foster care who are age 14 to 18 years old.
- Youth who turn 18 years old while in foster care and who sign a Voluntary Extended Care (V9) Agreement with the Department to the age of 21, while residing in Maine or temporarily in another state as part of their V9 Agreement by meeting the requirements outlined in V.T. Youth Transition Policy.
- Youth who turned 18 years old while in foster care, but who were legally adopted after the age of 18, when that adoption disrupts prior to the age of 21.
- Youth who reside with birth parents, may enter into a V9 Agreement from age 18-21, when OCFS oversight and support is needed to ensure youth safety and permanency.
- Youth in the custody of the Department or on V9 Agreement who are pregnant and/or parenting, transitioning from residential placements, in apartment placements, homeless, and likely to need adult services will be given priority.
- Youth who experience adoption or permanent guardianship disruption, but who do not re-enter foster care may submit a letter of request for V9 status to the district office from which they were adopted or entered permanent guardianship.
- Youth who have a signed V9 Agreement, and who are subsequently adopted through Probate Court between the ages of 18 and 21 may continue to receive V9 services with OCFS Management approval.
- Youth, 18-21, who have a signed V9 Agreement, and have their parent's parental rights reinstated, in

accordance with Family Reunification Policy VII, F may remain in V9 status after the reinstatement of parental rights.
- Youth who was in foster care and is now experiencing factors that place the youth at risk of homelessness may request to enter into a V9 Agreement.
- Youth who were adopted, entered permanency guardianship, or were reunified with family at age 16 or older from foster care, may be eligible to receive Education and Training Voucher (ETV) funds.

The Department does not discriminate with regard to Chafee youth transition services or ETV funding based on race, sexual orientation, religious affiliation, or any other factor that might prevent an older youth in care from receiving the benefit of program services.

Purposes for Which Chafee Foster Care Independence Program Funds Were Used in FY 2016, and for which they will be used in FY 2017:

- Help youth explore and find their permanency options and connections before exiting foster care.
- Transition planning with youth, beginning with a comprehensive assessment of youth strengths and needs and including the active participation of young people and their supports in case planning.
- To offer an array of opportunities, services, and supports that that meets the individualized needs of youth to ensure youth have regular, ongoing opportunities to engage in age and developmentally activities.
- To support youth well-being by honoring the youth's culture, beliefs, sexual orientation and gender identity.
- Create a normalized growing up experience for youth in care that is consistent with their peers not in foster care.
- Increase and enhance educational achievement, vocational and employment skills, and academic knowledge.
- Help youth learn essential daily living skills, effective problem solving and informed decision making skills.
- Expand the resources available to youth in their community.
- Work with older youth to increase their knowledge of how to access the array of services and informal resources in their community.
- Encourage opportunities for youth in care, which may lead to permanent lifelong connections.
- Provide needed academic supports, including post-secondary education financial support using federal Education and Training Voucher program funds.
- Improve and enhance the leadership skills of older youth in care related to employment preparation, employment maintenance, and career planning.
- Increase knowledge of Departmental staff, foster parents, group care providers, and other adolescent service providers of the needs of older youth in care and youth transitioning to adulthood.
- Encourage and promote meaningful and productive communication between older youth in care and OCFS Managers to promote improved youth outcomes.
- Seek youth input in developing Departmental policies, programs, and practice to prepare older youth in care to transition to adulthood.

Overview of Strategies to Meet the Needs of the Eligible Population:

The goal of the Department's Chafee Independent Living Program (Youth Transition Services) is to ensure that all youth in care are prepared for a successful transition to adulthood. The Department does this by: assisting youth to have legally permanent family and life long connections; partnering with youth in decision-making;

providing services youth want to meet their needs; and ensuring youth have opportunities to develop essential life skills that prepare them to live interdependently in the community as young adults.

Services to older youth in care are provided by OCFS Youth Transition Specialists, OCFS caseworkers, contracts with the University of Southern Maine's Muskie School, Jobs for Maine Graduates, therapeutic and non-therapeutic foster home parents, group home staff, transitional living programs, adult developmental services, other contracted providers, and through community partnerships. Youth Transition Services are funded by a combination of federal and state funds. We intend to continue this structure in FY 2017.

The Department coordinates services with other Federal and State programs for youth such as juvenile justice, adult mental health and developmental services, housing and homeless youth services, high school education, vocational training programs, post-secondary educational supports and services, substance abuse, children's mental health, and various community-based resource providers.

The role and responsibilities of Youth Transition Specialists (TYS) changed in May 2015. YTS no longer carry cases, and have taken on the role of expert consultant and partner to youth, district casework staff, and the youth's team to ensure improved youth outcomes through a focus on the distinct needs of older youth, such as support in postsecondary education and life skills development.

The Department continued to provide youth leadership opportunities to youth through a contract with the University of Southern Maine (USM) Muskie School of Public Service.

Planning continues regarding overall strategies to meet the transition needs of youth placed within various agencies, including contracted therapeutic foster care and residential care providers. The Department is focused on ensuring all youth in care have opportunities to experience similar activities and opportunities as their peers in the community, and are provided with a variety of opportunities to develop essential life skills.

The Department's Office of Child and Family Services (OCFS) and the Office of Aging and Disability Services (OADS) continued to meet to improve the transition process of youth from children's services to adult services. We have instituted a statewide approach for convening early planning meetings for all youth served by OCFS and revised our Protocol. This Protocol allows a youth who is eligible for adult services to remain on a V9 Agreement and benefit from collaborative planning with OADS until the youth can enter the Section 21 Adult Waiver Program. Early Referral Meetings occurred across the State to ensure collaboration and coordination of services to individuals to ease the transition process.

The Office of Family Independence (OFI), MaineCare Services, continued to provide youth who age out of Maine's foster care to remain eligible for coverage until the age of 26, as allowed through the Affordable Care Act. OCFS continues to partner with YLAT and others to get the word out to youth and young adults across the State.

Maine does not exceed the 30% limit for housing costs as specified in Chafee legislation. Due to limited Chafee funding, Maine continues to use a combination of state general funds and allowable ETV room and board funding to assist youth with their housing support while in extended care from age 18 to 21. We anticipate this to continue.

ELIGIBLE POPULATION (FFY2016):

Number of youth who were in care **aged 15-21 on Oct. 1, 2015**:

AGES	FEMALE	MALE	TOTAL
Age 15	35	31	66
Age 16	30	38	68
Age 17	37	34	71
Age 18	19	28	47
Age 19	11	16	27
Age 20	14	13	27
TOTAL	**146**	**160**	**306**

Of youth **age 15-21**, the length of time these youth had been in care on **October 1, 2015:**

Length of time	# of youth	% of total
Less than 6 months	20	7%
6 months to 1 year	34	11%
1 to 2 years	55	18%
2 to 3 years	31	10%
3 to 4 years	35	11%
4 to 5 years	23	8%
5 to 6 years	23	8%
6 to 7 years	14	5%
7 to 8 years	16	5%
8 to 9 years	10	3%
9 to 10 years	9	3%
10 to 11 years	6	2%
11 to 12 years	7	2%
12 to 13 years	6	2%
13 to 14 years	6	2%
14 to 15 years	1	0%
15 to 16 years	2	1%
16 to 17 years	3	1%
17 to 18 years	2	1%
18 to 19 years	2	1%
19+	1	0%
TOTAL	306	100%

Estimated Eligible Population for 2016 (as of 2/1/15- youth currently in care):

AGES	FEMALE	MALE	TOTAL
14yo	30	26	56
15yo	31	33	64
16yo	27	41	68
17yo	31	33	64
18yo	26	25	51
19yo	13	19	32
20yo	12	12	24
TOTAL	170	189	359

As of 2/1/15, the number of youth placed in residential placements was 57 youth (16% of the total youth age 14-20 population).

Youth Leadership Development Activities:

Maine's Youth Leadership Advisory Team (YLAT) (www.ylat.org) is nationally recognized as one of the most effective and active youth leadership boards in the country. Maine is focused on enhancing youth and adult partnerships through YLAT and promoting effective systems change.

YLAT Groups met monthly in six sites in Maine from January 2015-May 2015 and September 2015-December 2015. Monthly meetings were held in Augusta, Bangor, Lewiston, Rockland, Saco and Skowhegan. Nine meetings were held in Aroostook County from January 2015-December 2015, expanding their meeting sites to two locations: Caribou and Houlton in September 2015. Between January 2015 and December 2015, there were 130 youth and 62 adult partners (unduplicated) who participated in at least one (1) meeting.

A group at Preble Street Teen Center for young people in care experiencing homelessness was held weekly from January 2015-May 2015. This group began again in October 2015, meeting on a monthly basis at an off-site space through December 2015. The group expanded its members; now open to all young people experiencing homelessness as well as other systems, including foster care.

Seven (7) Alumni co-facilitators were supported during 2015. These individuals participated in three (3) retreats over the year (February, September and November) that provided the opportunity to practice facilitation skills, gain a deeper understanding of facilitating and enhance connections with each other and Muskie staff.

A teen conference planning committee met five (5) times between January 2015 and December 2015, and was made up of fourteen (14) youth and eleven (11) adults. The 25th Annual Teen Conference for Maine's Youth in Care, was held on June 25th, 2015 at Kennebec Valley Community College. Over 140 youth and adults came together with a conference theme of: "Something to Stand For: 25 Years of Change". There were four (4) keynote speakers, all who were in care in Maine who highlighted the power of youth voice, and the importance of building connection and advocating for both yourself and others. Youth attended afternoon workshops including: communication strategies, budgeting, college resources and how to build networks of support as you exit foster care. A resource fair was offered in the afternoon where young people had the opportunity to connect with multiple vendor booths focused on: health & wellness, finances, employment, housing, and education.

YLAT members served on the Maine Youth Transition Collaborative (MYTC) Advisory Committee, The New England Youth Coalition (NEYC), and the Southern Maine Transition Network (SMYTN). YLAT members served as a pivotal role in the development of the Alumni Transition Grant Program (ATGP). A group of Alumni served on an advisory committee for the grant program and helped establish rules and regulations.

In the spring of 2015, six (6) events were held to educate caseworkers on how being in foster care impacts a young person's experience of "normalcy," (the everyday opportunities, experiences, and challenges of being a "typical" teenager). Each event included a panel of current YLAT members, whose age ranged from 14-23.

YLAT members also presented at the annual MYTC dinner in May 2015 about the importance of youth in care having access to financial literacy.

During the spring of 2015, YLAT members were asked to be part of several other organization's panels including: Adoptive and Foster Families of Maine's Annual Conference focused on normalcy, the Child Welfare Conference focused on supporting cultural connections for young people in care, and the Opportunity Alliance focused on LGBTQ and Normalcy for youth in foster care.

In September 2015, YLAT Alumni Co-Facilitators participated in an integration training focused on facilitation with other youth leaders from Portland Empowered and the Southern Maine Youth Transition Network (SMYTN).

In October 2015, an Alumni Co-Facilitator and Muskie Staff attended a national conference in Washington D.C. hosted by Foster Youth in Action (FYA), called "Leaders for Change". The conference focused on trauma and federal recommendations around adults working with young people in care related to trauma. Connections were made with other state partners doing similar youth/adult work, and YLAT will become a partner of FYA in 2016.

In November 2015, current YLAT members attended a training focused on strategic sharing. The training offered the opportunity for young people to be self-reflective on their experiences through journal, to partner with other youth from across the state, and to practice a panel presentation. Two more training events are scheduled for the spring of 2016.

In April 2016, YLAT members participated on a panel as part of the clinical training for OCFS personnel entitled, **"Working with LGBTQ Youth in Care."**

Consultation and Collaboration:

The Department is strongly committed to collaboration with youth, parents, community service providers, and various community stakeholders. We believe this ensures a coordinated approach to meet the needs of older youth in care and encourages public/private partnerships that maximize Maine's limited resources. Maine is involved in a number of collaborative efforts at the state and local levels and intends to continue these collaborations. Some examples include:

Maine Tribes and Bands: OCFS continued Chafee funded Agreements with the Houlton Band of Maliseets, the Aroostook Band of Mic Macs, the two Passamaquoddy Tribes, and Penobscot Nation. Tribes and Bands define their eligible youth population as well as the services and supports they provide utilizing Chafee funding. The eligible population is generally defined as youth between the ages of 14 and 21, although they may serve some younger youth, who are under Tribal or Band care and responsibility, and extends to youth who reside within the Tribal or Band community. Through this collaboration, Bands and Tribes are provided funding to meet the

transitional needs of youth in their communities that they identify, while ensuring youth have culturally supported experiences.

Maine Youth Transition Collaborative: The goal of MYTC is improve outcomes for youth transitioning from foster care to adulthood by establishing lasting partnerships with public and private organizations and focusing on Youth Leadership, Community Engagement, and Opportunity Passport. Successes over the years have ensured on-going involvement and support from a variety of public and private entities, such as youth in care, service providers, post-secondary educators, employers, and others to address the needs of transitioning youth. Since 2004, this Collaborative has worked to reduce barriers identified by youth in the areas of housing, education, employment, and lifelong connections. www.maine-ytc.org

Training: in April 2016, The Muskie School of Public Service, at the University of Southern Maine, partnered with OCFS to provide clinical training for OCFS personnel entitled, **"Working with LGBTQ Youth in Care."** The needs of LGBTQ Youth in care are often not fully understood or appreciated by caseworkers and resource families which can contribute to adverse outcomes. This training was designed to present some of the issues confronting LGBTQ youth, identify some of the ways in which caseworkers, resource parents, and others working with LGBTQ youth in care can best support them, and offer an opportunity for a conversation with young LGBTQ who are themselves alumni of the foster care system. Following the youth panel presentation, audience participants were challenged to create an action plan and have a conversation about how they can implement some of the suggestions identified by the keynote speaker and the panelists.

The keynote speaker for this presentation was be Gerald P. Mallon, DSW, who is the Julia Lathrop Professor of Child Welfare and Executive Director of the National Center for Child Welfare Excellence at the Silberman School of Social Work at Hunter College in New York City. For more than 38 years, Dr. Mallon has been a child welfare practitioner, advocate, educator, and researcher. Dr. Mallon is the Senior Editor of the professional journal, Child Welfare and the author or editor of more than twenty-three books. In his role as the Executive Director of the NCCWE, Dr. Mallon has traveled to all 50 states, territories and tribes to improve outcomes for children, youth, and families and to build organizational capacity with child welfare systems.

Homeless Youth Provider Committee: is made up of providers of homeless youth shelter and outreach services. The primary goal of the committee to establish a comprehensive system of services to meet the needs of homeless youth as defined. Legislation was passed and signed by the Governor in June 2009. In 2015 this network completed a comprehensive needs assessment and count of homeless youth in Maine. *http://www.mainehomelessplanning.org/wp-content/uploads/2016/01/Rural-Homeless-Youth-Count-Report-2015-12-FINAL.pdf* In addition to partnering with our homeless youth outreach and shelter providers through this Committee, OCFS has provided in-kind support to Maine's largest shelter program in Portland, ME by having two Youth Transition Specialists stationed at the shelter for a designated time period during the week to provide assistance and information to youth and staff, and to assist the MYTC in supporting youth leadership efforts at this shelter.

New England Youth Collaborative: This Collaborative aims to improve outcomes for older youth in care by learning from each and supporting the implementation of innovative practices that strengthen the youth transition programs in all of the New England States. The NEYC is a youth driven, adult supported organization that has begun to develop resources for New England, such as a Sibling Bill of Rights, and a post-secondary PSA. In 2015, the NEYC remained focused on promoting normalcy for youth in care, as well as post-secondary education. http://neyouthcoalition.org/

Maine State Housing Authority: OCFS continues to partner with MSHA to support youth transitioning from foster care. Beginning in 2016, through a federal demonstration project, OCFS will work with MSHA and

others to pilot a youth FUP-voucher program for homeless youth in the Bangor area.

Maine Center for Disease Control and Prevention: In 2016, OCFS plans to partner with the Maine Center for Disease Control and Prevention for their federal PREP (Personal Responsibility Education Program) Grant. One of their target goals is reducing unintended pregnancies for youth in from foster care between the ages of 18 and 24. Maine CDC has access to curriculums and health education materials, and we believe this will be a valuable new partnership and educational opportunity for youth in foster care.

Program Goals:

Goal 1: Improve permanency outcomes for older youth in foster care, ages 15-18.

Maine continued Permanency Review Teaming to review permanency outcomes for all children and youth, who have been in care for six months. Follow-up Family Team Meetings include youth and their supports.

OCFS continued to seek feedback from young people in care and made revisions to the Youth Transition Policy as a way to better support youth to be involved in their own case planning and court hearings.

OCFS continued to provide financial and in-kind support to *Camp to Belong Maine* (CTBM) in 2015, which allows siblings separated by out-of-home care to reunite for a week to bond and enjoy a typical camp experience together.

Goal 2: Improve educational success for youth by improving post-secondary retention and graduation rates.

The Department continues to provide ETV funds to youth to support post-secondary education programs. For youth whose post-secondary education needs that cannot be funded through ETV because of federal restrictions, such as training programs through adult education, OCFS utilizes state funds to pay for these programs. Youth Transition Specialists and caseworkers meet monthly with youth on V9 Agreements to provide support and to connect youth to supportive resources at their post-secondary institution.

OCFS continues to partner with the Maine Youth Transition Collaborative to develop resources and supports aimed at improving the post-secondary educational outcomes for youth in Southern Maine.

The Alumni Transition Grant Program (ATGP), resulting from LD 1683, began serving eligible youth on 1/1/15, and began providing financial and navigator support to youth from foster care, ages 21-27, to complete their post-secondary education and training. To date, fifteen (15) youth (unduplicated) have been supported through the ATGP. Three (3) students have graduated with a bachelor's degree since the program began; the ATGP Advisory Committee began meeting in 2015; and OCFS Youth Transition Specialists serve as ATGP Navigators to support ATGP Recipients.

Maine's Jobs for Maine's Graduates (JMG) received funding through legislation to establish Post-Secondary Navigators in several Maine Colleges and Universities.

Maine's Tuition Waiver program continues to provide 30 new waivers per year, on a first come, first served basis to youth who are in foster care at the age of 18, and for youth whose guardian receives an adoption or permanent guardianship subsidy from DHHS. Once qualified, students have up to 5 years of waiver eligibility to complete their undergraduate degree.

Goal 3: Improve the quality of permanency hearings and better incorporate youth decision-making.

Maine continued to hold annual permanency hearings for youth on Voluntary Extended Care (V9) Agreements as supported by Maine's "Extension to 21" legislation which defines DHHS support and care to youth in foster care, aged 18-21.

In 2015, OCFS provided training to OCFS caseworker staff and youth to help youth feel better prepared to participate in their case planning, family team meetings, and court hearings. This will continue in 2016.

Goal 4: Expand availability of support and services to youth in all areas of the state.

OCFS continued to partner with the Maine Youth Transition Collaborative to increase resources for youth transitioning to adulthood, such as "work ready" training. This involves a partnership with MYTC member, Goodwill Industries, to provide a five day training curriculum to youth in and from foster care around job searching, resume writing, interviewing, job skills training, and supported summer employment. This has been offered in York County for the past four (4) years, with increasing numbers of youth participating, as well as now being offered for a second (2nd) year in Cumberland County.

In January 2016, MYTC won a Social Innovation Fund (SIF) Grant. Called Maine LEAP, this grant will allow Maine to expand educational supports to youth in care. In years one (1) and two (2) of this grant, Maine LEAP will support students in Cumberland, Kennebec, Somerset, and Penobscot Counties. Maine intends to serve all youth in foster care, statewide, by year three (3). This grant will allow Maine, through our Jobs for Maine's Graduates (JMG) partner, to:

- Support high school juniors and seniors to begin postsecondary education or training planning, and to get caught up on any missing needs before the end of high school; and,
- Provide an intensive summer bridging program in which students can earn college credit while preparing for their 1st year of postsecondary education or training programs; and,
- Support first (1st) year postsecondary students on campus or in their training program through JMG Navigators.

OCFS continued a contract with Jobs for Maine Graduates (JMG) to provide financial literacy training and a matched savings program to youth in and from foster care, ages 14-25, across the State. Since 2003, 490 youth have been served through this program, which also includes a matched savings program. In 2015, JMG celebrated the $1 Million Dollar match youth made in this program. To date, JMG has served over 500 youth, and also established financial mentors for youth. OCFS intends to continue this contract for 2016.

Caseworkers also continue to assist youth in care to access community resources, such as with Career Centers, Goodwill Industries, and training programs.

In 2014, OCFS was awarded a five (5) year $5,000,000,000 "Now is the Time—Healthy Transitions" grant from the Substance Abuse and Mental Health Services Administration.
The Moving Forward (NITT-HT) Initiative serves youth and young adults, aged 16-25, living in Androscoggin, Cumberland, and Penobscot Counties who have, or are at risk of having, serious mental illness and co-occurring disorder. Many of these youth and young adults will have experienced trauma from domestic violence, child welfare and juvenile justice involvement, and homelessness. This *Initiative* seeks to improve the outcomes of young people transitioning to adulthood in the areas of: education, housing, employment, relationships, as well as other needs as identified by participating youth and young adults.

As part of this *Initiative*, OCFS Youth Transition Specialists have been trained in the use of the Transition to Independence (TIP) model, which serves as a foundation of case management support to participating youth.

In FY 2017, OCFS will further revise its Youth Transition Policy to better define Department expectations around supporting youth's sexual orientation and gender identities. OCFS will work with experts in the community to develop educational materials for staff, care providers, and youth. Youth will be provided with educational information LGBTQ resources at this year's Teen Conference.

Goal 5: Increase housing options for older youth in care and youth transitioning from care.

OCFS continues to utilize state funds to pay for the housing needs of youth with a Voluntary Extended Care (V9) Agreement as a way to prevent homelessness and staff work with landlords to help youth secure housing.

In 2015, OCFS continued conversations with Maine State Housing Authority. OCFS is planning to partner with MSHA in 2015 to implement a demonstration program to utilize 10 Family Unification Program (FUP) vouchers for youth experiencing homelessness in Penobscot County.

Maine will continue to partner with homeless youth providers in Maine and other housing resources to ensure better coordination of services and increased resources to for youth experiencing homelessness, some of whom are pregnant or parenting teens, and who have experienced the child welfare system.

Goal 6: Improve the outcomes for youth placed in congregate and therapeutic foster care.

Maine continues to use the DHHS Intensive Temporary Residential Treatment (ITRT) process to review the appropriateness of youth placements in congregate care and remains committed to youth being placed in the least restrictive environment possible to meet their safety needs.

One of the target populations for Maine's Recruitment Contract is for youth who are ready for discharge from residential but who do not have an identified family with whom they can be placed. OCFS Management meets with treatment agency providers and is working with them to identify new strategies to increase the number of newly recruited families to meet the needs of youth who are ready to step-down from residential to therapeutic foster home settings.

In addition to new recruitment efforts, OCFS has developed a protocol which allows for a time-limited enhanced rate to be provided to a caregiver, when all other usual forms of exploration of placement for a youth leaving residential have not been successful.

OCFS also began compensating a caregiver who is actively participating in a youth's transition from residential care so this caregiver can be involved in the transition process with the youth prior to discharge from residential placement. This allows the caregiver to become familiar with a youth's needs prior to discharge and provides the youth a chance to become comfortable with a new family prior to placement.

National Youth Transition Database:

Maine implemented NYTD (the National Youth in Transition Database) and was fully operational on 10/1/10. Over the past year OCFS continued outreach efforts to ensure compliance with NYTD requirements and to look at ways to use the data collected through NYTD to help improve youth outcomes related to permanency, safety, and well-being.

OCFS is completing 17 year old NYTD plus surveys yearly, even on non-reporting years. In 2015, OCFS also completed the 19-yo Follow-up Surveys. OCFS will continue to look for ways to utilize NYTD data for program improvements.

SECTION II: EDUCATION AND TRAINING VOUCHER PROGRAM

Older youth in care are well supported by the Chafee Foster Care Independence Program in Maine for the pursuit of post-secondary education and specialized vocational technical job training programs. There are no identified statutory or administrative barriers that prevent DHHS from fully implementing the ETV program in Maine. Education and Training Voucher (ETV) program funds continue to provide "gap assistance" to eligible students in-state or out-of-state or in-state.

The Youth Transition Specialist continued to track the utilization of ETV funds to assure that the funds provided do not exceed $5000 or the total cost of the program, taking into account all other financial aid assistance and awards. Youth who were receiving ETV funds at the age of 21, are eligible for continued ETV funds until the age of 23, when making progress toward completing their post-secondary undergraduate or graduate degree.

ETV Eligibility Criteria:

- Youth who were in the custody of DHHS at the age of 18, and who have a signed Voluntary Extended Care (V-9) Agreement, and who are placed in-state or temporarily out-of-state for the purpose of post-secondary education.
- Youth who were Reunified, Adopted, or entered Permanency Guardianship (PG) at age 16 or older from Maine DHHS, or who were Adopted or entered PG at age 16 or older from foster care in another state when the youth was placed in Maine on an Interstate Compact on the Placement of Children (ICPC) prior to the age of 18, and the sending state does not provide ETV funding.

Youth in care and caregivers continue to be informed about post-secondary educational supports through face-to-face meetings, Family Team Meetings, transition planning, YLAT and other youth leadership events. Youth Transition Specialists coordinate post-secondary educational planning in district offices. Youth apply for federal FAFSA funds and are encouraged to apply for available scholarships. Students must maintain good academic standing as considered satisfactory academic performance at their specific institution, or may be on academic probation, provided they are working towards regaining good academic standing.

OCFS staff worked with students and post-secondary institutions to ensure that the amount of ETV assistance provided to a student in combination with any other federal assistance programs does not exceed the total cost of attendance or duplicate other benefits.

Utilization of ETV funds:

Academic Year	New Participants	Continuing Participants	Total Participants
2012-2013	31	49	80
2013-2014	23	37	60
2014-2015	31	31	62
2015-2016	29	36	65

RESPONSIBLE STATE AGENCY

The State's Independent Living Program, as set forth by the Chafee Foster Care Independence Act, will be administered by the Department of Human Services; the State agency that administers the Title IV-E Program in Maine. The employer identification number for the Maine Department of Human Services is 1-01-600-0001A6. The Department of Human Services will administer these directly, or will supervise the administration of these programs in the same manner as other parts of Title IV-E and well as administer the Education and Training Voucher Fund Program. The Department of Human Services agrees to cooperate in national evaluations of the effects of the Chafee Independent Living Program's services.

ASSURANCES

The State assures that:

1. Title IV-E, Section 477 Chafee Foster Care Independence Program funds will supplement and not replace Title IV-E foster care funds available for maintenance payments and administrative and training costs, or any other state funds that may be available for Independent Living programs, activities, and services,
2. The Department will operate the Chafee Foster Care Independence Program in an effective and efficient manner,
3. The funds obtained under Section 477 shall be used only for the purposes described in Section 477 (f) (1),
4. Payments made, and services provided, to participants in a program funded under Section 477 as a direct consequence of their participation in the Chafee Foster Care Independence Program will not be considered as income, or resources for the purposes of determining eligibility of the participants for aid under the state's Title IV-A, or IV-E plan, or for the determining of the level of such aid;
5. Each participant will be provided a written transitional independent living plan that will be based on an assessment of his/her needs, and which will be incorporated into his/her case plan, as described in Section 475 (1);
6. Where appropriate, for youth age 16 and over, the case plan will include a written description of the programs and services which will help the youth to successfully prepare for the transition from foster care to interdependent living;
7. For youth age 16 and over, the dispositional hearing will address the services needed that assist the youth to make the successful transition from foster care to interdependent living;
8. Payments to the State will be used for conducting activities, and providing services, to carry out the programs involved directly, or under contracts with local governmental entities and private, non-profit organizations,
9. Funds will be administered in compliance with Departmental regulations and policies governing the administration of grants, 45 CFR, Parts 92 and 74, and OMB Circulars A-87, A- 102, and A-122, including such provisions as Audits (OMB Circulars A-128 and A-133) and Nondiscrimination (45 CFR, Part 80) and;

CERTIFICATIONS

The certifications shown below will be certified by the Department's Commissioner as part of the submission of the Title IV-B Child and Family Services Plan to be submitted before the end of June 2009.

1. Certification Regarding Drug-Free Workplace Requirements (45 CFR, Part 76.600).
2. Anti-Lobbying Certification and Disclosure Form (45 CFR, Part 93).
3. Debarment Certification (45 CFR, Part 76.500).

Attached to the CFSP are also the additional certifications required for the Chafee Foster Care Independence Program as signed by the Governor of the State of Maine.

STATE MATCH

The State will continue to provide the required 20% state matching funds as required by the Chafee Foster Care Independence Program and the Education and Training Voucher Fund Program. The State match for these funds includes the state's value of the Tuition Waiver Program.

Appendix C

Annual Reporting of Education and Training Vouchers Awarded

Name of State: **Maine**

	Total ETVs Awarded	Number of New ETVs
Final Number: **2014-2015 School Year** (July 1, 2014 to June 30, 2015)	62	31
2015-2016 School Year* (July 1, 2015 to June 30, 2016)	65	29

Comments:

ETV Eligibility Criteria:

- Youth who were in the custody of DHHS at the age of 18, and who have a signed Voluntary Extended Care (V-9) Agreement, and who are placed in-state or temporarily out-of-state for the purpose of post-secondary education.

- Youth who were Reunified, Adopted, or entered Permanency Guardianship (PG) at age 16 or older from Maine DHHS, or who were Adopted or entered PG at age 16 or older from foster care in another state when the youth was placed in Maine on an Interstate Compact on the Placement of Children (ICPC) prior to the age of 18, and the sending state does not provide ETV funding.

Appendix D

State of Maine Department of Health and Human Services
Office of Child and Family Services
Child Abuse Prevention and Treatment Act 2015-2016 Update

The Maine Department of Health and Human Services' ("DHHS"), Office of Child and Family Services (OCFS) 'commitment to ongoing improvements in its work of increasing child safety and greater wellbeing is strongly supported by the Child Abuse Prevention Treatment Act ("CAPTA") and the Children's Justice Act ("CJA") grant program requirements (CAPTA Section 106; CJA Section 107).

DHHS meets CAPTA Section 106 and CJA Section 107 grant requirements through a range of programs and supports in its agency child welfare work and through ongoing, strengthened, and increased inter-agency, intra-agency, interstate, intrastate, and multidisciplinary team work within our communities, supported by federal, state, and private resources, including parent partners and community members.

There were no substantive changes during 2015 to state law or regulations including laws and regulations relating to the prevention of child abuse and neglect that could affect the state's eligibility for the CAPTA state grant (section 106(b)(1)(C)(i) of CAPTA).

There were no significant changes during 2015 from the state's previously approved CAPTA plan in how the state proposes to use funds to support the 14 program areas enumerated in section 106(a) of CAPTA.

The requirements under Title 22 meet CAPTA requirements of Section 106.b.2.B.ii and iii, and support Maine's interagency response efforts in ensuring those infants' are safe and appropriate and services are made available to them. Notifications from health care providers that an infant has been born affected by illegal substance abuse or withdrawal symptoms resulting from prenatal exposure (legal or illegal substances) are identified as "drug affected baby" reports, including infants determined to be affected by Fetal Alcohol Spectrum Disorder. Notifications which are determined to not involve allegations of child abuse and/or neglect are referred directly to Public Health Nursing under a memorandum of understanding between OCFS and the Maine Center for Disease Control and Prevention, Division of Family Health, Public Health Nursing (CAPTA Section 106.b.2.B.v.).

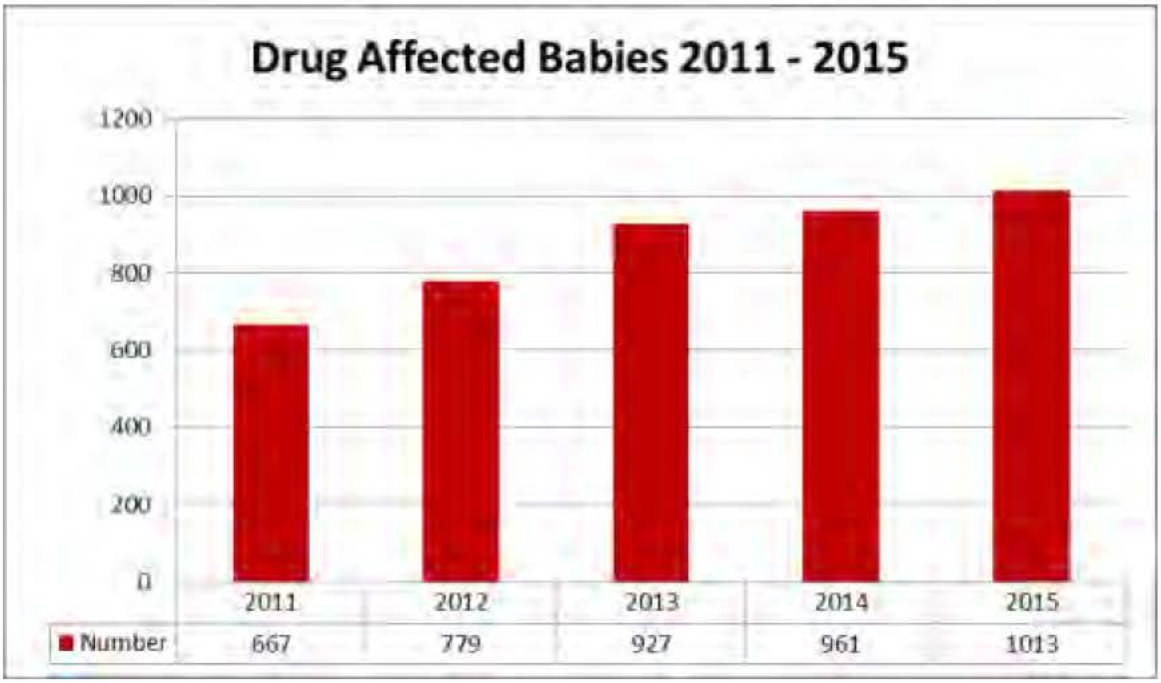
ANNUAL STATE DATA REPORT

During calendar year 2015, there were 8455 reports assigned for assessment for child protective services involving 13,927 children as alleged victims of child abuse or neglect of those assigned 8445 were completed; 2130 were substantiated or indicated and 6251 were unsubstantiated. In 2015, there were 2176 reports which were assigned to a Contract Agency for alternative response at the time of initial report. Referrals are also made to alternative response programs at the conclusion of a child protective assessment or case with a family, when ongoing services and support are deemed necessary. In addition, 7534 reports were deemed "inappropriate" (screened out) during calendar year 2015, as they did not contain allegations of child abuse or neglect. Some families were provided services through Community Partnership for Protecting Children. Through March, 2016, 408 families in Biddeford, Lewiston, Auburn, Portland and Bangor have engaged in preventive services.

During 2015, OCFS received 1013 reports of drug affected babies and 961 reports were received in 2014, 927 in 2013, 779 in 2012 and 667 reports for 2012. Of the 1013 reports received by OCFS in 2015; 3 were referred

to appropriate Tribal Welfare staff, 3 were referred to Home Visitors, 78 were referred to a Contract Agency, 489 were assessed by OCFS child protective services and 415 were referred for Public Health Nursing services.

FINAL DISPOSITION	# REPORTS
Assign to Contract Agency	78
Child Protection Assessment	489
DAB - Completed Assessment	25
DAB - Refer to PHN	415
DAB- Referred to Home Visitors	3
Referred to Tribes	3
TOTAL	**1013**



Maine's Department of Health and Human Services, Office of Child and Family Services has a policy in place regarding substance exposed infants. The policy has been in place since 2004. In the policy there is a decision tree regarding the steps that caseworkers must follow after receiving notice of a report of a substance affected newborn. Also within Maine's statutes there are two laws regarding substance exposed infants. Maine Revised Statutes, Title 22, Chapter 1071, §4004-B. Infants Born Affected by Substance Abuse or After Prenatal Exposure to Drugs or with Fetal Alcohol Spectrum Disorder and §4011-B. Notification of Prenatal Exposure to Drugs or Having Fetal Alcohol Spectrum Disorders. In the current OCFS policy there is a decision tree when a report is received regarding a substance exposed newborn. Also Paragraph 5 in §4004-B requires a development plan for safe care is part of statute.

In 2015, Maine's Office of Child and Family Services received 1013 substance-exposed baby notifications. In response to this rising need, and in recognition of the often complicated, multi-layered and unique needs of families with infants born substance-exposed, OCFS brought the Bridging model to child welfare services in

2016. Through a new partnership with the Maine Center for Disease Control and Prevention and Maine Families Home Visiting Program, Public Health Nurses and Maine Families Visitors trained as "Bridgers" will support parents and caregivers on a variety of topics, including mental health and substance abuse, trauma, crisis intervention, poverty and other risk factors. Originally implemented with nurses and home visitors in Washington County, Maine in 2009, Bridging is a strengths-based, community wrap-around model that offers individualized, flexible support through a family-driven plan that links or "Bridges" identified needs with available resources.

Nurse Bridgers are reserved for infants or mothers who have specific needs for short-term or intermittent nursing assessment and care which can include a variety of health specific referrals and supports. Maine Families Bridgers will provide concurrent and longer-term parenting support and education for families.

DHHS, OCFS has partnered with the Hornby Zeller Agency regarding the effectiveness of the Bridging Program. This project will evaluate the effectiveness of the Office of Children and Family Services partnership with Public Health Nursing and Home Visiting through the Bridger programs. Nurse Bridgers target mothers with substance exposed infants who need some form of clinical intervention while the Home Visiting Bridgers also work with substance exposed newborns after PHN or in lieu of it when the infants' risks are not clinical. The evaluation will include both formative and summative components, questions which look at the processes and the level of coverage of the program as well as the results for parents, their newborns and the public system that serves them.

The number of children, under age 18, in State custody at the end of calendar year 2015 was slightly higher than last year. At the end of 2015, there were 1,925 children in state custody. At the end of calendar year 2014 there were 1,857; 1,908 in 2013, 1,324 in 2012 and 1,471 in 2011. Although, the number of children in custody in Maine rose slightly from 2014 to 2015, the rise was not as evident as the rise from 2012 and 2013. As of March, 2016, there are 1961 children in DHHS custody. 1221 of those children are placed in licensed foster homes, 285 in an unlicensed foster home and 45 are placed out of state. The remaining 410 children are placed in other settings such as residential, hospital, correctional facilities, independent living programs, youth on own, trial home placements, etc.

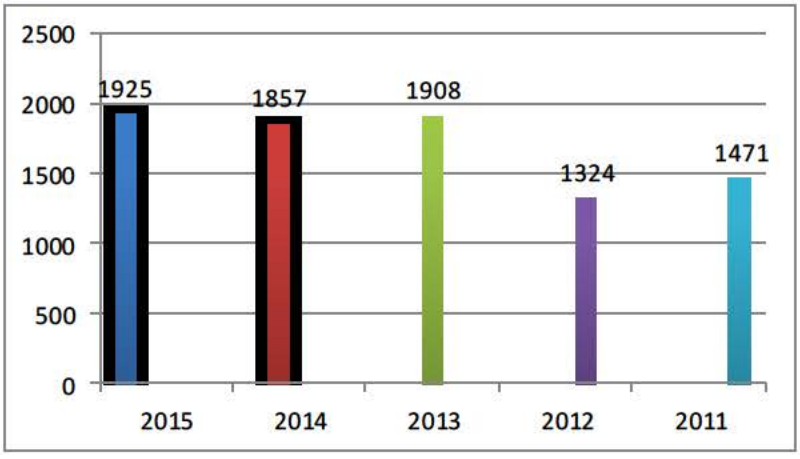


Table to left shows the # of children in custody at the end of each year.

The number of children for whom individuals were appointed by the court to represent the best interest of such children varied based on children that entered and then left state custody in 2015. Therefore, this data is relative to the number already described in the previous paragraph; which was 1,925. In 2015, 600 child protection

cases were filed in Maine District Courts. Maine does not currently track the data on out of court contacts between such individuals and children.

The ACF Summary Data- CFSR Round 3 Statewide Data Indicators (May 2015) reflect that Maine no longer meets the national standard related to recurrence of maltreatment. The national standard is 9.1%, Maine's observed performance is 11.2%. Based on this data Maine would be required to address this through the PIP process. It is anticipated that the adoption of the ERSF process will positively impact the challenges we face related to recurrence of maltreatment.

In calendar year 2015 there were 19 child deaths reported to CPS. After investigation, two of the deaths were substantiated or indicated by DHHS. Although there was maltreatment involved in each case based on the definition, maltreatment may not have directly caused the death of the child.

None of the 19 child deaths in Maine in 2015 occurred while the child was in foster care.

The Office of Child and Family Services previously was actively pursuing the use of a real-time quality assurance practice, "Rapid Safety Feedback" system. The system would allow for a specifically-trained group of staff to review cases, assess for unaddressed risk/safety factors, and take action on creating plans to address the identified concerns.

The Eckerd Rapid Safety Feedback (ERSF) was first introduced in two counties in Florida as a result of multiple child deaths within a three year span of time in open cases actively receiving services from the local child welfare lead agency. The results of the model has been viewed positively with no abuse related deaths in the population receiving services after implementation. Eckerd describes the process as a true partnership between the field and Quality Assurance that shares decisions and responsibility on cases and assessments.

Maine OCFS began conversations with Eckerd in the fall of 2014 with an interest in bringing the model to Maine. In the fall of 2015 Maine SACWIS system and the technology supporting the ERSF Model began sharing data in order to identify those risk factors that would most likely lead to high severity child abuse and neglect. In 2015 QA staff were positioned and trained to support ERSF. All of the QA staff were trained in the model in November 2015 with full implementation of the model rolled out on March 7, 2016 with 2 primary and 1 back up reviewer from the QA unit assigned to this responsibility. Leading up to full implementation the group participated in weekly 'practice' reviews to become more proficient in the model. The feedback on the process has been that staff view that as a collaborative/teaming approach to ensure child safety. This process does rely on child welfare staff entering assessment activity into MACWIS within 10 days of the assignment date for the ERSF review, child welfare staff are notified when their assessment has been pulled into the prediction model. Following the review, staffings with child welfare caseworkers and supervisors occur to answer any questions that the ERSF staff have and, when appropriate, action steps are developed to address unanswered questions. Timeframes are also established to complete those steps and, if they are not met, a second level of accountability is initiated to ensure that management is aware of the concerns and can support staff to accomplish the actions steps.

In the six weeks of implementation there have been 33 assigned reviews and 19 staffings held.

OCFS experienced a more positive year for maintaining stable child protective staffing when compared to previous years. The child protective caseworker statewide turnover rate was approximately, 22.66% for 2015 vs. 23.85% for 2014, 27.87% for 2013 and 27.3% for 2012. The turnover rate for supervisors in 2015 was 6.7% roughly the same as 2014.

This trend in caseworker turnover is very similar to nationwide statistics. One study from the General Accounting Office indicates staff turnover in child welfare is estimated to be 30-40% annually nationwide; the average length of employment is less than 2 years (GAO, 2003)[1]. Another study from the Annie E. Casey Foundation estimated the annual turnover rate for public agencies is 20% and private agencies 40% and the average length of employment for public agencies is 7 years and for private agencies is 3 years. (AECF, 2003)[2]. Maine's 2015 turnover rate of 22.66% is acceptable based on the two studies. One of OCFS's goals to further reduce the turnover rate among caseworkers.

The fact that there has been a drop in turnover in Maine over last few years suggests that the establishment of the Maine's Recruitment and Retention Specialist position has had a very positive effect. This position continues to provide focused efforts in managing the child protective workforce. OCFS child protective caseworker and combined supervisor staffing levels are currently at 93%. Caseworker applicants with good qualifications and skill sets continue to apply for open positions.

OCFS is working to reduce the caseworker turnover rate to 15%. With respect to recruitment Maine's Recruitment and Retention Specialist does a lot of work with Maine, New Hampshire and Massachusetts colleges and Universities and with Maine Department of Labor to increase the applicant pool. The Recruitment and Retention Specialist attends many job fairs throughout the three states and also presents directly in the classroom to students considering the Social Work profession. OCFS has streamlined the application process in many ways to make it easier to identify those that qualify and those that do not. Applicants use the Recruitment and Retention Specialist as a contact person to assist them through the application process and the licensure process. The Recruitment and Retention Specialist also works to bring consistency to the interview process across all state offices and personally assists with interviews of applicants in all offices so that each interview consistent.

With respect to retention of Maine's child welfare personnel, OCFS has taken the following steps:

1. OCFS is in the third quarterly process of STAR awards. These awards recognize exemplary employees of any category within OCFS. STAR stands for Service. Teamwork, Attitude and Respect.
2. OCFS started reimbursing all OCFS caseworkers and supervisors for the cost of the renewal of their professional Social Work license beginning Jan 1, 2016.
3. Tuition reimbursement is now offered to all employees who have been with the agency one year or more. On site MSW classes are offered in some locations.
4. Clarifications around Flexible Schedules have been provided to employees.
5. Quality Circles run by front line district staff have been running in each district. The QC has addressed areas such as mentorship for new employees, staff safety and case flow processes.
6. OCFS is addressing Internal Customer Service issues to improve the way TAMS and reimbursements occur to make it easier for the employee.
7. OCFS's onboarding is improving with better information sharing at the time of hiring. Entrance surveys are conducted to determine how the recruitment process is functioning.
8. OCFS has increased supporting staff and tasks to decrease workload for caseworkers.
9. Supervisory training has been provided to all supervisors to increase supervisory awareness regarding recruitment and retention and their role around that as well as to increase overall supervisory skills.

[1] The U.S. General Accounting Office (GAO). (2003). Child welfare: HHS could play a greater role in helping child welfare agencies recruit and retain staff. Retrieved on August 18, 2009, from: http://www.cwla.org/programs/workforce/gaohhs.pdf

[2] Annie E. Casey Foundation (AECF). (2003). *The unsolved challenge of system reform: The condition of frontline human services workforce.* Retrieved from http://www.aecf.org/resources/the-unsolved-challenge-of-system-reform/

The average caseload for workers conducting assessment and investigation ranges between 72 and 96 per year. The agency response time with respect to each report and the initial investigation during 2015 was within 72 hours approximately 75% of the time. Maine's goal of completing assessments within 35 days with the respect to the provision of services to families and children where an allegation of child abuse or neglect has been made was achieved during 2015 on approximately 85% of completed assessments.

OCFS had 335 child protective caseworkers and 65 child protective supervisors conducting the work of intake, screening, assessment, investigation, and permanency work, noted below by geographical district office, on March 22, 2016.

District	Number of Caseworkers	Number of Supervisors	Number of CPS Assessments	Number Vacant Positions
1	45	9	1233	5
2	47	10	1199	2
3	48	10	1484	3
4	24	4	792	2
5	54	10	1529	4
6	46	9	1271	2
7	22	4	461	1
8	22	5	476	1
9 (intake)	27	4	--	0
Total	**335***	**65***	**8445****	**20**

** It should be understood that because turnover occurs at a random but continuous rate reporting on caseworker and supervisor numbers may or may not be the same tomorrow as they were today. These are simply point in time numbers derived on March 22, 2016.*
***Assessments completed are based on calendar year 2015.*

Currently there are 27 child protective service personnel responsible for intake and screening, 112 child protective service personnel responsible for the assessment and investigation of reports, 135 child protective service personnel responsible for permanency of children in state custody and approximately 61 child protective service personnel responsible for adoption, foster home licensing and resource services for children in state custody. Based on the Table above and the numbers provided here it is apparent that the ratio which exists between caseworkers and supervisors is approximately 5:1, where there is 1 supervisor responsible for 5 personnel.

Of the caseworkers currently working for the Office of Child and Family Services, 93 caseworkers are between 22-29 years of age, 103 are between 30-39 years of age, 70 are between 40-49 years of age, 48 are between 50-59 years of age and 11 are between 60-69 years of age. 95.6% of the caseworkers between the ages of 22-29 are female, 93.2% of the caseworkers between the ages of 30-39 are female, 84.2% of the caseworkers between the ages of 40-49 are female, 87.5% of the caseworkers between the ages of 50-59 are female and 45.4% of the caseworkers between the ages of 60-69 are female.

The average salary for a caseworker between the ages of 22-29 is $39,605.21; 30-39 is $42,315.58; 40-49 is $43,406.75; 50-59 is $45,560.23 and 60-69 is $45,081.16.

Of the caseworker supervisors currently working for the Office of Child and Family Services, 26 are between the ages of 30-39 years of age, 24 are between 40-49 years of age, 12 are between 50-59 years of age and 3 are

between 60-69 years of age. 96.1% of the caseworker supervisors between the ages of 30-39 are female, 83.3% between the ages of 40-49 are female, 100% between the ages of 50-59 are female and 33% between the ages of 60-69 are female.

The average salary for a caseworker supervisor between the ages of 30-39 is $51,912.; 40-49 is $58,266.; 50-59 is $56,988.53 and 60-69 is $55,882.67.

Maine OCFS child protective caseworkers and supervisors are required to have full social work Maine licensure before they can begin managing a child protective case. Newly hired caseworkers are also required to complete a Caseworker Pre-Service training program ("Pre-Service") conducted by OCFS. Pre-Service provides a comprehensive curriculum and job shadow components to ensure caseworkers have the competencies and skills to perform child protective work. Personal safety training is provided for all State employees through the State of Maine's educational training services.

In order to qualify for a Human Services Caseworker position applicants must have a Bachelor's Degree from an accredited institution in Social Work or a Bachelor's Degree in a related field such as Behavioral Science, Childhood Development, Education and Human Development, Mental Health and Human Services, Psychology, Rehabilitation Services or Sociology. Casework lines are generally exempt from the hiring freeze and open for recruitment which can be found on the government website.

The state application process includes a numerical evaluation that considers the applicant's background, training and experience. All selected applicants undergo a panel interview conducted by at least three management level staff in order to fill a district child welfare vacancy. The salary for caseworker staff ranges from $35,131.20 to 47,611.20 with health and dental benefits.

All new caseworkers are required to participate in pre-service training that covers a multitude of topics, including Introduction to Public Child Welfare in Maine, Fact Finding Interviewing, Legal Training, Family Team Meeting training, Psychosocial Assessment and Case Planning (a requirement for a Maine Social Work License), Assessing Child Safety, Risk and Danger, Introduction to ICWA, Medical Indicators of Child Abuse and Neglect, Impact of Substance Abuse on Families and Children and Impact of Domestic Abuse on Families and Children.

Within the first two years of hiring, new staff are expected to participate in several core trainings which would expand upon what they had experienced in pre-service and include: Medical Indicators of Child Abuse and Neglect, Dynamics of Substance Abuse and Domestic Violence and Batterer Intervention/Accountability.

There are district allocations for staff to continue their professional development in accordance with licensing requirements as well as to allow access to professional literature.

All supervisors hired in DHHS are required to participate in the training; *Managing in State Government*. The focus of this training is the role of the supervisor in an organization and how it differs from the task based role of the employee. The training covers policies and procedures that are unique to supervision within state government including employee selection and performance evaluations. The salary for caseworker supervisor staff ranges from $42,848 to $58,656 with health and dental benefits.

To further the effort for supervisory training and development, Maine OCFS was approved to receive training assistance (TA) from the National Resource Center for Organizational Improvement (NRCOI). The TA provided assistance in developing a plan for supervisory training for staff who supervises front line child welfare social workers. The goal was to develop a robust training plan that will encompass a variety of training

venues and extend to supervisory staff who supervise other OCFS programs. Key goals of the Supervisory Plan are to provide trainings that encompass the "real" work that they and their staff do on a an everyday basis, topics that touch on the strength and challenges they each bring to the work, training venues that allow for attendance and interaction, and trainings that morph into sustainable practice and integration of service that meets the needs of the children and families we serve. The training was provided over the last year and will continue to be provided on a quarterly basis.

Supervisors also participate in Supervisory Academy- *Putting the Pieces Together*. The training was developed by the Butler Institute. This is a 54 hour training which consists of three modules that are three days each. The training covers the three main areas of effective supervision (Administrative, Educational, and Supportive Supervision) that, while related, are also distinct and that each is an important component or piece of the bigger picture puzzle of child welfare supervision. Each module emphasizes self-reflection and application to the unique circumstances of each supervisor. This training has been rolled out across the State of Maine in 2015 (each of the three modules being trained North, Central and South) training all Child Welfare Supervisors (80 total). This training is due to roll out again in 2016 on the following dates (there are currently 13 enrolled): Module 1: May 17, 18, & 19, Module 2: August 16, 17, & 19 and Module 3: October 18, 19, & 20.

All new state employees receive a three month evaluation followed by annual performance evaluations. Casework supervisors are expected to conduct quarterly field observations focused on individual casework practice and provide supervisory feedback on those observations. In terms of measurement, each district has a Performance and Quality Improvement Specialist who reviews district cases and provides feedback to staff related to practice. All supervisors have access to the Results Oriented Management data system that provides information related to meeting federal outcomes. Supervisors have access to an array of management reports to monitor the key components of practice and can be used in individual supervision to help track caseworker workload, activities and help set caseload priorities based on that information.

In Maine, children in the care of the child protection system are not transferred into the custody of the State Juvenile Justice System if they become involved with the criminal justice system, but rather remain under the custody of the Department of Health and Human Services unless custody is returned to a parent or guardian.

There were 1090 unique children under the age of 3 who were a victim or in a home where child abuse and/or neglect was indicated or substantiated. These children were referred to Children's Development Services (CDS) for assessment to determine what services the child/children would benefit from.

At the completion (supervisory approval) of the Safety Assessment, the caseworker will inform the parent(s) that a referral to CDS will be made. The caseworker will inform the parent(s) of the potential benefits to their child of such a referral. The caseworker will give the parent(s) a copy of the informational brochure from CDS that explains the program to them.

At the same time as the substantiation notification letter is generated, a referral form to Child Developmental Services will also be generated regarding children in the home under the age of 3. This form is to be mailed to the appropriate Child Developmental Services office immediately.

Beginning in February, 2016 OCFS have been trialing a new referral process which consists of our central office sending a biweekly report to CDS with the names of all the children who are required to be referred according to CAPTA. This has resulted in a 100% referral rate since the commencement. OCFS plans to implement this process ongoing for the coming year.

Training around the risk factors and dynamics of Commercial Sexual exploitation and human trafficking will be delivered to each child welfare district office. This training is a full day training co-trained by the Maine Coalition Against Sexual Assault and the Policy and Training Unit for the Office of Child and Family Services. As part of the training staff learn the newly implemented protocol of convening a multidisciplinary team with sexual assault advocates, law enforcement, child welfare and others who are important to the child when there is heightened concern that a youth in care is a victim or when a youth in care is an identified victim.

Information on Commercial Sexual Exploitation of children (CSEC) has been added to our mandated reporter training. Community members will now learn about red flags and risk factors and will be instructed to report such information to the child protective hotline like any other suspected child abuse or neglect. Intake staff will soon be able to track allegations of CSEC through a new allegation screen and assessment staff will be able to make findings specifically around CSEC and our MACWIS system will be able to trach such allegations and findings.

No changes are necessary to the State of Maine laws regarding victims of sex trafficking as exploitation is already incorporated in the law. LD 1159 "An Act To Address Human Trafficking, Sex Trafficking and Prostitution" was signed into law on July 8, 2013.

With respect to the State of Maine's progress to develop provisions and procedures regarding identifying and assessing all reports involving known or suspected child sex trafficking victims, child welfare staff will receive training in regards to the risk factors and dynamics of sex trafficking. A policy has been implemented to add the use of a screening tool to identify levels of risk and corresponding next steps for victims.

With respect to the State of Maine's progress and planned activities to develop provisions and procedures for training CPS workers about identifying, assessing and providing comprehensive services to children who are sex trafficking victims, OCFS in collaboration with community partners offer combined local trainings as well as statewide conferences are offered around the state to cross train these disciplines.

Maine's Citizen Review Panel (CRP)

The Citizen Review Panel had productive meetings during the first six months of 2015. The CRP worked to enhance the membership of the panel by seeking out community stakeholders that would complement the panel. Panel members reached out to clergy member, law enforcement personnel, etc.

The CRP worked on a survey tool for caseworkers and decided to do focus groups with caseworkers from each of the different districts. The group decided to use survey monkey and once the survey was put together, OCFS senior management would help deliver the survey to caseworkers. The group discussed the possibility of a public service announcement (PSA). The content would reflect the positives of child welfare, social workers and caseworkers, etc. The panel was going to connect with the media group at the local university to determine what next steps would be to move the project forward. The group discussed a project for sending "thank you" notes to caseworkers and resource families. The panel looked to have that project completed by April/May of 2015. In May, 2015, the panel signed the Thank You notes to the caseworkers and the Thank you notes were sent. *(Attachment A)*

In October, 2014, the Panel submitted a report title *'Maine Citizen's Review Panel Recommendations for a Coordinated Health Plan for Children in Foster Care':* a coordinated health plan for children in foster care. A portion of this plan was brought before the Maine Legislature as LD 213. In the 127th Maine Legislature's First Regular Session-2015, it was ordered that LD 213 "An Act to Ensure the Comprehensive Medical, Dental, Educational and Behavioral Assessment of Children Entering State Custody" was carried over to the 127th

Maine Legislature's Second Regular Session. *(Attachment B).* In the Legislature's Second Regular Session, LD 213 was changed by Committee Amendment. *(Attachment C).* LD 213 was passed by the House and the Senate. On March 21, 2016, LD 213 was vetoed and that veto sustained by the Legislature. While LD 213 did not become law, OCFS is working on revising policy and protocol on the issue of a coordinated health plan for children in foster care.

In September, 2015, the Citizen's Review Panel, the Child Death and Serious Injury Review Panel, Child Abuse Action Network and Child Welfare Steering Committee were notified by DHHS that OCFS would no longer provide administrative support to the CRP and CWSC. *(Attachment D).* Members of those groups were encouraged and invited to join the CAAN panel. The new group formed in December, 2015 includes members of CAAN, CRP and CWSC. The panel has been renamed Maine's Child Welfare Advisory Panel. MCWAP will serve as the State of Maine's Citizen's Review Panel pursuant to CAPTA Sec. 106(c). MCWAP in collaboration with the State of Maine's Judicial Branch, Justice for Children's Task Force will serve as the State of Maine's Task Force pursuant to CAPTA Sec. 107(c).

Maine's Child Death and Serious Injury Review Panel (CDSIRP)

The Maine Child Death and Serious Injury Review Panel is a multidisciplinary team of professionals established by state law in 1992 to review child deaths and serious injuries with a focus on improving our systems of child safety and care. The Panel meets monthly to review cases evaluating sentinel events, patterns of injury and/or death and the effectiveness of the state programs that provide for child protection, safety and care. Through the Panel's findings and recommendations the Panel hopes to help reduce the number of preventable child fatalities and serious injuries in the state. The members of the Maine Child Death and Serious Injury Review Team are volunteers who give generously of their time and expertise and who represent both public and private agencies with an interest in the welfare of Maine children. Through their commitment, the Panel has been able to build a collaborative network to foster teamwork and to share the recommendations with the larger community.

Maine's Child Death and Serious Injury Review Panel (CDSIRP) completed 8 comprehensive reviews of fatalities and near fatalities in 2015 and early 2016. These reviews were comprised of the following themes and trends: Abusive Head Trauma (AHT), Unsafe Sleep, Unsatisfactory Home Birth and Significant Bruising and Fractures. The CDSIRP also participated in two dual comprehensive dual reviews with Maine's Domestic Violence Homicide Review panel. The themes in the two dual reviews with DVHRP were homicide. One case was a murder-suicide and the other consisted of an infant beaten to death by his mother's boyfriend. There is a benefit to both panels by participating in a dual review. Many services provided to families are seen by both panels when cases are reviewed. The dual comprehensive reviews allow members of both panels to look at the services provided to the families and how to improve those services so tragic events can be avoided.

It came to the attention of the Maine Centers for Disease Control that in 2012 there was a dramatic rise in the infant mortality rate in Maine. 2012 was the most current data available. The Medical Director of the Maine CDC is a panel member of the CDSIRP. The infant mortality rate information regarding the rise in the infant mortality rate in Maine was presented to the members of the CDSIRP and they voted to form a subgroup to take a deeper look at the infant mortality rate and what the cause of the substantial increase could be. The Infant Mortality Subgroup is currently waiting for linked birth and death certificate files for 2013 and 2014 in order to determine next steps for the group. The IMSG provides monthly updates to the members of the CDSIRP regarding the progress of the investigation into the infant mortality rate.

The panel chair of the CDSIRP generally attends the annual meeting of Child Fatality Review Teams from all over New England. The New England meeting is scheduled to be held in East Hartford, Connecticut. The

meeting in Connecticut in June will focus on building the structure of the coalition, identifying goals for future work, sharing the work of regional members, and providing substantive knowledge to state coordinators and attendee members of Child Death Review teams.

CAPTA funding continues to support the work of the Maine Child Welfare Advisory Panel (MCWAP) and the Child Death and Serious Injury Review Panel (CDSIRP).

DHHS has used a portion of its CAPTA funds to help defray the cost for the Spurwink Child Maltreatment Conference that was held in October, 2015. Many OCFS child welfare personnel attended this conference and found the information presented informative and useful. On the second day of the conference, Bryan Lindert, Director of Quality Management of Eckerd, gave a presentation entitled "Eckerd Rapid Safety Feedback: A New Approach to Reduce Fatal Child Maltreatment". This was a very timely presentation given that the State of Maine, DHHS, OCFS was in the beginning stages of planning implementation of Eckerd. *(Attachment E)*.

The Department has also provided funds to Maine Pretrial Services, Inc., a non-profit entity, that has contracted with Substance Abuse and Mental Health Services (SAMHS) to provide adherence case management for the six Adult Drug Treatment Courts (ADTC) in Maine, to provide general court case management for two Family Treatment Drug Courts (FTDC), and to provide case management for the Co-occurring Disorders Veterans' Court (CODVC). The contract specifies the provision of case management at sites in Washington, Penobscot, Androscoggin (two courts), Cumberland, Hancock, York and Kennebec Counties (two courts). The contract period began July 1, 2015 and will end June 30, 2016 for ADTC, FTDC, and CODVC.

Under this SAMHS contract, six counties have Adult Court Adherence Case Managers on site and three counties have Family Court Case Managers. One county has an aftercare Case Manager. This contract also covers one Veterans' Court staff. Each staff member reports to the Case Management Director, the Deputy Director, and the Executive Director. The Executive Director reports to the Office of Substance Abuse, as well as the Judicial Branch.

Case Managers meet with all Maine Pretrial Services'(MPS) staff a minimum of once monthly for Staff Meeting and Supervision. Staff meetings are attended by MPS staff. A total of three staff meetings occurred in this fourth quarter. Topics presented at staff meetings included: community case management, risk assessment, case planning for risk reduction, suicide prevention, domestic abuse risk assessment, lethality risk assessment, policy review, eligibility, capacity building, technology troubleshooting.

DHHS has also used a portion of the CAPTA funds to purchase Period of Purple Crying information in a variety of formats. The information is given to child protective personnel who interact with families that have infants. The families generally receive Period of Purple Crying information from hospital personnel when the family was in the hospital delivering the infant. The information presented from the child protective personnel reinforces the information the family received at the hospital. In the event the family did not receive the information in the hospital, the Period of Purple Crying information is valuable and may be lifesaving information for the family.

DHHS has also used a portion of the CAPTA funds to contract with Susan Righthand, PhD. for consulting services. DHHS is working with Dr. Righthand to facilitate clinical consultations regarding youths with problematic sexual behavior or other aggressive behavior problems. Dr. Righthand has extensive experience working with youths and adults who sexually offend, as well as children and adults who experience or perpetrate child maltreatment and other forms of violence. Dr. Righthand participates in three monthly consults with OCFS staff regarding complex cases. The monthly consults are well attended by Clinical Care Specialists and Mental Health Coordinators. Child protection staff members attend as do clinicians and on occasion,

members of the Department of Corrections, Division of Juvenile Services. Dr. Righthand also provided consultation at a number of administrative meetings. She has been requested to do research and write reports regarding Project Keep and Mendota Juvenile Treatment Center in Wisconsin. Dr. Righthand will also be facilitating a Program Enhancement Project (PEP) to provide OCFS consultation to residential treatment providers. Together with 4 Care Specialists, Dr. Righthand is reviewing the research literature on effective residential treatment programs to identify the core components of evidence supported programs. Dr. Righthand and 4 Care Specialists will use their findings to develop a program enhancement protocol which will be used to assist programs in identifying the program's strengths and to determine what the program can do to further enhance the program's effectiveness.

DHHS has used a portion of its CAPTA funds, for Promoting Safe and Stable Families and State funds, in equal shares, to support the work of the Maine Children's Trust (Maine Revised Statute Title 22, Chapter 1058) in its administration of the CAN Council grant program for the promotion and delivery of parent access to evidence-based parent education. The Maine Children's Trust has seventeen financial awards open to community parent education program providers located throughout the State's communities. Those parent education programs include the Nurturing Fathers Program, 123 Magic, 1234 Parents, Incredible Years, Parents Are Teachers–Too with an emphasis on Fathers, Active Parenting Now, Nurturing Program for Teen Parent, Nurturing Program for Families and a training series for case managers and in-home support staff to parents with children with autism spectrum disorder. The Maine Children's Trust and the Child Abuse Prevention Councils of Maine are currently accepting applications for 2015-2016 child abuse and neglect prevention grants. There is a total amount of $60,000.00, up to $8000 each, available for grants intended to prevent child abuse and neglect. The Maine Children's Trust is required to submit quarterly reports on the progress of the goals as agreed to with DHHS.

Through September 30, 2015, the Department has also used CAPTA funds in support of the Maine's Coalition Against Sexual Assault (MECASA), supporting MECASA's ability to provide expert assistance and training to sexual assault support center direct service staff, including the creation of a statewide train-the-trainers resource.

Through liaison with MECASA, Children's Advocacy Centers (CACs) are child-focused, facility-based programs in which representatives from many disciplines, including law enforcement, child protection, prosecution, mental health, medical and victim advocacy, and child advocacy work together to conduct interviews and make team decisions about investigation, treatment, management and prosecution of child sexual abuse cases.

MECASA passed some of the grant funds through to providers. Kennebec/Somerset CAC and Androscoggin used the grant funds for program development. Cumberland CAC used the grant funds to support the family advocate position. Spurwink CAC used the grant funds to set up their CAC interview room. MECASA used the remaining grant funds to support staff time at the Network to provide TA and training for both existing and emerging CACs. MECASA also used the CAPTA grant funds for the Network Coordinator's time providing TA toward accreditation. The CAPTA funds also supported the Executive Director's time on a policy development project as well as the Communications Director's work regarding materials creation and media work and some of the Associate Director's work on outcome measurement and creation of data collection tools.

Maine currently uses MACWIS (SACWIS) and information gathered from the state's vital statistics department, child death review panel, law enforcement agencies, and the medical examiners' office (the Chief Medical Examiner for Maine is also a member of the CDSIRP) when reporting child maltreatment fatality data to NCANDS.

State of Maine SLO/CAPTA Coordinator

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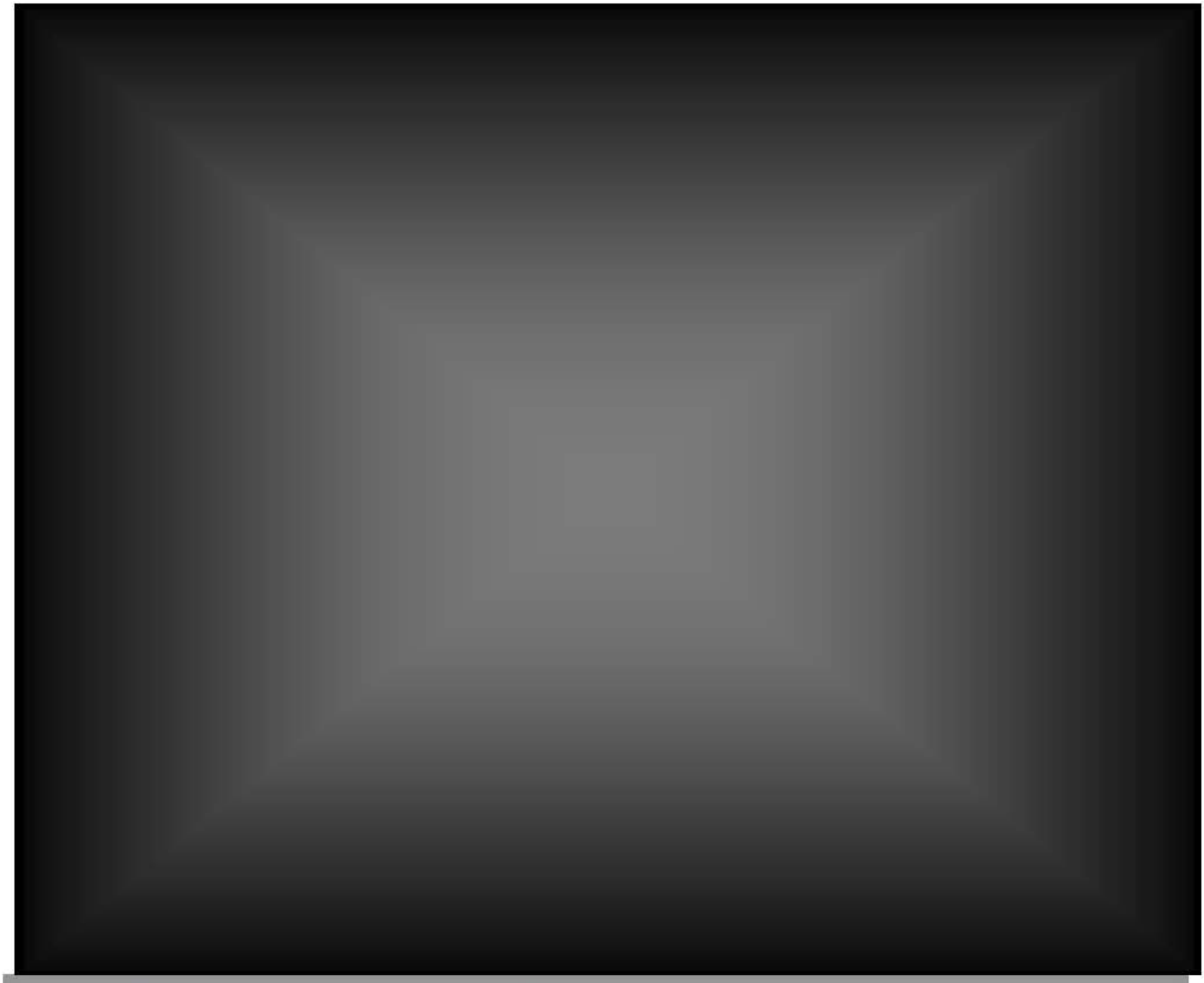


Department of Health
and Human Services
Maine People Living
Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that attended the reviews. Their attendance enriches the work of the panel. Without them, this report would not be possible.

All data analysis and writing for this report was completed by:

Maine Child Death and Serious Injury Review Panel and

Prepared by John Jacobs

With support from the Maine Automated Child Welfare Information System (MACWIS) Personnel

For information about this report or to request copies, please call the Maine Department of Health and Human Services Office of Child and Family Services 207-624-7900

"Children are among the most vulnerable members of society. This susceptibility can be further increased by biological factors, such as a genetic predisposition or disability, and by extrinsic factors in their physical or social environment and in the care provided to them"[16]

TABLE OF CONTENTS

"Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub)."[3]

LETTER FROM THE CO-CHAIRS

January 20, 2015

To the Honorable Governor Paul LePage;

The Maine Child Death and Serious Injury Review Panel is a multidisciplinary team of professionals established by state law in 1992 to review child deaths and serious injuries with a focus on improving our systems of child safety and care. We meet monthly to review cases evaluating sentinel events, patterns of injury and/or death and the effectiveness of our state programs that provide for child protection, safety and care. Through the Panel's findings and recommendations we hope to help reduce the number of preventable child fatalities and serious injuries in our state.

The members of the Maine Child Death and Serious Injury Review Team are volunteers who give generously of their time and expertise and who represent both public and private agencies with an interest in the welfare of Maine children. Through their commitment, the Panel has been able to build a collaborative network to foster teamwork and to share the recommendations with the larger community.

Additionally, the Panel meets annually with the Child Fatality Review Teams from all of New England to share experience, information and review cases that involve services from more than one state or which represent a challenge that all of our States are trying to address.

The challenges leading to case reviews from 2010 to 2013 to help improve the system of care include:

[3] US Department of Health and Human Services Administration for Children, Youth and Families. (2009, April). Retrieved June 23, 2010, from Child Abuse and Neglect, Fatalities: Statistics and Interventions: www.childwelfare.gov

- The rate of home birth is increasing and there is evidence suggesting that home birth is not as safe in Maine as it is in other countries. Our task was to assess the safety of home birth in Maine compared to hospital based deliveries and identify ways to strengthen care for families choosing home birth in our state. The Maine Legislature has determined that birth is a natural, not a medical process, but Maine needs to develop a definition of medical practice and to define when a birth is so complicated that it rises to a level requiring medical practice. The Maine Medical Association and Maine's home birth midwives need to work together to develop systems that will improve the selection of low risk deliveries for home birth and develop a strategy that will enable a smooth transfer of care from home birth midwives to hospital care when needed. Maine families should not feel that they are being punished for choosing home birth.

- The rise of infants exposed to drugs in utero. Our task was to review specific cases in Maine, consider risk of death and disability in this group, and recommend improvements in care for these infants. These babies are known to have immature breathing patterns, which may put them at risk for unexpected infant death, and are at higher risk for developmental delay than other babies born in Maine. Professionals working in systems providing care for adults in treatment for substance abuse need to understand and consider the fragility of the infants in the care of their clients.

- Along with a rise in babies exposed to narcotics and other drugs in utero, we have seen a dramatic increase in drug ingestions in children in Maine. The problem of drug ingestions is not isolated to our state. Our poison control center serves to support Vermont and New Hampshire as well as Maine and they have documented similar poisoning, whether intentional or unintentional in children throughout Northern New England. The leading medications involved in such poisonings are psychotropic prescribed for adults or older children, but also include medical marijuana, methadone and buprenorphine.

- Over the last 4 years we reviewed many cases where a child presented to a mandated reporter with bruises and other injuries that turned out to be inflicted and which should have resulted in a report to the Department of Health and Human Services because of concerns over child abuse. At times, the mandated reporter was quoted as saying that the injuries could not have been intentional because the caregiver, whether parent or other guardian was so nurturing and attentive to the child's needs. Our current mandated reporter laws specify the importance of suspecting that a child has been abused before making a report. The vague nature of suspicion has led to many unnecessary reports to the Department and provides a barrier in cases where a report should be made. Also, current mandated reporter laws do not go far enough to protect individuals from legal attack when they do make a good faith report.

- In order to accurately identify trends, surveillance of serious injury and death in children in Maine must improve. The panel applauds the efforts of the Maine DHHS in beginning to develop such a surveillance system. However such a system does not end with DHHS, it must include law enforcement, the medical examiner's office and others.

- The Panel continues to be distressed at the number of Maine children dying in an unsafe sleep environment. This includes unsafe bed-sharing, inadequate bedding, or even shared couch sleeping. Maine needs to develop a coordinated education program for parents on safe sleeping. Babies born prematurely and infants exposed to drugs in utero are at much higher risk of dying suddenly and unexpectedly when sharing a sleep surface with

an adult or other child. The American Academy of Pediatrics has issued clear guidelines for safe sleeping that should be implemented in the state. Although bed-sharing rates are increasing in the United States for a number of reasons including the facilitation of breastfeeding, the AAP task force concludes that the evidence is growing that bed sharing, as practiced in the United States and other Western countries, is more hazardous than the infant sleeping on a separate sleep surface. They therefore recommend that infants not bed-share during sleep.

Some of their recommendations include:

- The "Back to Sleep" initiative which involves placing infants on their backs to sleep.
- Use a firm sleep surface: A firm crib mattress covered by a sheet is the recommended sleeping surface.
- Keep soft objects and loose bedding out of the crib
- Do not smoke during pregnancy
- A separate but proximate sleeping environment is recommended

Additionally, we report on the activities of the abusive head trauma prevention workgroup, organized under the Maine Children's Trust, through whose efforts the evidence based "Shaken Baby" prevention program was implemented in every birth hospital in the state. These efforts were spawned after a past review of the CDSIRP.

The Panel has become acutely aware of the lack of parenting skill and knowledge among the young adults whose choices result in serious injury or the death of their child. We recognize that parent training is a cultural responsibility, best left to the parents and extended family. Unfortunately, in too many instances we review cases of child death and injury that have generations of abuse and neglect. We must act to break this cycle and the panel recommends implementing an evidenced based program such as Triple P for parents involved in the child welfare system, especially those with histories of generations of abuse.

The Panel has made a number of valuable contributions since its inception, but there is still work to be done. The Panel will continue to look at ways to clarify issues, develop and implement recommendations and to maximize the impact of these recommendations on the policies and practices of the agencies and individuals who care for Maine's children.

In recognition of the commitment and dedication of the members of the Panel and in the hope that our recommendations continue to support and improve the welfare of Maine Children we would like to present the 2010-2013 Child Death Serious Injury Report to the Honorable Paul LePage, Governor of the State of Maine.

On behalf of the Maine DHHS Child Death and Serious Injury Review Panel,

Stephen J Meister, M.D.
Co-Chair

Karen K Mosher PhD
Co-Chair

CHILD DEATH AND SERIOUS INJURY REVIEW PANEL MEMBERS 2010

Luanne Crinion, RN, MSN	Public Health Nursing, DHHS
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Renna Hegg	Director of Juvenile Programs, Maine DOC
Alan Kelley, Esq., DDA	Office of the District Attorney
Marie Kelly, MSW	Child Welfare, DHHS
Ann LeBlanc, PhD	Director of State Forensic Service
Sgt. Anna Love	Maine State Police, CID II
Virginia Marriner	Director of Child Welfare Policy & Practice, DHHS
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Mark Moran, LCSW	Family Service & Support Team Coordinator, EMMC
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Chief Judge Ann Murray	Chief Judge, Maine District Court
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Katrina Rowe	Panel Intern, UMO, Ad Hoc member
Richard Aronson, MD	Director, Humane Worlds for Child and Youth Health
Lou Ann Clifford, AAG	Attorney General Office, Child Protection Division

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Virginia Marriner	Director of Child Welfare Policy & Practice, DHHS
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Christopher Gardner	Maine Drug Enforcement Agency, Special Agent
Jeffery Love, Sgt	Maine State Police, Major Crimes Unit North
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William Hafford	Pre-Doctoral Intern, Kennebec Behavioral Health
Marcella Butler	CDSI Panel Coordinator, DHHS
Christine Theriault, LMSW	Behavioral Health Prevention Manager, DHHS

MISSION AND PURPOSE

The mission of the Child Death and Serious Injury Review Panel 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 to both professionals and the general public. Furthermore, the panel strives to collect facts and to provide opinion and articulate them in a fashion that 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.

The Child Death and Serious Injury Review Panel follows the review protocol below to meet the purpose defined by 22 MRSA, Chapter 1071, Subsection 4004, the panel is to recommend to state and local agencies methods of improving the child protective system, including modifications of statues, rules, policies and procedures.

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

2. The Panel will conduct comprehensive, multidisciplinary reviews of any specific case that can be initiated by the Office of Child and Family Services, by the Commissioner of the Department of Human Services or by any member of the multidisciplinary review panel.

3. The Panel will receive a monthly report from the Medical Examiner's Office that includes child deaths in the preceding month.

4. All relevant case materials will be accumulated 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 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 fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

The Maine Child Death and Serious Injury Review Panel (CDSIRP), is comprised of representatives from many different disciplines. Its membership, which is mandated by state law, shall include the following disciplines; the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.

MALTREATMENT

Physical Abuse, Citation: Ann. Stat. Tit. 22, § 4002

'Abuse or neglect' means 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, or failure to ensure compliance with school attendance requirements under Title 20-A, § 3272(2)(B), or § 5051-A(1)(C), by a person responsible for the child.

'Jeopardy to health or welfare' or 'jeopardy' means serious abuse or neglect, as evidenced by serious harm or threat of serious harm.

'Serious harm' means serious injury. 'Serious injury' means serious physical injury or impairment.

Neglect, Citation: Ann. Stat. Tit. 22, § 4002

'Abuse or neglect' means a threat to a child's health or welfare by deprivation of essential needs or lack of protection by a person responsible for the child.

'Jeopardy to health or welfare' or 'jeopardy' means serious abuse or neglect as evidenced by:

- Deprivation of adequate food, clothing, shelter, supervision, care, or education when the child is at least age 7 and has not completed grade 6
- Deprivation of necessary health care when the deprivation places the child in danger of serious harm
- Abandonment of the child or absence of any person responsible for the child that creates a threat of serious harm
- The end of voluntary placement, when the imminent return of the child to his or her custodian causes a threat of serious harm

Persons Responsible for the Child, Citation: Ann. Stat. Tit. 22, § 4002

The term 'parent' means a natural or adoptive parent, unless parental rights have been terminated.

A 'person responsible for the child' means a person with responsibility for a child's health or welfare, whether in the child's home or another home or facility that, as part of its function, provides for care of the child. This includes the child's custodian.

UNIQUE FUNCTIONS

Some states have multiple local review panels in addition to a central state-level panel. In such circumstances only selected cases are reviewed by the state-level team. Because the state of Maine is less populous than other states, all cases are reviewed by the full, central, state-level team. The centralized forensic medical examiner system and representation on the panel promotes standardized forensic child death investigations and post mortem exams and the State of Maine has specialized medical examiner training for child death investigation units of law enforcement. The Panel is established by a state statute that permits confidentiality of Panel's work and grants the Panel with 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.

The Maine Child Death and Serious Injury Review Panel(CDSIRP) belongs to the consortium of Northern New England Child Fatality Review Teams and works closely with the National Center on Child Death Review. Our work and methods conform to the standards of our companion States. A team of Maine panel representatives have both participated in presented at each of the past fifteen annualNorthern New England Child Fatality Review Team Meetings.

and

ACTIVITIES

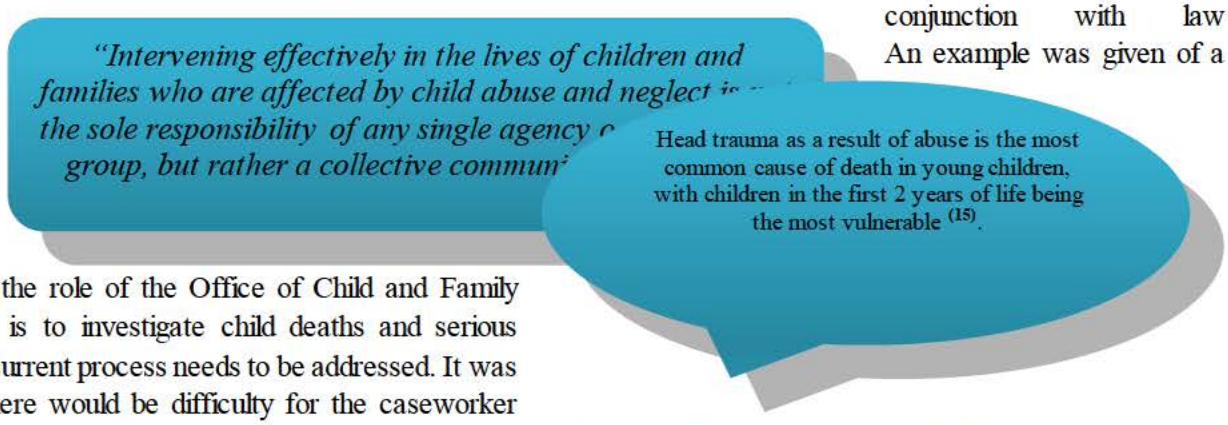
When children die or are seriously injured as a result of a caregiver's abuse and/or neglect it is an extremely saddening event. In communities with small populations like Maine, such events may seem rare and unpreventable. Nevertheless, it has been shown that when a community takes a public health approach and tracks the patterns of serious injuries and deaths of children over time they are able to identify risk factors, to help create informed policies, which result in improved outcomes for children, families, victims, and communities.

Our group has been meeting for many years and has provided useful information for many stakeholders, and just like prior years the activities over the past four years have been equally useful in producing meaningful recommendations and special contributions. The next few paragraphs describe and highlight some of this work.

The discussion on mandatory reporting resulted in the suggestion that each district have a "go to" person that providers could work with in order to aid their decision to report or not to report. Failure to report, false reports, level of suspicion, definition of suspicion, family and provider relationships, licensing, and level of understanding of when to report were all topics that raised emotions. The safety, health, and well-being of the child/children involved should always remain the focus of reporting. The mysteries of what providers perceive reporting means to the family (they will be torn apart) and the notion that the child welfare system functions as a negative force must be rejected. Better understanding, communication and collaboration of all stakeholders are required when it comes to mandatory reporting and ending child abuse and neglect.

Tracking of data, incorporating the use of a case reporting tool; the National Child Death Review Case Reporting System (NCDR-CRS) is a case reporting instrument that provides standardized data elements and data definitions for the purposes of analyzing and reporting information on child deaths and injuries over time. The first cases were entered into the Reporting System beginning in January 2010. Unfortunately, because of staffing challenges, which included turnover in support to the panel, we were unable to maintain this effort into 2011-2013. We are extremely hopeful that we will be able to take advantage of the National Center's database to help manage our data as we go forward.

It was recommended that caseworkers should go out and do an assessment whenever there is a child death and they should be going out in conjunction with law enforcement. An example was given of a child coming into an Emergency Department and only the police being notified. If the role of the Office of Child and Family Services (OCFS) is to investigate child deaths and serious injuries, then the current process needs to be addressed. It was recognized that there would be difficulty for the caseworker doing an assessment after the police investigation, because it would cause additional emotional challenges for the family. Along the same line, concern was expressed that child deaths and serious injuries are not consistently being reported to OCFS. It was noted that a death or injury may be deemed accidental, but that does not mean it may not have resulted from child abuse and/or neglect. "Unintentional" does not mean there was not neglect, and without seeing the reports it is impossible to identify those trends. The proposed suggestion would have the Panel look at a number of such cases involving both areas of worry and, after clarifying OCFS policy expectations for those child deaths and serious injury assessments, determine if policy is being consistently practiced.



To ensure coordination of efforts in evaluating and developing a response to the challenge of our growing Drug Affected Baby (DAB) problem, we invited Attorney General William Schneider to our Panel meeting in July 2011, representatives from Maine's Office of Substance Abuse (OSA) also took part in this panel presentation; along with some other very respected community members. An OSA representative is now a permanent member of our panel. The Panel review of and work on Drug Affected Babies has led to many policy changes to improve outcomes and influenced other New England states to examine their DAB issue.

The Panel hosted two presentations in June 2010; "Reducing Infant Mortality in Maine: Risk Factors, Protective Factors and Dilemmas," (Ashley Oliver and Stephen Meister, MD). "Someone's Been Sleeping in My Bed: Bed-sharing and Infant Safety", (Stephanie Joy). Discussion followed the presentations and resulted in some notable findings and recommendations that can be found under the 'unexpected infant death and un-safe sleep heading of this report.

During this period over three hundred summary OCFS intake reports were looked at and from these, twenty four child death and/or serious injury cases were selected for an in-depth panel analysis. These cases involved elements of abusive head trauma, unexpected infant deaths including un-safe sleep or co-sleeping, ingestions of legal and illegal substances, young adults formerly in protective placements that harmed others, home births, drug affected babies, and cases that succumbed to evidence where there was a lack of reporting based on Maine's mandatory reporting statute. Some other significant issues were also briefly discussed and are included in this report.

ABUSIVE HEAD TRAUMA

Abusive head trauma (AHT) in infants is a serious community health problem both in the United States and worldwide. The act of aggressively shaking an infant or striking a baby's head usually occurs because caregivers become frustrated in response to a child's constant crying. This type of injury to a child can lead to long term mental and/or physical health issues and even death. There is also evidence lending to a belief that some of these abusive injuries may not immediately be reported to authorities, the perpetrator instead will wait a period of time to see if the child will recover [1, 2, 3, 4].

Serious injuries that end in the death or debilitation of infants or young children are not often the result of accidents. Estimates suggest that more than 90% of severe intracranial injuries and at least 60% of all head injuries in children 1 year of age or younger are caused by violence inflicted by parents or caretakers [5]. Shaken baby syndrome (SBS) should also be recognized by the medical terminology pediatric **abusive head trauma** (AHT). AHT is the leading cause of death and debilitation in children among all forms of physical abuse [9]. The unfortunate tragedy is that AHT and especially SBS is understood to be highly preventable with parental education programs and access to support networks and services.

In 2007, the Maine Department of Health and Human Service professionals and the medical community noted an increase in the incidence of serious physical abuse and in particular abusive head trauma (shaken baby syndrome). Maine's Center for Disease Control and Prevention in conjunction with the Office of Child and Family Services convened a group of state and community partners to research this issue discuss and recommend strategies to reduce serious child maltreatment. The group selected the Period of PURPLE [14] crying as their evidence based program to introduce on a statewide basis. This program was developed and is offered by the National Center on Shaken Baby Syndrome and is still in effect today, in order to help eliminate this serious child health problem.

The following case composites have been included to acknowledge the serious nature concerning the abuse of children in Maine, in particular incidences of abusive head trauma (AHT). These summaries have been provided to bring awareness, by presenting the outcomes that are characteristic of these heinous acts, which often result in the death of the child victim, imprisonment of the perpetrator and a family torn apart.

CASE COMPOSITES

This concerns an infant with a skull fracture and an open service case at the time; the mother missed multiple medical provider appointments and reported a welt on the child's head, the injury was diagnosed six days later after the DHHS caseworker took child to the medical provider's office. The mother provided multiple conflicting stories to explain the injury.

A toddler was left home with his mother's boyfriend. The boyfriend reported that the child fell down a flight of stairs. The child died. The medical examiner's office determined that the injuries could not be explained by a simple fall down six or seven steps. The autopsy revealed numerous head injuries, broken bones and other inflicted injuries. The boyfriend ultimately pled guilty to manslaughter in the death of the toddler.

A young infant sustained inflicted trauma to his head and died from a traumatic brain injury. His father was charged with manslaughter.

A young infant was brought to the hospital by her parents; the father stated that he had dropped the baby. The child had a severe brain injury and other injuries consistent with shaken baby syndrome (SBS) or AHT. The autopsy revealed that the baby died from non-accidental craniocerebral and spinal cord trauma. The father was charged with manslaughter.

Because of the serious nature of these types of cases, legislative action was taken in 2013 to include the following amendment to Maine's mandatory reporting law.

§4011-A. Reporting of suspected abuse or neglect

7. Children under 6 months of age or otherwise non-ambulatory. A person required to make a report under subsection 1 shall report to the department if a child who is under 6 months of age or otherwise non-ambulatory exhibits evidence of the following:

A. Fracture of a bone; [2013, c. 268, §1 (NEW).]

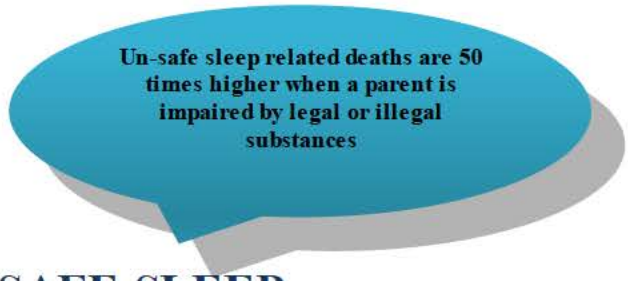
B. Substantial bruising or multiple bruises; [2013, c. 268, §1 (NEW).]

C. Subdural hematoma; [2013, c. 268, §1 (NEW).]

D. Burns; [2013, c. 268, §1 (NEW).]

E. Poisoning; or [2013, c. 268, §1 (NEW).]

F. Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ. [2013, c. 268, §1 (NEW).][2013, c. 268, §1 (NEW) .]



UNEXPECTED INFANT DEATH – UNSAFE SLEEP

CASE COMPOSITE

An infant was found deceased in its mother's bed in a publically supported venue. The mother was on a daily methadone dosage and also used other drugs. The infant was sick and fussy. The baby was placed between its mother and a wall on a twin bed layered with a quilt and blankets, face down for the reason that she felt it would be easier for the baby to breathe. When the mother awoke she found the infant non-responsive.

Findings & Recommendations:

Finding: Safe sleep guidelines were not emphasized or displayed.

Recommendation: Bed sharing information should be posted, emphasized and available at any public venue where infants might sleep with their parent. Such public venues need a policy promoting best practices on safe sleep in these situations.

Finding: This infant had numerous risk factors for sudden unexpected infant death (SUID). These factors include, for example, bed sharing, face down sleep position, prematurity, respiratory illness, drug affected baby, parental impairment with either prescribed or non-prescribed medications including Methadone and Suboxone. Any one of these factors would not necessarily result in infant death, but in combination the risk increases exponentially.

Recommendation: A stronger message informing parents about risk factors for unexpected infant death and SIDS needs to be developed and delivered to parents by multiple providers including: DHHS caseworkers, home visitors, public health nurses, primary care providers, midwives, case managers, and staff of methadone and suboxone treatment programs. This should include information emphasizing that bed sharing and substance use could result in the death or serious injury to their child.

CASE COMPOSITE

Children risk suffering physical and emotional harm when their parents experience social, mental health, drug and or alcohol abuse challenges.

A family awaiting the birth of a child is vulnerable to experiencing increased economic and emotional stress. In one family a father had to move out of town in order to support his family. While Home Visitors were intermittently involved with the family, their services were not consistent, nor were they adequate to the needs of this family. In essence, the young mother was alone, without supports and experienced an overall deterioration of her mental health status, substance abuse recovery, and her organizational and self-care skills. The mother stopped attending her prenatal as well as her substance abuse treatment appointments.

At the time of birth both the mother and the baby were positive for substances including marijuana and opiates. After she went home with the baby she experienced additional family stress including her husband's arrest. Mother began to sleep with the infant and one morning found the baby had died during the night. At the death scene investigation the police found the home to be unkempt and chaotic

Key Points:

- Studies have shown that narcotic addicted parent's compliance with an opiate treatment program effectively decreases the risk of harm from child abuse or neglect in that family. This mother was doing well with her children until she stopped following through with her services.
- This is a situation in which the expertise of Public Health Nursing may have been able to better assess the challenges this family was facing. Consistent with the research findings on the Nurse Family Partnerships, trained professionals may well have been in a better position to support and successfully intervene to support this mother.

CASE COMPOSITE

A baby was found dead mid-morning when its mom got home from work; the father was sleeping "half on and half off" the baby in the caregivers double bed. The 911 call was made and CPR was attempted. The infant was transported to the hospital and was pronounced dead at the hospital.

Findings & Recommendations:

Finding:
In this case, a scene investigation was not conducted and law enforcement rendered an opinion on cause of death to DHHS.

Recommendation:
The panel recommends in cases of a child death, death scene investigations should always be conducted and completed

INFANT FATALITY RISK FACTORS

- Sleeping in adult beds with adults and other children
- Sleeping in beds with comforters, blankets and duvets
- Sleeping on couches or chairs when caregivers sleep holding them
- Sleeping in cribs with stuffed animals, blankets, toys and other items
- Overdressing/overheating baby
- Propping bottles

thoroughly, even if the cause of death at the scene appears to be straightforward. Furthermore, it is recommended that DHHS always request and receive the initial scene investigation from law enforcement. Only the Medical Examiner can determine the official cause of death.

Finding: There was no documentation that the parents had been advised of the dangers of bed-sharing.

Recommendation: The Panel recommends that when DHHS is involved with a family, caseworkers should advise the parents of the risks associated with bed-sharing, especially when there are multiple risk factors for Sudden Unexpected Infant Death.

Finding: The final autopsy report for this case was never received by DHHS, despite the fact that the caseworkers called the ME's office several times inquiring on the status of the report.

Recommendation: DHHS always request the final autopsy report in the case of child deaths.

Response: The Medical Examiner's office agrees to automatically send the final report to DHHS when it is complete. This procedure will be more efficient than calling repeatedly to check on the status of an autopsy.

Finding: In this particular case, communication between the involved investigating parties was fractured and inefficient. Each department, because of their differing purposes, worked at differing speeds making it difficult to correspond with each other.

Recommendation: In the case of an infant death, the panel recommends that a protocol be developed, using a subcommittee, so that a multidisciplinary team of all involved agencies meet within a specified amount of time after the date of death (DOD) to collaborate on the evaluation and to improve communication. Vermont and/or New Hampshire could be used as models for developing such protocol.

ADDITIONAL RISK FACTORS ASSOCIATED WITH SUDDEN INFANT DEATH

- Mental health challenges, including depression
- Substance use, including alcohol or drugs
- Smoking
- Obesity
- Parental isolation

CASE COMPOSITE

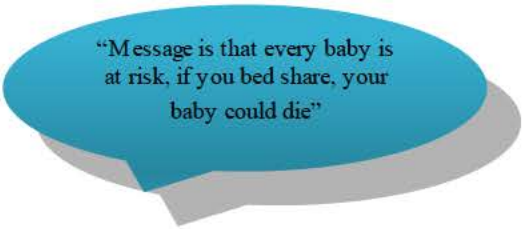
A young infant was found dead underneath its father on a couch. Both parents had a history of substance abuse and were involved in a methadone treatment program. Dad had consumed some alcohol, but mother reported that he "did not seem impaired." Mom awoke in the night to find the infant partially underneath the father. The infant was deceased.

Findings and Recommendations:

Finding: Despite considerable effort, DHHS was unable to obtain records from the Methadone treatment program regarding their care of the parents of the deceased child. There are many barriers to DHHS obtaining information about the clients from Methadone treatment centers.

Recommendation: The panel recommends that an OSA representative be involved in the investigation when a child death occurs while in the care of a parent receiving services from a substance abuse treatment program. Furthermore, the panel recommends that the Department caseworkers develop a collaborative relationship with Methadone clinics in their area; doing so should increase their ability to obtain necessary records and implement crucial services for clients.

Finding: These parents were receiving Methadone treatment, which can increase the risk of SUID in the bed-sharing environment. Home Visitors were aware of the bed-sharing but did not record their efforts to dissuade the parents from this risky practice.



Recommendation: The panel recommends that all Home Visitors inform parents about the dangers of bed-sharing, including sleeping with an infant on a couch. Home Visitors should identify cases where several risk factors are present, especially with substance affected parents and ensure that these parents are aware of the risks of bed-sharing.

Finding: It was noted that Foster Parents are not exposed to training on the dangers of bed-sharing.

Recommendation: The panel recommends that Safe Infant Sleep brochures be provided to all foster parents and that the Department develops specific rules warning foster parents from bed-sharing with infants in their care.

Finding: The Department re-referred this case to Home Visitors after the baby's death, though the case was high severity substantiated.

Recommendation: The panel recommends that in cases where there has been a child death and a vulnerable child remains in the home, that the Department keep the case open until safety plans have been developed and implemented.

Finding: The Department is required to make decisions quickly. This does not coincide well with the resources of the Medical Examiner's office. In this particular case, the autopsy report had still not been completed even though the Department had already closed the case.

Recommendations:

a. The panel recommends that the Medical Examiner's office prioritize child autopsy reports when reviewing an infant death, in the same way that they prioritize homicide cases. This will enable the Department to have the information they need when deciding whether or not to close and/or refer a case.

b. The panel recommends that a multidisciplinary approach be established by the Department to ensure that interdepartmental communication and collaboration has occurred on a case by case basis, before closing any case.

Finding: In this particular case, parents were not engaged in grief counseling, though they were emotionally affected by their child's death and even though at risk children remained in the home.

Recommendation: The panel recommends that parents who experience a child death be offered and encouraged to receive grief counseling and support services, especially when another child or children remain in the home.

Finding: There were philosophical differences in the approach that each agency took towards these parents.

Recommendation: The panel recommends and encourages interdepartmental collaboration and communication of all parties involved in a specific case and that a common approach be developed to best serve each individual client's needs.

Finding: Despite the efforts that the Department takes to educate parents about the dangers of bed-sharing, many still participate in unsafe sleep practices. The manner in which the Department approaches parents with the subject of bed-

sharing is vital to whether or not those parents will be honest with the caseworker and/or receptive to their recommendations.

Recommendation: The panel recommends that the Department continue its effort to educate parents. Furthermore, they suggest that when caseworker's talk to parents that they consider the family's reasons for choosing to bed-share are different and try to specialize their approach to the subject for each specific client. The panel understands that many caseworkers already do this and commends their good work.

INGESTIONS

CASE COMPOSITE

Methadone ingestion by a child caused acute cerebellitis. Numerous close family members and neighbors were reportedly taking prescription methadone. A child abuse specialist was not consulted during the hospital stay and the case was not reported to DHHS until many days into the hospitalization. The Poison Control Center helped identify the relationship between the methadone ingestion and the neurologic injury. The child survived with neurologic impairment and requires specialized services to support developmental tasks.

Findings& Recommendations:

- The Panel would like to reiterate the importance of having a child abuse specialist available for consultation to DHHS and the hospital providers.
- The panel noted that there is a need to identify signs of and screen for maternal depression
- The panel highlighted the need for better provider understanding of the risks for and identification of child abuse and neglect
- The panel would like to echo the value of having a Poison Control Center
- The panel recognizes and underscores the significance of sharing information regarding risk factors for child abuse, especially around the time of birth
- Referrals made by the hospitals and other trained healthcare providers need to be taken seriously

TYPES OF INGESTION REPORTS

"Thirteen month old female ingested prescription Adderall, pills are left in his pant pockets on occasion."

"Nineteen month old ingested a benzodiazepine while in the care of boyfriend; loose pills had been seen before belonging to relative"

"Two year old ingested a synthetic opiate while in the care of a relative. There were prior concerns about this relative caring for the child, due to allegations of physical abuse and duct taping."

"Three year old ingested 300 mg of Benadryl while in the care of mother's boyfriend."

"Two year old female was reported to have ingested an antidepressant prescribed to her great-grandfather. The child tested positive for other non-prescribed, non-indicated medications, but negative for the antidepressant. The same child ingested her great-grandfather's diabetes medication last year."

"Two year old female ingested 2 antidepressant tablets while visiting the home of her maternal great-grandmother. The medication was prescribed to great-grandmother."

"Ten month old female tested positive for opiates; parents and child were staying with maternal grandparents at the time other relatives were visiting the home, one of whom kept her medications in a baggie in her purse."

"Two and half year old female ingested mother's prescribed suboxone tablet; mother reported that the child climbed onto a piece of furniture and got the container."

"Fourteen month old ingested either suboxone or oxycodone pill while in the care of two babysitters. Mother found pills on the floor and pill fragments in the child's mouth and on the child's hands. Both caretakers were impaired by substances"

"Two year old child was left alone while all of the adults in the home were sleeping. The child took grandparent's medications while parents were sleeping.

"Two year old was found sleeping with a benzodiazepine pill next to him. The mother believed that four benzodiazepine pills were missing and brought the child to the hospital with concerns that the child had ingested the pills"

"Two year old ingested father's prescription medications while the mother was in the kitchen and the child was in the family room. The pills were in one of the father's pockets.

YOUNG ADULTS, FORMERLY IN PROTECTIVE PLACEMENTS, THAT HARM OTHERS

CASE COMPOSITE

The Panel reviewed a number of cases where children who had been in the care of the Department of Human Services ultimately committed violent crimes.

Findings& Recommendations:

- The panel inquired as to whether there is anything in place at this time to provide structure to teens aging out of foster care, the panel indicated that DHHS should be aware that children are not fully developed when they turn eighteen, lacking the skill to self-regulate, and still need structure. Teens are provided with life skills and the V-9 program to provide educational assistance.

- The panel questioned whether the same type of situation, with multiple reports of maltreatment, would result in the same response at this time. It cannot be determined with certainty, but the Department would most likely become involved.

- Foster parents who are caring for children, who are aggressive when they enter foster care, require special training and supports in order to optimally care for these children.

- The Department would attempt to meet many of these children's needs in different ways now. Screening, educating and supporting resource families continues to be a necessary focus of attention.

HOME BIRTH

The Maine Child Death and Serious Injury Review Panel completed a report on Home Births in Maine in June 2012. The report was approved for public release by the Commissioner; the letter of response to the panel was received on October 2, 2012, respective to their work on this significant project. The next four pages are dedicated to that work.

HOME BIRTH REVIEW, LETTER TO THE COMMISSIONER

Commissioner Mayhew
State of Maine
Department of Health and Human Services

Dear Commissioner Mayhew,

Please accept this special report from the Child Death and Serious Injury Review Panel concerning Home Birth in Maine.

In 2009, the Child Death and Serious Injury Review Panel (CDRP) was asked by the Department of Health and Human Services to consider the safety of Home Birth care in Maine. This request was based on anecdotal reports concerning serious adverse events necessitating transfer of mother and child from home to a hospital either during or immediately after birth.

In 2007, a bill was brought before the State Legislature proposing licensure of Certified Professional Midwives (CPMs). In the process of considering the bill; a "Sunrise Review" was requested by the Joint Standing Committee on Business, Research and Economic Development, charged with considering the argument for licensure. A law allowing CPMs in Maine access to and the right to administer certain medications in the practice of midwifery was signed into law by Governor Baldacci in May, 2008, with final implementation of rules under the Pharmacy Board occurring on Feb. 9, 2009.

The Child Death and Serious Injury Review Panel's standard process includes a review of the scholarly, and sometimes the popular literature as it relates to the cases, interviews of professionals, family members and others involved, and a detailed review of the specific cases. The process culminates in a report summarizing the review process followed by specific findings and recommendations. In applying this process to evaluate outcomes of Home Birth in Maine, it was not

the Panel's intent to revisit the debate surrounding the need for licensing of Certified Professional Midwives as this had already been addressed by the legislature. Ultimately, the Panel's charge was to identify areas in the system of care that could be changed to improve outcomes and prevent or minimize risk of harm to infants and mothers in our State.

In the 3 years since initiating the review the CDRP has had the opportunity to look at a number of home births that have had problematic outcomes, as well as a number with positive outcomes. The panel has reviewed the literature on the subject, consulted with experts in relevant areas, and has carefully considered and analyzed the findings. The emergence of a few very clear directions that can be promoted, with confidence, to improve the safety of home birth and to further the development of a system of care are found in the report. These findings and recommendations are summarized below:

We find the rate of perinatal mortality is unacceptably high in home births in Maine. Certified Professional Midwives and other non-licensed providers of home birth support are offering to deliver moderate and high risk pregnancies (including breech and twin pregnancies) at home because of a mistaken belief that they can perform these deliveries safely. We reviewed the results of their unfortunate and uninformed opinion and conclude that the high rate of poor outcome from home birth in our state is because the home birth midwives are not selecting only low risk pregnancies for delivery at home.

Families are rationally choosing home birth, even when there is risk to their unborn child, because of their desire for personalization of care and fear of unwarranted surgical intervention. Our current rate of cesarean section deliveries is too high and not in our young mothers best interest. Another problem often occurs when families and their home birth caregiver decide to transfer care to a hospital. In cases where the transfer of care is readily accepted by the hospital and hospital based professionals, care is enhanced as are birth outcomes. In situations where the professionals and hospital staff are disdainful of the family's choice and disrespectful toward the home birth caregiver, transfer is delayed and outcomes are impaired.

The State of Maine needs to define a standard where birth rises from a natural process, which anyone can attend to a medical process requiring the care and services of a licensed medical practitioner. It is recommended that the assignment of risk include consideration of the recommendations promulgated by the American College of OB/GYN as published in the annual Compendium of Selected Publications. It is further recommended that:

1- Any low risk birth be considered as appropriate for home birth delivery.

2- No high risk birth be considered acceptable for home birth delivery.

3- The possibility that some circumstances exist where a moderate risk birth is acceptable for home delivery, these circumstances should be carefully defined.

The midwives need to adopt consistent, written, and agreed upon standards, which define low risk, moderate risk and high risk births

Midwives and the families they care for would benefit from developing a well thought through written crisis plan that could include things such as:

1- Information sharing with EMTs.

2- Information sharing with hospital providers.

3- A transport plan.

4- Consideration of weather, distance, accessibility.

5- Any other factor that the midwife or the family believes or fears might arise.

The families need to be offered informed consent, which:

1- Explains the true, statistical risks and benefits of home birth.

2- Explains the true, statistical risks and benefits of hospital birth.

3- Explains the value, risks and benefits of blood spot and hearing screening and the risk of not screening.

4- Explains the value, risks and benefits of Group B strep testing and screening for gestational diabetes and the true risk of not testing.

5- Explains the value, risks and benefits of Vitamin K, and the true risk of avoiding treatment.

6- Explains the possibility of transfer, and the circumstances under which transfer will and must occur including the importance of a crisis plan.

The EMT system, hospital and hospital providers, and midwives need to adopt policies where:

1- Hospital Professionals and staff readily accept transfer of care

    1. where they are supportive and respectful toward the family and the midwife;

    2. where they are aware of the birth during the pregnancy as well as the date of delivery and develop a plan of care should support be required; and

    3. care needs to be collaborative and respectful.

2- The midwives need to encourage the development of relationships with, access support and consultation with the medical/hospital providers without becoming the ostensible agent of the medical provider.

Statutes should not be developed that codify medical practice; however, statutes can require standards of care.
In terms of the development of standards, it is recommended that a combined advisory work group include respectful representatives of the Professional societies, the midwives, and public members including families. This work group would be advisory to the medical director for Maternal and Child Health who would draft the final legislation to be promulgated by the department. Families also need to be engaged in this process; we need to ensure the consumer has access to accurate information so they have every opportunity to make a highly informed choice.

Sincerely,

Stephen Meister MD, MHSA, FAAP
Chair
Maine Child Death and Serious Injury Review Panel

DRUG AFFECTED BABIES

The panel's activities with regard to Drug Affected Babies (DAB) prompted a forum, which included an examination of rules, laws, treatment, narcotic overdoses, and a discussion regarding an infant who died in a shelter while co-sleeping with mother who was attending a methadone clinic.

The conversation surrounded the rise in infants born affected by drugs and diverted narcotic use in Maine. The major focus was on the impact on infants and children affected by narcotics. Involved professionals shared information on what steps are currently underway to address these issues. Invited guests included: Mark Publiker, MD, an addiction medicine specialist and a physician, Kelley Bowden, a Nurse practitioner who cares for mothers and infants with narcotic addiction, Daisy Goodman RN, PhD, a Nurse Midwife with a PhD from Harvard on managing pregnant woman with narcotic addiction and Darrell Crandall, Northern Commander with the Maine Drug Enforcement Agency (MDEA).

Mark Publiker, MD indicated that mothers are usually motivated to seek treatment due to pregnancy but comprehensive treatment is not universally available. A high percentage of women who are addicted also have a history of being sexually molested, involved in toxic relationships, have no family support and experience poverty. Caution should be taken when screening, as the population that makes up the group living in poverty is not the only group who might be addicted to narcotics. The poverty group also has limited trust and is a reason why medicated assisted treatment needs to be assessed and it must be coupled with comprehensive treatment. It should be mentioned that opiates do not cause birth defects; it is the recurrent episodes of withdrawal that are the problem, this causes stress on the infant, imposes a low birth weight and is highly likely to induce prematurity. Opiate addiction is a chronic brain illness; treatment works and it is effective but difficult to access across the state.

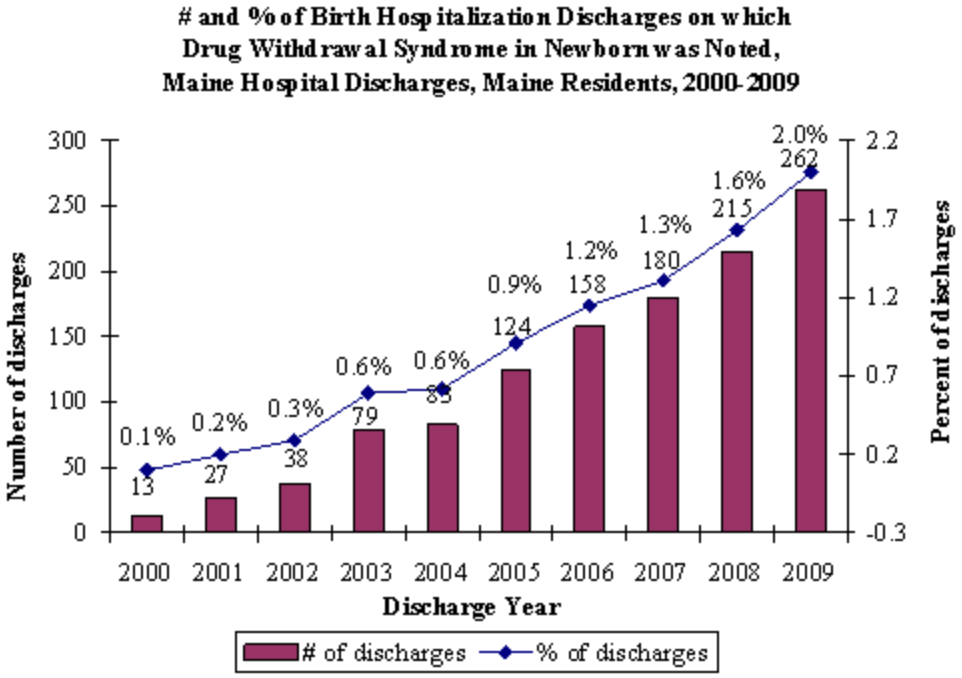
Kelley Bowden, RN discussed her work with hospitals around the state, in terms of education and consultation. Kelley said, "That she receives numerous requests to talk about narcotic exposed infants," which identifies an awareness of the issue. As a nurse, Kelley indicated she had no education on addiction and stated that this knowledge is often not studied in many common nursing educational programs. During screening, mothers are asked questions such as, do you smoke, drink, or use drugs, and many mothers normally do not disclose that information. Other mothers that are being treated for pain are not informed that their babies are at risk for withdrawal, and many babies go home to withdraw. Alcohol screening is seriously important, because of the relationship to birth defects and mental health illness. The AAP Narcotic Affected Infant policy introduced in 1998, which is under revision now, encourages a 5 day

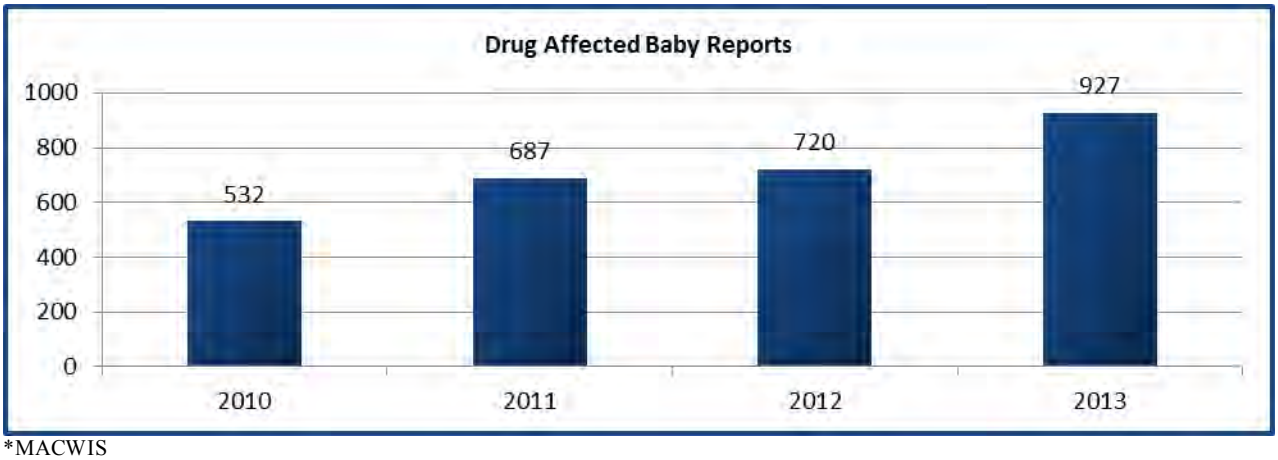
Reducing an infant's exposure to legal or illegal drugs, alcohol and tobacco would likely have a large financial benefit to the state. Not to mention the moral issue of protecting these infants who are more apt to suffer from the long term ill effects of exposure due to their small developing bodies.

monitoring in the hospital.

Daisy Goodman RN, PhD talked about the challenges in rural settings, such as the issues that arise from having very limited addiction support, behavioral health treatment programs, and margins for those with a dual diagnosis. Although mothers are often apt to enter treatment when pregnant, Maine law requires treatment for any female prisoner if pregnant there are disadvantages in rural communities because of the limited number of resources.

Darrel Crandall embarked on the Drug Endangered Child (DEC) protocol which addresses those children who are exposed to environments where drugs are used or manufactured. The DEC protocol arrived as a result of meth labs and now allows for inter-agency collaboration with child welfare. One of the Task Forces of the MDEA identified that 50% of arrests had a direct relationship to prescription medications/drugs.





*MACWIS

The OCFS Director of Child Welfare at the time requested the expertise of the Child Death and Serious Injury Review Panel (CDSIRP) to help in the development of clear, specific guidelines in what to consider when assessing and determining if child abuse or neglect is present in drug affected baby (DAB) reports. Thus, a strategy for addressing Child Protective Response to Drug Affected Infants was worked on during this period.

Although there had been work done to improve the reporting process from the medical provider and improve consistency across the state, there was a need for better guidance on how to determine the assignment process; which cases are assessed by child protective and which are the cases that can safely receive services in the community, such as, Home Visiting and Public Health Nurse (PHN). It is not always clear there is an informed correlation of the needs of the infant, resources of the family and identified risk factors. Direction was needed on how to assess the interaction of risk factors. If certain conditions exist, what are the concerns and what are the relevant questions that should be posed to the medical professionals and would it be beneficial to use one of the tools in the Signs of Safety model, such as, using scaling questions? An example; you might aska physician on a scale of 1 to 10 with 10 meaning CPS should request a court order to place the child in an alternative home immediately or 1 being there are no concerns, the child is functioning well and the parents have the capacity to fully care for the child with no additional supports. Then have a response follow up with, what makes it an 8 or what would it take to get to a 7? This could give CPS a better understanding of what action would be recommended and better develop a safe plan of care. There was discussion that this line of questioning would be helpful.

A further dialogue between the Attorney General and the panel was conducted, this exchange surrounded the differences in reporting, which convinced the panel chair to connect with the area hospitals about the variations in reporting but still consider if and when hospitals do make a report, is that information sufficient guidance to make decisions from the response side?

An identified issue that can interfere with reporting is fear by the parents and perhaps the nursing response to that; how presentation should shift to understanding and offer services rather than continue the perception of a CPS report as a threat.

Another identified issue around the state is the question surrounding a ‘drug exposed baby’ and/or ‘drug affected baby’; what does it mean for the baby? This can be interpreted differently in different hospitals.

Should there be differences in responses related to what drugs are used? Should there be consistent ways to validate risk? What are the factors to consider that bring it to a high stakes case and what are indicators that lead to CPS intervention? Some items were generated and listed below that should be used for consideration in the assessment process:

- *Methadone or other medication assisted therapy*
- *Marijuana use*
- *Illegal drug use*
- *Life style – not a lot of science to make determinations*
- *Refusal to accept treatment*
- *Infant experiencing seizures*
- *Environmental factors*
- *Plan of Care for infant at discharge – family supports*
- *Concern about mother's mental status – depressed, flat affect*
- *Mother under influence at time of delivery – were drugs in system, what is current use.*
- *Domestic violence indicators*

Other discussion points:

Often normal newborn care is provided and the infant does not go home on medication. Research shows that if parents are receiving treatment or using and are bed sharing, deaths of infants go up 50 times. Information on co-sleeping needs to be widely distributed. Caseworkers need to look at bed/sleeping environments and provide information on unsafe sleep environments. What are identified compromised parental conditions? Medication assisted therapy – who is prescribing, how obtained, impact on functioning. More targeted education is needed for the population of individuals receiving treatment who are pregnant or could become pregnant. Information that can focus on the neuro-developmental status of the baby is important and should/ needs to be provided to parents. Compromised DAB infants do not have protective capacity to startle and wake up, which would otherwise be expected with a case for a non-affected baby in a co-sleeping situation.

In conclusion, the Panel review of and work on Drug Affected Babies has led to many policy changes to improve outcomes and our presentation to the New England Child Death Review (NE CDR) group in Rhode Island during the Spring of 2012 resulted in all states in New England beginning a review of DAB in their states.

OBSERVATIONS

- *There were examples cited of mothers at WIC after taking their methadone that are falling asleep while holding their infants. The question was raised about how WIC communicates the risks of drug use and unsafe sleep environments.*

- *Confidentiality can be an issue as identified when there are cases of children in care and limited ability to communicate with the clinics where the parents are receiving treatment. What areas do caseworkers currently explore and what additional guidance can be provided?*

- *If there is evidence at time of birth that the mother is under the influence, then what questions do hospitals ask about the patterns of use and the environment? All agree that partnering with hospitals, having a consistent system to refer to Public Health Nurse (PHN) from hospital and the development of a decision making matrix is necessary.*

- *Panel members believe clinical and legal components must be coordinated but is this consistent with other's thinking? What are the model programs that can be mirrored? The panel needs sense of what is best data/ what are best outcomes.*

- *What are interventions for women who are in prescribed treatment, but also use illegal drugs? The panel does not want to criminalize drug use during pregnancy but what would be the alternatives? If there is evidence to increased criminal activity, how can law enforcement expand their role?*

- *What is occurring in the state to address the Doctors who over-prescribe medications if there is a serious injury in an infant when a child has been identified as a DAB?*

- *How long do NAS symptoms persist? Is there a baseline of higher irritability – what does that look like? Is it more related to substance abuse of parent/trauma issues? – Is it less about the fact of a child being a DAB? What is optimal practice for responding to infants in a medical setting?*

- *What percentage of infants born experiencing drug withdrawal in Maine end up dead or impacted by substance use? What factors affect morbidity and mortality and how do we hold parents accountable? Is there a recommended continuum of response?*

- *Neurochemistry in addiction information might benefit support systems, build on best responses, possibly allow for better outcomes by looking at different approaches and may even help when trying to engage family in a therapeutic response?*

MANDATORY REPORTING - FAILURE TO REPORT ABUSE

§4011-A. Mandatory Reporting of suspected abuse or neglect

1. Required report to department. The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred:

A. When acting in a professional capacity:

(1) An allopathic or osteopathic physician, resident or intern; (2) An emergency medical services person; (3) A medical examiner; (4) A physician's assistant; (5) A dentist;(6) A dental hygienist; (7) A dental assistant; (8) A chiropractor; (9) A podiatrist; (10) A registered or licensed practical nurse; (11) A teacher; (12) A guidance counselor; (13) A school official; (14) A youth camp administrator or counselor; (15) A social worker; (16) A court-appointed special advocate or guardian ad litem for the child; (17) A homemaker; (18) A home health aide; (19) A medical or social service worker; (20) A psychologist; (21) Child care personnel; (22) A mental health professional; (23) A law enforcement official; (24) A state or municipal fire inspector; (25) A municipal code enforcement official; (26) A commercial film and photographic print processor; (27) A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications; (28) A chair of a professional licensing board that has jurisdiction over mandated reporters; (29) A humane agent employed by the Department of Agriculture, Conservation and Forestry; (30) A sexual assault counselor; (31) A family or domestic violence victim advocate; and (32) A school bus driver or school bus attendant; [2009, c. 211, Pt. B, §18 (AMD); 2011, c. 657, Pt. W, §5 (REV).]

B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation; and [2003, c. 210, §3 (AMD).]

C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation. [2003, c. 210, §4 (NEW).]

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department. [2009, c. 211, Pt. B, §18 (AMD); 2011, c. 657, Pt. W, §5 (REV).]

1-A. Permitted reporters. An animal control officer, as defined in Title 7, section 3907, subsection 4, may report to the department when that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected. [2007, c. 139, §2 (NEW).]

2. Required report to district attorney. When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child or that a suspicious child death has been caused by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney's office. [2007, c. 586, §11 (AMD).]

3. Optional report. Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that there has been a suspicious child death. [2007, c. 586, §12 (AMD).]

4. Mental health treatment. When a licensed mental health professional is required to report under subsection 1 and the know ledge or reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred comes from treatment of a person responsible for the abuse, neglect or death, the licensed mental health professional shall r eport to the department in accordance with subsection 1 and under the following conditions.

A. The department shall consult with the licensed mental health professional who has made the report and shall attempt to rea ch agreement with the mental health professional as to how the report is to be pursued. If agreement is not reached, the licensed mental health professional may request a meeting under paragraph B. [2001, c. 345, §5 (NEW).]

B. Upon the request of the licensed mental health professional who has made the report, after the department has completed it s investigation of the report under section 4021 or has received a preliminary protection order under section 4034 and when the department plans to initiate or has initiated a jeopardy order under section 4035 or plans to refer or has referred the repor t to law enforcement officials, the department shall convene at least one meeting of the licensed mental health professional who made the report, at least one representative from the department, a licensed mental health professional with expertise in child abuse or neglect and a representative of the district attorney's office having jurisdiction over the report, unless that office indicates that prosecution is unlikely. [2001, c. 345, §5 (NEW).]

C. The persons meeting under paragraph B shall make recommendations regard ing treatment and prosecution of the person responsible for the abuse, neglect or death. The persons making the recommendations shall take into account the nature, exten t and severity of abuse or neglect, the safety of the child and the community and needs of the child and other family members for treatment of the effects of the abuse or neglect and the willingness of the person responsible for the abuse, neglect or death to engage i n treatment. The persons making the recommendations may review or revise these recommendations at their discretion. [2007, c. 586, §13 (AMD).]

The intent of this subsection is to encourage offenders to seek and effectively utilize treatment and, at the same time, provide any necessary protection and treatment for the child and other family members.

[2007, c. 586, §13 (AMD) .]

5. Photographs of visible trauma. Whenever a person is required to report as a staff member of a law enforcement agency or a hospital, that person shall make reasonable efforts to take, or cause to be taken, color photographs of any areas of trauma visible on a child.

A. The taking of photographs must be done with minimal trauma to the child and in a manner consistent with professional stand ards. The parent's or custodian's consent to the taking of photographs is not required. [2001, c. 345, §5 (NEW).]

B. Photographs must be made available to the department as soon as possible. The department shall pay the reasonable costs of the photographs from funds appropriated for child welfare services. [2001, c. 345, §5 (NEW).]

C. The person shall notify the department as soon as possible if that person is unable to take, or cause to be taken, these p hotographs. [2001, c. 345, §5 (NEW).]

D. Designated agents of the department may take photographs of any subject matte r when necessary and relevant to an investigation of a report of suspected abuse or neglect or to subsequent child protection proceedings. [2001, c. 345, §5 (NEW).] [2001, c. 345, §5 (NEW) .]

7. Children under 6 months of age or otherwise non-ambulatory. A person required to make a report under subsection 1 shall report to the department if a child who is under 6 months of age or otherwise non-ambulatory exhibits evidence of the following:

A. Fracture of a bone; [2013, c. 268, §1 (NEW).]

B. Substantial bruising or multiple bruises; [2013, c. 268, §1 (NEW).]

C. Subdural hematoma; [2013, c. 268, §1 (NEW).]

D. Burns; [2013, c. 268, §1 (NEW).]

E. Poisoning; or [2013, c. 268, §1 (NEW).]

F. Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ. [2013, c. 268, §1 (NEW).][2013, c. 268, §1 (NEW) .]

Failure to Report Rev. Stat. Tit. 22, § 4009

A person who knowingly violates a provision of this chapter commits a civil violation for which a forfeiture of not more than $500 may be adjudged.

False Reporting Rev. Stat. Tit. 22, § 4014(1)

Immunity from any criminal or civil liability for the act of reporting or participating in the investigation or proceeding is not extended in instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury.

CASE COMPOSITE

A young child died of acute physical trauma while in the care of his mother's boyfriend. Prior to this tragedy the young child's sister had been seen at a local hospital because the day care provider was concerned about bruising on her face. The police investigating stated the bruise was inflicted, but the mother convinced the physician's assistant in the ED that the bruises were not inflicted; meanwhile the caseworker investigating this referral also observed facial bruises on the young male child. There were too many caregivers to easily pinpoint the abuser. Ultimately the perpetrator (mother's boyfriend) was convicted of manslaughter.

Findings and Recommendations:

Finding:
The Department did not respond to a report from a hospital of physical injury to a two year old for several days.

Recommendation:
The Panel recommends that the Department provide immediate response for any child under age 6 reported by a hospital. (*Global estimates of child homicide suggest that infants and very young children are at greatest risk, with rates for the 0–4-year-old age group more than double those of 5–14-year-old* [15])

Finding:
The family primary care physician was not consulted in the initial assessment. The PCP did not have information about the family's adverse experiences; i.e., parental and other family member substance abuse and domestic violence.

Recommendation:
Information about a case needs to be shared between DHHS and medical providers. Currently, DHHS and medical providers work in their separate silos, leading to fragmented and poorly informed decisions. We need to improve collaboration and trust between the professionals investigating and providing care to these children and families.

Finding:
A two year old presented to the emergency room with suspicious facial bruising, yet the child did not undergo a complete physical exam and her sibling did not undergo a physical exam.

Recommendation:
When a child presents with facial bruises the whole body should be examined at the request of the Department.

Recommendation:
When there is suspicion of inflicted injury to one child, all children in the family should be medically evaluated.

Recommendation:
When the Department receives a referral that a child has physical injuries, a child abuse specialist/s* should be consulted and digital photos should be taken. Professionals involved; police, medical provider, CPS worker should coordinate the contact with the specialist.

Finding:
The referent's report was not given as much weight as the parent's explanation of the injuries.

Recommendation:
The Department should make an assessment of the reliability of the reporter and this should be weighed with the other evidence in the case.

Finding:
All household members and the alleged perpetrator were not interviewed in the initial assessment of the family.

Recommendation:
The Department should ensure that policy is followed in the interviewing of all household members and alleged perpetrators.

Finding
Caseworkers do not get consistent training in what injuries are typical and atypical.

Finding
There was no analysis of the mother's responsibility in the abuse.

Recommendation
All caregivers should be assessed.

DISCUSSION

The Panel discussed why professionals and medical care providers are not reporting as we would expect them to. The Panel questioned whether the professionals are not recognizing injury/incident as child abuse. The medical literature shows that medical practitioners only report 73% of injuries considered likely or very likely caused by abuse and only 24% of injuries considered possibly caused by child abuse.[4] The notion of suspicion of abuse is vague and fraught with confusion and error. Because a missed report may result in a child's death or serious injury, the Panel recommended mandated reporting of specific injuries to a child younger than 6 months of age. Please see the preceding description of the statute **§4011-A. Mandatory Reporting of suspected abuse or neglect #7 A-F** on page 35 of this report. There is a need to have mandated reporter training as part of professional licensing criteria, there should be an education avenue for mandated reporters and it should include all personnel having contact with children and families. Pennsylvania already requires the submission of two hours of mandated reporter training for licensing.

Some findings related to lack of reporting:

- Many clinicians in Maine and across the US, with high suspicions of child abuse do not report and do not consult with colleagues that have child abuse expertise

[4] Berkowitz, Carol, D.(2008) *Child Abuse Recognition and Reporting: Supports and Resources for Changing the Paradigm*, American Academy of Pediatrics, http://pediatrics.aappublications.org/content/122/Supplement_1/S10.full.html

- Providers are not being sued because they didn't report, but a number of providers do get taken to court by people who allege the report was "malicious."
- Providers should be reporting to a caseworker on an open case; there is a need for improved communications between medical personnel and DHHS; an avenue to build trust in order to support collaboration between these groups.
- Central intake office should have secured email for reporting as it has become a preferred method of communication for many people. *(There is currently a 5-6 year wait to get proposed information technology projects off the ground and implemented in DHHS.)*
- The mandatory reporting law states that when the Department/OCFS becomes aware that a mandated reporter failed to report, OCFS will send that information to the licensing board; it is up to the licensing board to determine what action to take with the information.

It was pointed out that there is a need to train everyone in a medical practice so that they would be able to identify and be aware of families at risk. Peer training should be regarded as a tool equal to DHHS training. A program in England, whereby "the named person" with child abuse expertise is a resource and provides advice to those questioning whether a report should be made was a topic of panel discussion. A similar program is currently active throughout the State of Florida. All Panel members agreed this type of support would aid a referent in their decision to 'report' or 'not report' by providing advice. DHHS central intake currently acts in this role but many mandated reporters are unaware of this service.

At the request of the Director of OCFS, injuries in children that were unlikely to occur unless they were inflicted were supplied to the Department by members of the CDSIRP; the Department then used this information to support appropriate changes and inform legislation.

- *Bruise in child under six months*
- *Fracture in child under six months, excluding birth injury*
- *Bleeding from nose or mouth, bleeding from frenulum*
- *Injury inconsistent with developmental age*
- *Injury inconsistent with explanation*
- *Changing history (the panel discussed whether the reporter will have the expertise to make this decision.)*
- *Reported to be inflicted*
- *Multiple locations, especially bilateral*
- *Atypical locations*
- *Adult bites (the panel questioned whether someone without experience will be able to make the distinction between adult and child bites.)*
- *Any injury in an infant less than six months old*
- *Burns – pattern burns, cigarette burns, all immersion burns*

- *Unexplained genital injuries*
- *Sexual disease, pregnancy in child under 14*
- *Implement pattern bruise*

PASSAGES - REASONS GIVEN FOR FAILURE TO REPORT

"Lack of knowledge inhibits reporting" (doctor)

"A guide indicating suspicious injuries at varying ages and advising when to report would be useful" or "consultation would be helpful in situations with questionable signs of maltreatment"(doctor)

"He might have made a report, had he received any training about when to report" (doctor)

"He did not feel the bruises were inflicted and felt the explanation of the parents was plausible" (law enforcement)

"Need for a decision tree to assist reporters/providers in determining whether to file a report" (doctor)

"When should the medical community be questioned regarding children in care? He indicated that he received conflicting information and recommendations of care during the case and did not know how to address his concerns" (caseworker)

"Impression of the family and their love of the baby, coupled with having an extra set of eyes going into the home, swayed him toward not reporting" (doctor)

"She worried more about a failure to provide care and neglect, than inflicted injuries" (nurse)

"He observed bruising and was told that it was the result of the child moving and wedging against the crib bars" (doctor)

"She had the support of her mother and the hospital staff and was appropriate in her care and paid attention to the baby making you feel the babies were safe in the home" (doctor)

"All the diagnostic testing made things confusing for the reporters/providers working with the family"

WHO REPORTS IN MAINE

REFERRAL SOURCE	2010	2011	2012	2013
Anonymous	8%	10%	11%	11%
Child Care Personnel	1%	1%	1%	0%
Law Enforcement Personnel	12%	16%	16%	17%
Medical Personnel	9%	13%	15%	15%
Mental Health Personnel	6%	9%	10%	10%
Neighbor/Friend	4%	6%	5%	4%

Other	2%	2%	1%	1%
Relative	6%	8%	8%	6%
School Personnel	12%	18%	17%	17%
Self/Family	6%	8%	8%	8%
Social Services Personnel	8%	10%	9%	10%

**Percentages are based on only the reports that were assigned for child protective assessment; excludes reports referred to licensing, out of home investigations, service requests and reports received where a case was already open and the information was not a new incident.*

SIGNS OF SAFETY

CHANGING THE PRACTICE MODEL

During 2011, the Child Death and Serious Injury Review Panel reviewed a case in which the perpetrator of the child's injuries could not be determined, but appeared to be one of the parents. As the child was returned to the care of the parents, despite the inability of the Department to identify the perpetrator, the panel expressed concern for the safety of the child and the decision of the Department to return care to a likely perpetrator. Casework staff at the review talked about their use of a new initiative, Signs of Safety. This raised substantive debate among panel members as to the possibility of protecting children in situations where the agent of the maltreatment and the source of risk have not been clearly identified. Based upon that debate, the panel requested that DHHS Office of Child and Family Services (OCFS) leadership meet with the CDSIR Panel to provide an overview of Signs of Safety, an approach to family engagement, safety planning, and service planning recently implemented by the Department.

At the March 2011 meeting, Paul Martin, Child Welfare Program Specialist with OCFS, provided the panel with an overview of the OCFS program developed in conjunction with *Signs of Safety*, *author, Andrew Turnell*[13]. He discussed the Department's strategy to place a child back in the home with confidence, even in situations of denied child abuse, through the development of an ongoing support system and safety plan that will remain in place when the Department is no longer involved with the family. Mr. Martin presented the approach as moving from "who did it" to "who in the family system will be responsible for protecting the child in the future." He indicated that this practice does not dismiss the importance of accountability and recognizing responsibility in the harm to the child, but focuses more on the common goal of preventing any further harm to the child in the future.

It was reported that the practice of Signs of Safety (SoS) in other states has shown promising results. He also indicated that the Department's historic emphasis on outside service interventions, such as therapy, has not created safety for the child beyond the life of the case. In the past, the Department has assumed the majority of the responsibility for safety planning. In contrast, Signs of Safety creates a network of support for the family and the Department works with the family and safety network to assess safety for the child.

This presentation raised a combination of interest and concern in some panel members. Members expressed concern that parents who may have injured a child were not held accountable and that, as a result, specific service planning could not be done. Additionally, some panel members raised concern about the dynamics of the perpetrator and the continued access to the child. Members questioned whether family members opposed to the plan might be excluded and stressed the need for seek out the "cynics" in the family. Other members, however, saw potential usefulness in a process that holds the entire family and support system accountable for safety planning and future child safety.

Department leadership agreed with the panel that the overall effectiveness of the initiative would best be reported through careful tracking of child safety outcomes related to the development of these plans. The Department indicated that data is being collected to show the effectiveness of the program and agreed to be held accountable to report these outcomes. They also invited a panel member to participate in the trainings in order to gain a more detailed understanding of the process.

The findings in this area are not specifically critical of the Signs of Safety model, as the model appears to have significant promise in its intended form. Implementation changes within the State, along with changes in Department leadership subsequent to those conversations, have left the panel uncertain of the progress in addressing child safety. The panel has, however, identified some issues that might inform the ongoing dissemination and implementation of this and other initiatives. They are as follows:

Planning around child safety, regardless of the model used, requires that the model be carefully understood and embraced by Department staff, as well as by the numerous stakeholders who participate in safety planning for children and are called upon to implement the practice. It also requires diligent critical review and adjustment to adequately establish a new practice pattern. The implementation of a partially understood "hybrid" model is not a fair test or representation of a new treatment or planning process. Sometimes the new model works well and sometimes it can become a disastrous mix of the worst elements of old and new.

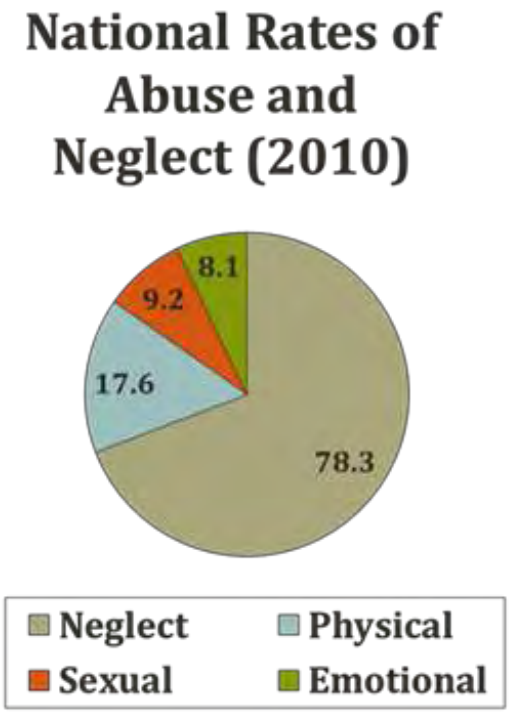
Child Welfare is a huge system with profound responsibilities in life and death matters. Any implementation of change in practice pattern will, by its nature, require careful planning, oversight, and ongoing expert supervision in order for it to be properly implemented and carry a reasonable chance for success. Additionally, there needs to be an ongoing review of data to ensure that the practice is increasing child safety and wellbeing.

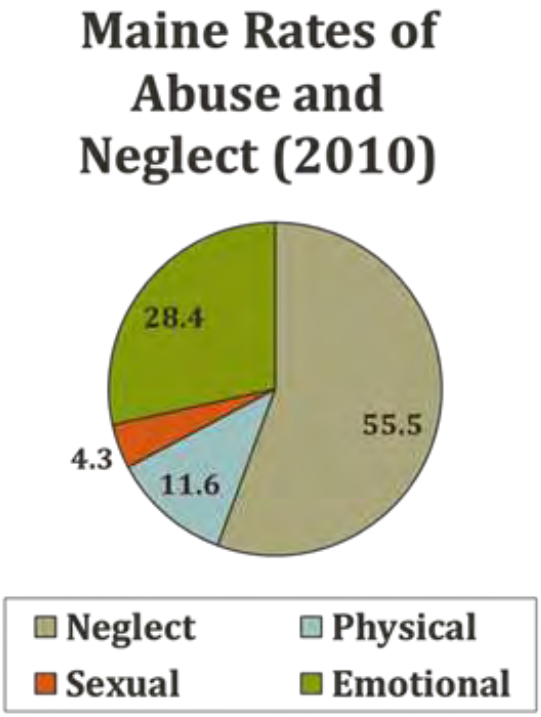
COLLABORATIVE RELATIONSHIPS WITH OTHER GROUPS

The Child Death and Serious Injury Review Panel understands that there are many effective ways to acquire knowledge and understanding; the relationship that the panel shares with the National Center for Child Death Review (NCRPCD), the

American Academy of Pediatrics Child Death Review (AAP CDR), and the Northern New England Child Death Review (NNE CDR) is evidence applying to the CDSIRP stratagem, to enlist and join other organizational entities in an effort to increase awareness and eliminate factors that result in serious injuries and deaths to children in Maine communities and across the nation. Focusing on better, more significant, ways to prevent the physical harm and deaths of children; these long-standing advocacy forces meet annually and discuss new areas and prominent issues surrounding the abuse and/or neglect of children and their families. This collaborative effort expands the approach, improves accuracy, and supports legislation; locally, regionally and nationally.

The following diagrams depict the nature of abuse and neglect nationally and here in Maine.





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Maine Department of Health and Human Services

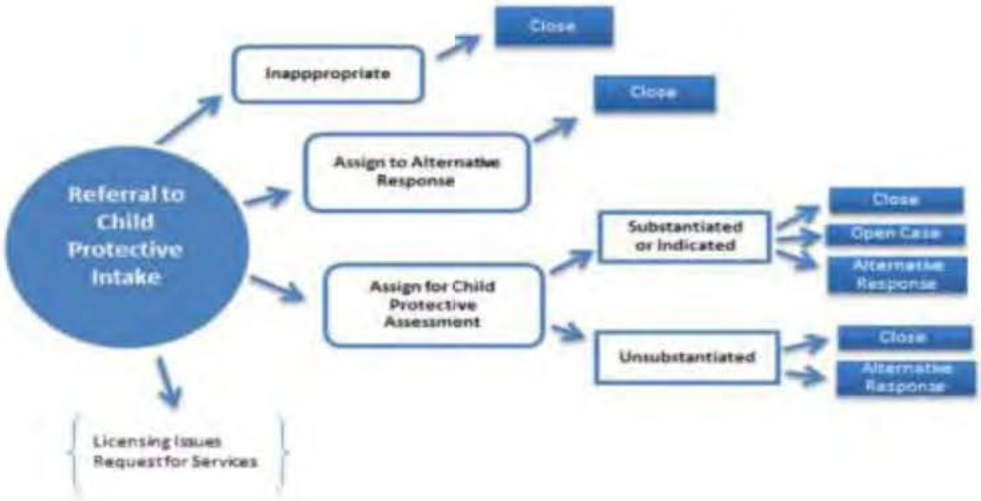
REFERRAL REPORTS

Title 22 MRSA, Chapter 1071, Subsection 4002 defines abuse or neglect 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."

The Department's decisions and ability to respond to reports of child abuse or neglect is based on factors such as the seriousness or complexity of the allegations and the availability of resources.

A referral is any written or verbal request for Child Protective Services intervention, in a family situation on behalf of a child, in order to assess or resolve problems being presented.

During calendar years 2010 through 2013 the Department of Health and Human Services received a large number of referrals for Child Protective Services intervention in a family situation. The following reports provide a summary of the number of referrals to Child Protective Services and the number of unassigned (inappropriate) referrals that were screened out.



TOTAL REFERRALS

	NUMBER OF REFERRALS BY CALENDAR YEAR			
Year	**2010**	**2011**	**2012**	**2013**
TOTAL REPORTS	**17457**	**18037**	**18867**	**19236**

**Excludes reports referred to Licensing, Out of Home Investigation Unit, Service Requests, and reports received where a case was already open and the information was not a new incident.*

APPROPRIATE REFERRALS

When reports contain allegations of abuse or neglect and are "appropriate" for intervention, the report may be assigned for a child protective assessment, or assigned to an Alternative Response Program (ARP).

	NUMBER OF APPROPRIATE REPORTS			
Year	**2010**	**2011**	**2012**	**2013**
Total Reports	**8119**	**6890**	**9071**	**8757**

ALTERNATIVE RESPONSE

The Department of Health and Human Services has contracts with private agencies to provide an alternative response to reports of child abuse and neglect when the allegations are considered to be of low to moderate severity. Between 2010 and 2013, there were **5617** reports which were assigned to a Contract Agency for alternative response at the time of the initial report. Referrals were also made to Alternative Response Programs at the conclusion of a child protective assessment or case with a family, when ongoing services and support were deemed necessary.

NUMBER OF REPORTS ASSIGNED FOR ALTERNATIVE RESPONSE				
Year	2010	2011	2012	2013
Total Reports	2135	1458	865	1159

INAPPROPRIATE REFERRALS

Some examples of reports that would be deemed inappropriate include:

- **Parent/child conflict:** Children and parents in conflict over family, school, friends, or behaviors, with no allegations of abuse or neglect. Includes adolescents who are runaways or who are exhibiting acting out behaviors that parents have been unable to control.
- **Non-specific allegations** or allegations of marginal physical or emotional care, which may be poor parenting practice, but is not considered abuse or neglect under Maine Law.
- **Conflicts over custody** and or visitation of children which may include allegations of marginal/poor care.
- **Families in crisis** due to financial, physical, mental health, or interpersonal problems, but there are no allegations of abuse or neglect.

The following is the breakdown of the total number of inappropriate reports received over the past four years.

NUMBER OF INAPPROPRIATE REPORTS				
Year	2010	2011	2012	2013
Total Reports	9338	9425	9315	8889

CHILD ABUSE AND NEGLECT VICTIMS BY ABUSE TYPE

The following reports show the victims by age group which includes both male and female and type(s) of abuse found during the child protective assessment for the past four years. Children may be counted multiple times if they were the victim of more than one abuse type in a given assessment, or the victim of subsequent abuse in following calendar year.

2010				
AGE	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	51	219	1205	339
5-9	37	110	520	318
10-14	36	95	353	311
15-17	63	75	306	253
Total	**187**	**499**	**2384**	**1221**
2011				
AGE	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	45	241	1252	270
5-9	47	152	639	456
10-14	75	119	443	402
15-17	41	51	151	155

Total	208	563	2485	1283
		2012		
AGE	**Sexual Abuse**	**Physical Abuse**	**Neglect**	**Emotional Abuse**
0-4	73	359	1469	332
5-9	95	221	883	544
10-14	83	171	581	503
15-17	20	56	180	134
Total	**271**	**807**	**3113**	**1513**
		2013		
AGE	**Sexual Abuse**	**Physical Abuse**	**Neglect**	**Emotional Abuse**
0-4	57	424	1436	323
5-9	78	241	750	509
10-14	75	171	459	438
15-17	29	55	151	147
Total	**239**	**891**	**2796**	**1417**

Children may be counted multiple times if they were the victim of more than one abuse type in a given assessment, or the victim of subsequent abuse in following calendar year.

FAMILY STRESS FACTORS INDENTIFIED

RISK FACTOR	2011	2012	2013
Prior History with CPS	71%	71%	72%
Mental Health Problems	47%	46%	44%
Involved with Court	22%	22%	21%
Spouse Abuse/Family Violence	21%	21%	21%
Drug Misuse by parent	20%	20%	19%
Pregnancy/New Child	19%	19%	19%
Heavy Child Care Responsibility	18%	18%	14%
Unstable Living conditions	13%	14%	14%
ADD/ADHD	13%	13%	12%
School Related Problems	15%	13%	12%
Parent / Child Conflict	12%	11%	12%
Alcohol Misuse by parent	11%	12%	11%
Physical Health Problems	12%	11%	11%
Severe Acting Out Behavior by Child	11%	10%	10%
Emotionally Disturbed child	11%	10%	9%
Divorce Conflict	9%	10%	8%
Former Foster Child	10%	9%	8%
Learning Disability	8%	8%	8%

Inadequate housing	5%	5%	5%
Social Isolation	4%	3%	4%
Physical Disability	3%	3%	3%
Drug Misuse by child	2%	2%	2%
Premature Birth	1%	1%	1%
Runaway	1%	1%	1%
Alcohol Misuse by child	1%	1%	1%
Abuse to Animals	1%	1%	1%
Visual/hearing impairment	1%	1%	1%
Previous Child Death	<1%	1%	1%
Failure to Thrive child	<1%	<1%	<1%
Fire Setting	<1%	<1%	<1%
Fetal Alcohol Syndrome	<1%	<1%	<1%

ENABLING LEGISLATION

22 MRSA 4004 (1)

E. Establishing a child death and serious injury review panel for reviewing deaths and serious injuries to children. The panel consists of the following members: the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.

The purpose of the panel is to recommend to state and local agencies methods of improving the child protection system, including modifications of statutes, rules, policies and procedures ; and [2007, c. 586, §3 (AMD).]

F. Investigating suspicious child deaths. An investigation under this paragraph is subject to and may not interfere with the authority and responsibility of the Attorney General to investigate and prosecute homicides pursuant to Title 5, section 200-A. [2007, c. 586, §4 (NEW).][2007, c. 586, §§2-4 (AMD) .]

22 MRSA 4008 (2)

E. A person having the legal responsibility or authorization to evaluate, treat, educate, care for or supervise a child, parent or custodian who is the subject of a record, or a member of a panel appointed by the department to review child deaths and serious injuries, or a member of the Domestic Abuse Homicide Review Panel established under Title 19-A, section 4013, subsection 4. This includes a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record. This may also include a member of a support team for foster parents, if that team has been reviewed and approved by the department; [2005, c. 300, §5 (AMD).]

3-A. Confidentiality, The proceedings and records of the child death and serious injury review panel created in accordance with section 4004, subsection 1, paragraph E are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commissioner shall disclose conclusions of the review panel upon request, but may not disclose data that is otherwise classified as confidential. [1993, c. 294, §4 (NEW) .]

22 MRSA 4021 (1)

Subpoenas and obtaining criminal history, the commissioner, his delegate or the legal counsel for the department may:

A. Issue subpoenas requiring persons to disclose or provide to the department information or records in their possession that are necessary and relevant to an investigation of a report of suspected abuse or neglect or suspicious child death, to a subsequent child protection proceeding or to a panel appointed by the department to review child deaths and serious injuries.

B. Obtain confidential criminal history record information and other criminal history record information under Title 16, chapter 7 that the commissioner, the commissioner's delegate or the legal counsel for the department considers relevant to an abuse or neglect case or the investigation of a suspicious child death. [2013, c. 267, Pt. B, §19 (AMD).]

LIST OF COMMON ACRONYMNS

AAG – Assistant Attorney General
AAP – American Academy of Pediatrics
ACES – Adverse Childhood Experiences Study
AHT – Abusive Head Trauma
APSAC - American Professional Society on the Abuse of Children
ARP – Alternative Response Program
CAPTA – Child Abuse and Prevention Treatment Act
CARES – Child Abuse Recognition Experience Study (AAP)
CARRET - Child Abuse Recognition, Research, and Education Translation
CDC – Centers for Disease Control and Prevention
CDS – Child Development Services
CDR – Child Death Report
CDSIRP – Child Death and Serious Injury Review Panel
CJA – Children's Justice Act
CME – Chief Medical Examiner
COCAN - Committee on Child Abuse and Neglect (AAP)
COD – Cause of Death
CPM–Certified Professional Midwife
CPS – Child Protective Services
CR – Child Resistant
CW – Child Welfare
DA – District Attorney
DAB – Drug Affected Baby
DHHS – Department of Health and Human Services
DEC –Drug Endangered Child
DOB – Date of Birth
DOD – Date of Death
ED – Emergency Department
EPIC – Educating Physicians in the Community
ER – Emergency Room
EMS – Emergency Medical Service
EMT – Emergency Medical Treatment
FD – Fire Department
HIPAA—Health Insurance Portability and Accountability Act
LE –Law Enforcement
MACWIS – Maine Automated Client Welfare Information System
MDEA – Maine Drug Enforcement Agency

MOD – Manner of Death
MRSA–Maine Revised Statue
OB/GYN – Obstetrician/Gynecologist
OCFS – Office of Child and Family Services
OSA – Office of Substance Abuse
PA – Physician Assistant
PD – Police Department
PFA/PA – Protection from Abuse
PHN – Public Health Nurse
PPPA – Poison Prevention Packaging Act
PURPLE – **P**eak, **U**nexpected, **R**esist, **P**ain Like, **L**ong-Lasting, **E**vening
FTM – Family Team Meeting
SACWIS – State Automated Child Welfare Information System
SBS – Shaken Baby Syndrome
SoS – Signs of Safety
TPR – Temporary Protection Order
WIC–Supplemental Nutrition Program, for Women, Infants and Children

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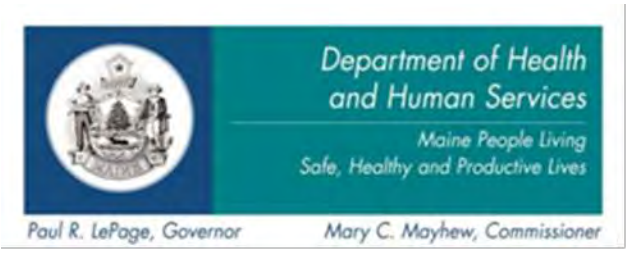

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Department Responses to the Citizen Review Panel Annual Report 2011-2013

V9 Subcommittee Recommendations

Recommendation: Each office should have a Youth Transition Worker who will assist youth in developing life skills as outlined in policy and to provide supports to them.

> **Response:** The Office of Child and Family Services currently has 7 child welfare social worker positions assigned to Youth Transition Work. Each Child Welfare District has a Youth Transition Worker work with children involved with the Child Welfare System between the ages of 14-25.

Recommendation: Engage in foster parent recruitment that will increase options for older youth in care. Matching is critical and attempts/supports to prevent disruptions should occur.

> **Response:** Through the competitive bid process, the Office of Child and Family Services currently contracts for foster parent recruitment and support services. This provider offers training, technical assistance, support and resources for all adoptive and foster families licensed by the Department. The Department will consider more clearly defining child specific, targeted recruitment needs in future requesting for proposals and purchasing of these types of services.

Recommendation: Youth should be provided with opportunities and appropriate supports to help them address their trauma.

> **Response:** The Office of Child and Family Services has been awarded a training and technical assistance grant to improve child welfare and mental health workforce capacity to collaborate and access evidenced based treatment for children involved in child welfare. This resource is designed to build capacity to jointly implement system changes that directly support the mental health needs of children. This work is scheduled begin January 2015.

Additionally, the Office of Child and Family Services has maintained its implementation of Trauma Informed Agency Assessment project within the contracting services division. The System of Care Trauma-Informed Agency Assessment (TIAA) is an in-depth, validated data-collection tool designed by dedicated family, youth and agency staff to identify areas of strength and pinpoint areas for improving trauma-informed service. It is designed to meet agencies and communities where they are at, and to build on established successes. TIAA data guides change according to each organization's unique strengths and needs. The assessment can be adapted for single or multi-agency use and its language modified to suit agency norms. Programs can be added to it that reflect a full service array, e.g., multi-systemic therapy, substance abuse, co-occurring, or day treatment services. Where data already exists on an environment's physical and emotional safety, youth and family empowerment, trustworthiness, trauma competence or cultural competence, components of the TIAA can be used to enhance existing data collection. The TIAA was developed over a two-year period by a workgroup that included youth and family. The assessment's initial content was based on Trauma-Informed Systems Theory (Fallot & Harris, 2006) and System of Care Guiding Principles. Evaluation partner Hornby Zeller Associates, Inc. validated the assessment using two analyses that demonstrate relatively high internal consistency reliability. In 2013, Office of Child and Family Services surveyed 99 agencies with responses from 3,300 personnel, 820 youth and 1,506 family members.

Recommendation: Mentors (adults and peers) are needed for youth in care

Response: The Office of Child and Family Services has issued a Request for Proposal for Intentional Peer Supports. Intentional Peer Supports are broadly described as an attempt to actively use reciprocal relationships to redefine help, with a goal of building community oriented (natural) help rather than simply creating another formal service. This service will be implemented in 2015.

Recommendation: There should be a formalized process to present the V9 Agreement to youth, such as a brochure.

Response: The Office of Child and Family Services, Child Welfare Services has a Youth Transition Policy that has been in effect since 2/10/2012. This policy has guided the work, set the expectations for child welfare social workers and explained the specific parameters for which introducing the V9 agreements for children in State care are given. Relevant excerpts from V. T. Youth Transition Policy Effective 2/10/2012 are below:

...All youth will be offered a Family Team Meeting to discuss the opportunity to participate in the V9 program, to negotiate the V9 Agreement, and to participate in their case/transition planning every six months.

... The youth's caseworker will document in the youth's Maine Automated Child Welfare Information System (MACWIS) case record that the V9 Agreement was offered and the youth's response. A copy of the V9 Agreement will be documented in MACWIS, and provided to the youth.

...Planning for the youth's transition to adult services should begin at age 17. The caseworker will also apply on behalf of the youth for other sources of possible financial support such as Supplemental Security Income, TANF, Medical Assistance program, and other local resources. These youth may be maintained on the V9 Agreement until an effective transition is made to the appropriate adult support resources.

... When a youth, who has previously declined the offer of a V9 Agreement or who has had their V9 Agreement suspended, contacts a caseworker within the Department, he/she will be told that they may be eligible to receive extended support services from the Department until the age of 21. In these situations, the caseworker and/or youth transition worker will contact the youth and may make one initial visit to discuss options with the youth prior to a case being opened in MACWIS. The youth's case will be reopened in MACWIS and all contacts

regarding the negotiation of a V9 Agreement will be documented. A copy of the signed V9 Agreement will be provided to the youth and put in the youth's case file.

Policy outlines the formal process as one that includes a family team meeting or face-to-face visit. Specific handouts to be provided during that meeting are not outlined in policy. The Department will consider ensuring adequate training for Youth Transition Workers and other related staff to use handouts as appropriate that review services available to youth when meeting with youth and families to discuss services.

Recommendation: The State should fund support for youth beyond age 21, while they are completing their technical or undergraduate education; this should include funds for tuition, living expenses, and case management services if requested.

Response: April 28, 2014 Public Law 577 was approved titled An Act To Improve Degree and Career Attainment for Former Foster Children. This law establishes a transition grant program to provide financial support to eligible individuals to pay for postsecondary education. The As a result of enabling legislation, the Office of Child and Family services has established a 40 slot transition grant program administered by the Office Youth Transition Specialist/ Moving Forward Program Director.

KINSHIP CARE SUBCOMMITTEE

Recommendation: To require DHHS caseworkers to review any medical needs and providers for a child at the FIRST family team meeting and list those needs in the safety plan; to make sure all parties at the family team meeting have a copy of the safety plan and understand their role in caring for the child; and to identify any need to develop relationship and parental consent for medical care for the child.

Response: The Office of Child and Family Services has recognized the need to continued growth and improvement of facilitating and communication with all individuals involved in children's lives while in care. As a result of this recognition, key goals identified in the Child and Family Services Plan for 2015-2019 is to work on:

Goal #2: Families increase the safety of their children by making and implementing agreed upon plans, supported by services they need.

Goal #3: Efficient, effective casework (engagement, assessment, teaming, planning & implementation) is evident in case documentation.

Goal #4: Improve OCFS sharing of responsibility with the community to help families protect and nurture their children

To reach these goals the Office of Child and Family Services has proposed key objectives; many of these objectives will serve to address critical elements of the recommendation put forward here by the Citizen Review Panel. The key relevant objectives that will impact this recommendation are:

- *Review/revise and strengthen Family Team Meeting Policy and Facilitated Family Team Meeting protocol.*
- *Training on Family Team Meeting and Facilitated Family Team Meeting protocol.*
- *Development and dissemination of FAMILY SHARE Policy.*
- *Ensuring FAMILY SHARE Meetings are occurring when children enter custody.*
- *Training for Resource Parents and staff regarding the need for and value of Family Share Meetings.*

Recommendation: Office of Child and Family Services take steps to ensure referrals to CDS are consistently being made as required under CAPTA Title 1, Section 106.

> **Response:** At this time a paper referral form to Child Development Services (CDS) automatically prints when a social workers prints the assessment findings letter in the Maine Automated Child Welfare Information System (MACWIS) whenever there is a child age 0-4 in that home. OCFS will have the accountability and information services unit and the leadership of the child welfare district offices work together to develop district plans to create a system to monitor the completion of the referral to the local CDS site. The plan will be created by June 2015.

Recommendation: To incorporate the Caregiver Agreement checklist into all the districts to use during family team meetings for both safety plan and custody cases.

> **Response:** The Office of Child and Family Services is committed to ensuring children's needs are met in all areas of their lives. The Policy and Training Unit in partnership with the Resource Parent Program Manager with OCFS will review the edited Caregiver Agreement developed by the subcommittee and determine the proper dissemination plan to the child welfare staff. OCFS will complete this internal review by the end of June 2015.

Recommendation: Disseminate a caregiver checklist for all kinship providers to use when they take a child into their care. This would be done via community providers such as AFFM, WIC, pediatricians, dentists, Head Start, and child care providers.

> **Response:** The Office of Child and Family Services wants to ensure that all families have appropriate resources and tools to safely provide care for children. At this time, OCFS practice is prior to any child being placed in a kinship home, it is expected that a kinship assessment of the home will be completed by the child' social worker or other staff to ensure home safety and caregiver capability to meet child's needs. If this placement is for a child who is in care of the Department then within 30 days the kin caregiver is required to apply for resource family licensing and is provided with information about all the required steps towards becoming licensed. Rather than relying upon a caregiver checklist, there is a set process in place for assessing home safety and for supporting the kinship family in moving forward with meeting the standards for licensing approval. OCFS currently contracts with Adoptive and Foster Families of Maine (AFFM) to provide an array of supportive services to kin providers, both those who are caring for children involved with the Department and those who are not involved with the Department. Through this contract a variety of resources and tools are provided to kinship providers.

Recommendation: AFFM, Maine Children's Alliance and interested parties continue to work with school personnel to understand the complexities and challenges kinship families face when trying to make decisions about what kind of legal relationship is needed for children being raised by kin and there is a need to enroll a child in a different school system due to living with a relative instead of their parents.

> **Response**: The Office of Child and Family supports and is actively involved with ongoing conversations regarding educational success for all children in care. OCFS will continue to partner school personnel and all interested parties to ensure educational stability of children.

Recommendation: To review the definition of a relative as it is written in Maine Statute and revise the definition to include great-great-grandparents, great grandparents, aunts, uncles, and cousins.

> **Response:** The Office of Child and Family Services thanks the Citizen Review Panel for recognizing the current parameters of the statute. OCFS would be willing to provide any technical answers necessary to the Panel should the Panel propose to revise the statue to change the definition of relative as it is currently defined.

Recommendation: Request the Office of Child and Family Services to convene a meeting with the TANF Agency and with representation from Adoption and Foster Families of Maine and other interested parties to discuss Child Only TANF and the accurate interpretation of benefits for kinship families caring for a relative's child.

> **Response:** The Office of Child and Family Services is willing to support and facilitate a meeting with the Office for Family Independence to share this recommendation. OCFS commits to doing this by June2015.

MENTAL HEALTH OUTCOMES SUBCOMMITTEE

Recommendation: Narrow the focus of the subcommittee to address issues of assessment, evaluation, and consistency of documentation between all regions.

> **Response:** The Office of Child and Family Services will support the Citizen Review Panel Subcommittee's decision to narrow their focus to address issues of assessment, evaluation and consistency of documentation in all regions. OCFS Policy and Training Unit is ready to embark on a statewide training to train district social work staff on the revised documentation policy. OCFS would welcome the Citizen Review Panel member attendance at the training.

Recommendation: Explore how community-based targeted case management and Behavioral Health Homes can assist OCFS in meeting the needs of youth in care

> **Response:** The Office of Child and Family Services feels strongly that well-being is inclusive of behavioral health and access to all needed services. OCFS agrees that a consistent statewide methodology to identify youth who are eligible for targeted case management and behavioral health services is important. We are working to develop a protocol by July 2015.

Recommendation: Explore the recommendations of the Academy of Pediatrics' guidelines for youth in foster care as it may apply to Maine.

> **Response:** Office of Child and Family Services has and will continue to follow the American Academy of Pediatrics recommendations.

Recommendation: Need to engage leadership of all DHHS districts

> **Response:** The Office of Child and Family Services has provided Senior Management time to participate on the Citizen Review Panel. Given the Deputy Director and Associate Director representation on the Panel, OCFS is committed continue to have statewide leadership involved with the panel. Additionally, we will continue to explore the means of staffing to support this work.

Recommendation: Assist districts in adhering to Maine law and mandates around assessment and evaluation.

> **Response:** The Office of Child and Family Services recognizes the need to maintain a rigorous continuous quality improvement plan. OCFS currently uses two primary methods to assist local child welfare offices in adhering to Maine law. The Policy and Training Unit develops, updates, and revises child welfare policy in accordance with state and federal law under the guidance of the Attorney General's Office. Additionally, this unit is responsible for creating and providing training to district staff on how to conduct their work in alignment with the aforementioned polices.
>
> The second strategy used is the services administered within the Accountability and Information Services Unit. This unit provides information, data and quality assurance services to all child welfare offices. Data storage,

reporting and compliance are the primary functions that are provided statewide and to the local child welfare office. This unit complete in addition to a number of quality assurance reports, the Child and Family Services Review and Plan which documents the success of the state to comply with state and federal mandates. OCFS welcomes any specific recommendations from the Panel on how the strengthen our adherence to Maine law.

Maine Citizen's Review Panel Recommendations for a Coordinated Health Plan for Children in Foster Care

The Maine Citizen Review Panel (CRP) in discussion with the Office of Child and Family Services (OCFS) staff made a decision in the spring of 2014, to form a work group to develop recommendations for the State of Maine's coordinated health plan for children in foster care. OFCS has stated they are developing a statewide plan and invited the Panel to make recommendations as to what should be included in such a plan.

The State of Maine, in order to be in compliance, needs to meet the requirements as stated in the Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 as follows:

The Health Oversight and Coordination Plan, section 205; section 422(b) (15) of the Social Security Act (42 U.S.C. 622(b)(15) is amended to read as follows:
''(15)(A) provides that the State will develop, in coordination and collaboration with the State agency referred to in para- graph (1) and the State agency responsible for administering the State plan approved under title XIX, and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and shall include an outline of—

(i) A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice

(ii) How health needs identified through screenings will be monitored and treated

(iii) How medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record

(iv) Steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care

(v) The oversight of prescription medicines

(vi) How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children

''(B) subparagraph (A) shall not be construed to reduce or limit the responsibility of the State agency responsible for administering the State plan approved under title XIX to administer and provide care and services for children with respect to whom services are provided under the State plan developed pursuant to this subpart[i]

The Child and Family Services Improvement and Innovation Act (P.L. 112-34) amended the law by adding to the requirements for the health care oversight and coordination plan. Whereas the law had previously required that the plan address "oversight of prescription medicines," the new provision builds on this requirement by specifying that the plan must include an outline of "protocols for the appropriate use and monitoring of psychotropic medications." In addition, **P.L. 112-34** requires that the health care oversight and

coordination plan outline "how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home" **(section 422(b)(15)(A) of the Act)**.[ii],[iii]

Further and in accordance with the federal law, the Child Welfare League of America (CWLA) and the American Academy of Pediatrics (AAP) call for mandatory health assessments and specify an initial health screening and comprehensive examination for children entering foster care. The AAP guidelines also label 3 key features of these mandatory health assessments: 1) assessments should be inclusive of all children entering foster care; 2) assessments should be comprehensive with respect to the identification of possible physical health, mental health, and developmental problems; and 3) assessments should be performed by a clinician who is knowledgeable about the treatment of children in foster care and can provide regular, ongoing primary care services.[iv],[v] It is important to recognize, that policies in many child welfare systems are set up for physical examinations but many do not have policies designed to address dental care, mental health and developmental needs. [vi]

In administering plans to meet compliance the following examples of recommendations from a few fairly well recognized groups is being provided and was captured from the National Screening and Assessment Recommendations for Children and Youth Entering Foster Care. [vii]

The American Academy of Pediatrics recommends:[viii],[ix]

Upon entry into foster care, children and youth should be seen by an appropriate health care professional, and have a health screening within 72 hours of placement.

- Within 30 days of foster care placement, children and youth should have a detailed, comprehensive evaluation of:
  - Mental health;
  - Developmental health (if under age 6 years);
  - Educational needs (if over age 5 years); and
  - Dental health.

- A follow-up health visit should occur within 60-90 days of placement.

The Council on Accreditation (COA) recommends:[x], [xi]

• Initial screening from a qualified medical practitioner within 72 hours of a child's entry into foster care to identify the need for immediate medical or mental health care, and to assess for infectious and communicable diseases; and

• Follow-up assessments within 30 days of foster care entry to help child welfare agencies determine the most appropriate placement for a child.

It is prudent to point out that Maine's most vulnerable population, which includes those children 5 years old and under, is also the same group with the highest number of children entering foster care. Because of this, it is critical that early intervention for this group occur to afford them a comprehensive examination, in order to reduce trauma and thus lessen future health issues. Notably, at this point there are only three clinics statewide that provide a broad range of services which meet the medical criteria outlined in this review but still lack the desired ongoing oversight.

The committee recommends that members of OCFS work with members of the medical and mental health field familiar with the needs of children in foster care, to support a plan for the State of Maine which would incorporate the resources of the state in effort to effectively provide comprehensive consistent services for children in all areas of the state, initiate such a plan in a timely fashion, integrate collaboration of agencies and provide a source of ongoing oversight to ensure continued success. A careful consideration of employing a systematic approach in amending the state's current legislation to meet these guidelines seems appropriate.

In gathering information to support the committee's recommendations 10 States were selected based on material available, which included Texas, Minnesota[xii], Colorado, Oregon[xiii], Indiana, Tennessee[xiv], Alaska, Ohio[xv], Missouri, California and New York. Another source of information that was used to discover methods of state practices for assessing health needs, facilitating service delivery, and monitoring children's care was the GAO February 2009 FOSTER CARE report [xvi]. Links to these references are found in the endnotes.

Maine statue currently provides the following language relative to a Health Plan for Children in Foster Care:

- The department shall ensure that a child ordered into its custody receives an appointment for a medical examination by a licensed physician or nurse practitioner within 10 working days after the department's custody of the child commences.

- If the physician or nurse practitioner who performs a physical examination and determines that a psychological assessment of the child is appropriate, the department shall ensure that an appointment is obtained for such an assessment within 30 days of the physical examination.

- Whenever a child is ordered into the custody of the department and the child is not expected to be returned to the home within 21 days, the department shall obtain counseling for the child as soon as possible, unless the department finds that counseling is not indicated.[xvii]

PANEL RECOMMENDATIONS

1) We recommend that the Maine Department of Health and Human Services collaborate with professionals in the field to develop a plan to meet the health care needs of children in foster care in a timely fashion.

2) We recommend that the plan should cover every child in every county in the state.

3) We recommend that the plan include ongoing oversight to see that all children are receiving comprehensive medical evaluations by providers who are familiar with the needs of children in foster care, as well as the care that is recommended in the evaluation. The plan should include measures to ensure that the medical records of children in foster care are available to providers and updated appropriately.

4) We recommend that a comprehensive examination plan should include evaluations for developmental needs and mental health needs. Children should be referred to trauma informed mental health services in a timely fashion, when indicated through evaluation by a qualified mental health professional. Young children should be enrolled in developmental services, with a thorough evaluation by a qualified Early Childhood evaluation team.

5) We recommend that the plan should include guidelines to ensure that complete mental health evaluation occur by a qualified mental health provider before any psychotropic medications are prescribed.

6) We recommend that the comprehensive evaluation include screening for oral health concerns and that the plans include recommendations for dental care services.

7) We recommend that the plan include steps to ensure that every child in foster care has a medical home[5].

8) We recommend that the plan include ongoing oversight to ensure compliance, such as, an evaluation to be completed on the entire foster care system and a report generated and delivered to the legislature or an advisory group in order to support continuous quality improvements

9) In preparing the plan the committee recommends coordination of funding and services for children in foster care should be reviewed, specifically the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)[6] ,Maine Care services, Behavioral Health home services and Case Management services.

10) Finally, the committee recommends that work be done to update the current legislation in Maine to include all aspects required by the federal law, and recommended by CHCS, AAP, CWLA and COA.

ENDNOTES

[1] http://www.gpo.gov/fdsys/pkg/PLAW-110publ351/html/PLAW-110publ351.htm

[1] CHCS – Center for Health Care Strategies Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities, Kamala Allen, Center for Health Care Strategies, Inc. November 2010.

[1] http://aaicama.org/cms/federal-docs/CRS_PL_112_34.pdf

[1] Child Welfare League of America. *Standards for Health Care Services for Children in Out-of-Home Care*. Washington, DC: Child Welfare League of America, Inc; 1988

[1] American Academy of Pediatrics, Committee on Early Childhood Adoption and Dependent Care. Policy statement: health care of children in foster care. Pediatrics. 1994;93:335–338. [PubMed]

[1] Comprehensive Assessments for Children Entering Foster Care: A National Perspective
Laurel K. Leslie, Michael S. Hurlburt, John Landsverk, Jennifer A. Rolls, Patricia A. Wood, Kelly J. Kelleher
Pediatrics. Author manuscript; available in PMC 2006 July 25. Published in final edited form as: Pediatrics. 2003 July; 112(1 Pt 1): 134–142.

[1] CHCS – Center for Health Care Strategies Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities, Kamala Allen, Center for Health Care Strategies, Inc. November 2010.

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[1] For more information about the AAP guidelines, visit: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx

[1] Comprehensive Assessments for Children Entering Foster Care: A National Perspective
Laurel K. Leslie, Michael S. Hurlburt, John Landsverk, Jennifer A. Rolls, Patricia A. Wood, Kelly J. Kelleher

[5] A "medical home," is an approach to primary care in which providers, families and patients work in partnership to improve health outcomes and quality of life for individuals, especially those with chronic health conditions and disabilities, and ultimately contain or reduce health care costs

[6] EPSDT program is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services.

Pediatrics. Author manuscript; available in PMC 2006 July 25. Published in final edited form as: Pediatrics. 2003 July; 112(1 Pt 1): 134–142.

[1] Note: COA is an international, independent, not-for-profit, child- and family-service and behavioral healthcare accrediting organization. For more information about COA accreditation standards, visit: http://www.coastandards.org/standards.php?navView=public&core_id=253

[1] http://www.health.state.mn.us/divs/fh/mch/ctc/factsheets.html

[1] http://www.oregon.gov/dhs/children/publications/cfsp/cfsp-2010-2014.pdf

[1] http://www.state.tn.us/youth/fostercare.htm

[1] http://www.metrohealth.org/upload/docs/Medical%20Services/Pediatrics/MH%20Medical%20Home%20for%20Children%20in%20Foster%20Care%200714.pdf

[1] http://www.gao.gov/new.items/d0926.pdf

[1] http://www.mainelegislature.org/legis/statutes/22/title22ch1071sec0.html

An Act To Ensure the Comprehensive Medical, Dental, Educational and Behavioral Assessment of Children Entering State Custody

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §4063-A, as enacted by PL 1991, c. 194, is amended to read:

§ 4063-A.Medical examination; comprehensive assessment

1. Physical examination required. The department shall ensure that a child ordered into its custody receives an appointment for a medical examination by a licensed physician or nurse practitioner within ~~10~~3 working days after the department's custody of the child commences.

~~2. Psychological assessment.~~ ~~If the physician or nurse practitioner who performs a physical examination pursuant to subsection 1 determines that a psychological assessment of the child is appropriate, the department shall ensure that an appointment is obtained for such an assessment within 30 days of the physical examination.~~

3. Medical, dental, behavioral and educational assessment. The department shall obtain relevant records and ensure that a child ordered into its custody is referred for a comprehensive medical, dental, behavioral and educational assessment meeting the standards of a national academy of pediatrics within 30 days after the department's custody of the child commences.

SUMMARY

Current law regarding the physical examination and psychological assessment of children entering state

custody requires the physical examination of a child within 10 working days after the child enters into the custody of the Department of Health and Human Services and a psychological assessment within 30 days of the examination if an assessment is determined appropriate by the doctor or nurse practitioner performing the physical examination. This bill shortens the time requirement for the physical examination to 3 working days and replaces the language regarding the psychological examination with language requiring a comprehensive medical, dental, behavioral and educational assessment meeting the standards of a national academy of pediatrics within 30 days after the department's custody of the child commences.

Appendix E

Effective February 2014

The DHHS Child Welfare Emergency Response Plan consists of the State of Maine Employee Emergency Guide; copies should be with each employee, the Child Welfare Disaster Plan and addendum. The Child Welfare Disaster Plan is activated when ordered by the Director of the Office of Child and Family Services or designee and when Central or District Offices can no longer follow their usual procedures due to natural or man-made disasters. Complementing The Plan will be the sound judgment of Office of Child and Family Services (OCFS) leadership and staff, ongoing communication among affected parties and improvisation as needed to meet the specific conditions of an actual disaster.

Child Welfare Disaster Plan

Leadership

The Director of the Office of Child and Family Services has the authority to activate the Child Welfare Emergency Response Plan. The Emergency Management Team, consisting of the OCFS Deputy Director, Associate Director of Intervention and Care, Associate Director of Policy and Prevention, Associate Director of Community Partnerships, Associate Director of Accountability and Information Services, Director of Mental Health Services, OCFS Medical Director, Child Protective Intake Manager, and Child Welfare Program Administrators of affected districts will assist the Director with the management of the emergency which includes ensuring that essential functions of the agency continue.

Emergency Management Team

The Emergency Management Team collaborates with the Director of the Office of Child and Family Services, Child Welfare Program Administrators, state agency authorities and others to assist with managing Child Welfare Services response to disasters.

Responsibilities of Emergency Management Team members include:

- Initiate plan operation
- Deliver communications to staff, clients and providers
- Communicate with Commissioner or designee and with the Director of Public and Employee Communication
- Coordination with DHHS officials and other departments of state government as necessary
- Ensure Intake continues to function: receive reports, communications hub if necessary
- Facilitate relocation if necessary
- Other responsibilities assigned by the Director of the Office of Child and Family Services

Continuing Essential Functions of Child Welfare Services

Essential Functions

Child safety is the highest priority to be attended to during and after a disaster. Knowing that staff as well as families we work with will be affected during a disaster, each office may not be functioning at full capacity. To assure that essential functions are covered, staff may need to take on functions not normally part of their

daily duties. All caseworkers, Quality Assurance staff, and other qualified staff could be called upon to perform any casework or support function as needed. Essential functions include:

- Child Protective Intake: ensuring reports of CAN are received and assigned.
- Responding to reports of CAN. Includes assessing child(ren)'s safety and managing threats of harm. If child(ren) are not safe at home an alternative plan must be developed and/or court action initiated.
- Ensuring safety of children in state custody. includes assessment of child safety as needed for children in DHHS custody or care and determining that child(ren)'s and caregiver safety needs are met.
- Prompt family contact to share information on child/family situation related to the disaster.
- ICPC disaster related functions, i.e. coordination and information sharing when children and families cross state lines
- Court Hearings unless otherwise determined by the court.

Communications Plan

Emergency Management Team, coordinating with the Director of Public and Employee Communication, develops messages for families, providers and staff. Message is communicated through a variety of means to ensure the broadest reach. Means to be used for families and providers include:

News releases to radio and television stations, cable tv, newspapers
Information on the state (maine.gov) and OCFS (http://www.maine.gov/dhhs/ocfs/) websites.

Intake

- Means used to communicate with staff include the above and the use of phone trees.
- Information could include office closures, current status of services and how to access them, disaster updates, toll free #s and other contact information, links to other resources, information for staff, status of MACWIS.

The Emergency Management Team is responsible for having on hand, a current list of newspapers, television stations and radio stations with their contact information and the OCFS website alert password.

Each district has a phone tree as determined by the Program Administrator.

Emergency Management Team is connected to District phone trees through the Program Administrator and designee.

Program Administrator and designee have the Emergency Management Team contact information
Staff to contact caregivers and children.

Staff have programmed caregivers' and supervisor's contact numbers into their cell phones.
Supervisors have programmed staff and other essential contact numbers into their cell phones.
Intake to be hub for communication in the event that the District Office is down.
Intake to temporarily relocate to a district office, MEMA or Public Safety if necessary.

Information System Plan

- Develop MACWIS Disaster Recovery Plan: Contract to develop DRP that meets federal SACWIS requirement awarded to i-CST. Plan to be completed by 12/31/07.
- Information Services Manager or designee prints MACWIS Children in Care – Current Primary Open Placement Report weekly.
- Information Services Manager or designee to load the following reports onto the SMT folder weekly.
- Children in Care – Current Primary Open Placement Report.
- Worker Demographic Report.
- Listing of Assessments Report.
- Listing of Service Cases Report.
- Resource Capacity Availability: Foster Care-Regular Report.
- Resource Capacity Availability: Foster Care-CPA-Level of Care Report.
- AAG and judges contact information.
- Templates for Petition for Child Protection Order, Affidavit, Preliminary Child Protection Order, Proof of Service, Rehabilitation and Reunification Plan, Safety Plan, Purchase Order, Placement Agreement, Release of Information.

Back-up system off-site is in place.

Office Disaster Supply Kit

The Program Administrator or designee will have a thumb drive containing the following information:

- USB thumb drive with important documents loaded including: Calling Tree
- Employee and management contact information and their emergency contact information (Worker Demographics Report to be developed)
- Children in Care – Current Primary Open Placement Report
- Resource Capacity Availability: Foster Care-Regular Report
- Resource Capacity Availability: Foster Care-CPA-Level of Care Report
- Listing of Assessments Report
- Listing of Protective Cases Report
- AAG and judges contact information
- Templates for Petition for Child Protection Order, Affidavit, Preliminary Child Protection Order, Proof of Service, Rehabilitation and Reunification Plan, Safety Plan, Purchase Order, Placement Agreement, Release of Information.

Each District Office will have a disaster supply kit consisting of the following:

- Supply of paper forms: Petition for Child Protection Order, Affidavit, Preliminary Child Protection Order, Proof of Service, Rehabilitation and Reunification Plan, Safety Plan, Purchase Order, Placement Agreement, Release of Information
- Paper copies of :Calling Tree
- Employee and management contact information and their disaster plan contact information (Worker Demographic Report under development)
- Children in Care – Current Primary Open Placement Report
- Resource Capacity Availability: Foster Care-Regular Report
- Resource Capacity Availability: Foster Care-CPA-Level of Care Report
- Listing of Assessments Report
- Listing of Protective Cases Report

- AAG and judges contact information
- Radios and extra batteries or hand-crank radios
- Disaster plans
- Flashlight, lantern with extra batteries
- First aid kit
- Agency vehicles with at least ¾ full gas tanks

Emergency Management Team and Central Office Disaster Supply Kit

The Emergency Management Team will have a disaster supply kit consisting of the following:

- USB thumb drive with media outlet list, phone tree for Central Office including contact people in the Commissioner's Office and other state departments, federal liaison contact info, neighboring state liaison contact information, OCFS website alert password and important documents. The Director of the Office of Child and Family Services will determine who will have access to the thumb drive.
- Employee and management contact information including their emergency contact information (Worker Demographics Report under development)
- Children in Care – Current Primary Open Placement Report
- Supply of paper forms.
- Radios and extra batteries or hand-crank radios
- Disaster plans
- Flashlight, lantern with extra batteries
- First aid kit

Staff

Encourage staff to develop personal disaster kit

Staff identify 2 contacts who would know where they are; at least one of them should be out of the area.

All employees will enter their name, address, home phone, work phone, work cell and both emergency contact numbers in MACWIS Worker Demographics

Staff will report to the next closest Child Welfare Services office in the event of office closure related to the disaster if directed by the Director of the Office of Child and Family Services, Program Administrator or designee.

Staff must check in after a disaster with Intake or other entity as identified by the Emergency Management Team or Program Administrator

Recognizing that staff would also be affected by a disaster CWS supervisors will work with staff to ascertain their need for assistance so that they may be able to attend not only to their professional responsibilities but also to their own safety issues.

Providers

Family caregivers will complete the Family Resource Disaster Plan as part of their Foster or Adoption Application and at their annual update and biennial renewal. Each district will designate a caseworker to assist relative and fictive kin caregivers to complete the plan if the caregivers will not apply to become a license/approved resource. Included in the plan are relocation and emergency contact information and agency contact requirements. Each family will have an Emergency Supply Kit consisting of:

- Water, one gallon per person per day for at least 3 days
- Food, 3 day supply of non-perishable food
- Battery powered or hand crank radio
- Flashlight and extra batteries
- First aid kit
- Whistle
- Moist towelettes, garbage bags
- Wrench or pliers
- Can opener
- Medications
- Medical equipment
- Wired phone

Resource family disaster plan

Resource families will inform local first responders when a child with special medical needs is placed with them.

Residential facilities will follow emergency procedures as required by residential licensing regulations.

District staff will contact children in residential facilities to assess for safety as soon as possible.

MACWIS includes the resource family physical address, primary phone number and secondary phone number and fields as well as relocation and emergency contact information.

Caseworkers with youth in independent living situations, children in trial home placements and in other unlicensed placements will acquire two emergency contact names and their phone numbers and addresses and record in MACWIS.

Coordination with Courts

The Director of the Office of Child and Family Services will inform the court administration of the development of the Child Welfare Emergency Response Plan. Program Administrators and district Assistant Attorneys General will coordinate with local courts during an emergency.

Liaison with Federal Partners and Neighboring States

Director of the Office of Child and Family Services or designee will initiate and maintain contact with federal partners to communicate about waivers and about what is happening on state and federal levels in regard to the disaster.

Staff should document overtime and work done related to the disaster for possible reimbursement.

Director of the Office of Child and Family Services or designee will identify liaison in neighboring states, work with them to coordinate and share information when children and families cross state lines and will maintain complete contact information for those liaisons and their alternates.

Director of the Office of Child and Family Services or designee will ensure that federal partners and neighboring state liaisons have Emergency Management Team contact information.

Districts

Districts will go into "after hours services mode" initially in the event of a disaster. Districts will determine who is available to respond to reports of CAN and inform Intake. Districts will receive direction from the Emergency Management Team through the phone tree, Intake, media announcements and the OCFS web site regarding where to report to work and status of MACWIS. District phone trees will be activated to provide direction and to obtain and deliver information from/to staff. Districts will:

- Develop a plan for continuation of services to include:
  - Assessment of new reports within 72 hours of the report.
  - Service provision to Child Protection service cases within 5 days of the disaster.
  - Contact with children on caseloads and their caregivers to learn current situation, whereabouts, safety, needs, service provision as soon as possible.
  - Contact with parents of children in custody to give them updates on child's situation and to learn of parent's situation, service provision as soon as possible.
  - Coordinate with other agencies that have information about child and family location, needs.
- In the event that a child needs to be moved due to the emergency and another placement cannot be quickly located, with approval of the supervisor and PA the caseworker may take the child home with him/her.
- Per the Director of the Office of Child and Family Services, Policy V. D-4 which restricts placement of children in state custody or care with employees will be temporarily abrogated.
- Develop staff phone tree.
- Maintain list of District Court judges and AAG's home phone number, cell phone, and address.
- When youth are participating in off-grounds activities, the trip leader or other adult leader will have control of medications and emergency and first aid supplies.

- The Plan will need to be implemented incrementally in order to allow time for MACWIS changes that will enable the production of reports that include emergency contact information to occur.

- 155B **HOSTAGE TAKING**
- <u>If a hostage situation occurs, staff on the scene should follow the following guidelines</u>:

1)Evaluate the situation. Be very observant to detail. (Perpetrator's name, clothing, weapons, etc.)
2)Isolate the perpetrator from innocent bystanders or potential victims if possible.
3)Secure the perimeter. Do not allow clients, staff, or visitors to enter the risk area.
4)Evacuate the area if possible. If feasible, open outside window curtains and leave doors open.
5)Remain calm and attempt to keep others calm.
6)Dial 9-1-1 or attempt to have someone contact help.
7)Negotiate if possible if a rapport is existent. Do not be condescending or sarcastic – be bold, confident and calm.
8)Avoid heroics. Don't threaten or intimidate. Keep a safe distance and your hands visible.
9)Think about potential escape plan for yourself and other.

136B **<u>Roles of Management In Hostage Taking</u>**

1)Notify local law enforcement immediately and provide them with any pertinent information necessary.
2)Utilize cellular phones between the safe and crisis zones.

3)Notify all staff not in the crisis zone of the incidents. (Evacuate immediately and calmly)
4)If staff or clients are advised to stay put, stay away from windows, drop to the floor, take cover, and wait for a signal.
5)Stay in constant communication with law enforcement.
6)Have a designee secure the doors to avoid innocent bystanders from complicating the situation.
7)Meet law enforcement officials at a pre-designated location and provide them with good directions to and description of the site.
8)Identify a safe place away from the building for interviews.
9)Once the situation has been resolved, the "all clear" signal should be announced.
10)Make sure master keys are readily available to responding law enforcement.

Appendix F- OCFS Training Plan

Training	IV-E Eligibility	Venue	Trainers	Hours	Target Audience
New Worker Training This training is for new Child Welfare Caseworkers prior to working with children and families. The topics in this training include assessment of child abuse and neglect, impact of child abuse, family dynamics, interviewing skills, substance abuse, medical indicators of abuse, domestic violence, family team meetings, and permanency.	Yes	Held in house	Policy & Training Team Staff Community experts.	72 hours not including field instruction. Held every other month	New Child Welfare Staff
Indian Child Welfare Act (ICWA) Working with Native American Tribal Child Welfare This training provides the background and rationale for specialized child welfare policy and practice in working with Native American children. A historical perspective of child welfare practice in Native American communities is provided, leading to an overview of the Indian Child Welfare Act (ICWA). Guest presenters from Maine's Tribal Child Welfare system are contracted with to facilitate the session, lending their expertise and first-hand perspective in working with this population. Also discussed is the Truth and Reconciliation Commission.	Yes	Held in various locations throughout Maine	Contracted staff from Maine's Tribal Child Welfare	3 hours Held quarterly	Child Welfare Staff Alternative Response Teams
Psychosocial Assessment Training This training is designed to help participants to be able to write a psychosocial assessment of a family. It initiate's participants thinking in a more complete manner about what additional information may be needed regarding a caregiver. This process can assist caseworkers in developing key questions that would be asked of the mental health professional around caregiver functioning and capacity to change as it relates to child safety, permanence and well-being.	Yes	Held in House	Policy& Training Team Staff	6 hours Held Quarterly	Child Welfare Staff who hold conditional Social Work Licensure

Legal Training The training begins by discussing substantiated, indicated and unsubstantiated findings. The training moves into case flow focusing on law and procedure during each part of a case. Petition writing is explained, preparing for court and discovery is reviewed. Factual documentation is stressed throughout the training. The various types of hearings are explained from initial court action to TPR and how to prepare for court.	Yes	Held in House	Policy & Training Team Staff Assistant Attorney General	6 hours Held quarterly	Child Welfare Staff
Advance Medical Indicators This training describes and examines the medical indicators of child physical abuse, sexual abuse, and neglect. This training also includes information to help caseworkers understand when to seek further medical evaluations and tests, and how to give meaning to information obtained, in light of what we know about the dynamics of child abuse and neglect.	Yes	Held in various locations throughout Maine	Policy & Training Team Staff Dr. Lawrence Ricci- medical expert on child abuse and neglect.	6 hours Held Quarterly	Child Welfare Staff Resource Parents Community Partners. Alternative Response Teams
Trauma Informed Practice This training is conducted using the curriculum from the National Child Traumatic Stress Network (Child Welfare Trauma Training Toolkit). This training is to educate OCFS staff about the impact of trauma on children and families as well as how to recognize vicarious trauma and promote self-care for OCFS staff.	Yes	Held in the District offices	Policy & Training Team Staff Mental Health Program Coordinators Community Partners	12 hours – was delivered statewide to all OCFS Child Welfare Staff. Is presented quarterly	Child Welfare Staff
Failure to thrive Diagnosis, treatment and family support This training provides information on Failure to Thrive i.e. what it looks like, how to seek medical intervention, what has to happen within the family to treat this condition and how to provide supports to the child and family in order to provide safety to the child and have successful outcomes.	Yes	Held in various locations in Maine	Policy & Training Team Staff Dr. Lawrence Ricci- medical expert on child abuse and neglect	3 hours Once per year	Child Welfare Staff Resource Parents Community Partners Alternative Response Teams
Commercial Sexual Exploitation and Sex Trafficking in Maine This training is for Child Welfare staff to understand the demographics and	Yes	Held in various locations in Maine	Policy & Training Team Staff	4 hours	Child Welfare Staff Community Partners

dynamics of sex exploitation and sex trafficking in Maine, to understand the red flags and signs of sex exploitation and trafficking, and to understand how to meet the needs of victims regarding trafficking.			Maine Coalition Against Sexual Assault staff		Alternative Response Teams
Understanding the Dynamics of Sexual Assault This training is on the dynamics of sexual assault and how this impacts our work with families – topics to include victimization, protecting their children from abuse and the trauma they have endured.	Yes	Held in various locations in Maine	Policy & Training Team Staff Maine Coalition Against Sexual Assault Staff	3 hours	Child Welfare Staff Resource Parents Alternative Response Teams
Substance Abuse and Youth This training will focus on substance use in our youth. Types of substance abuse, relevance to the work we do with youth, signs of substance abuse/use, prevention and recovery.	Yes	Held in various locations in Maine	Policy &Training Team Staff DHHS-Office of Substance Abuse and Mental Health Services staff	4 hours	Child Welfare Staff Resource Parents Alternative Response Teams
Clinical Pathways This training is centered on five of the most common mental health diagnosis of children in our care, what case management activities are required to ensure that proper treatment modalities are being utilized.	Yes	Held in various locations in Maine	Policy & Training Team Staff OCFS Medical Director Dr. Lindsey Tweed OCFS Clinical Care Specialist Team Staff	3 hours	OCFS Staff
Special Topics for the 0-4 Population: Abusive Head Trauma and Safe Sleep The training focuses on the target age group of 12 months of age or less and that they are the primary victims of critical incidents of abuse and /or neglect. Presenters discuss that this age group are the most vulnerable to risk of harm from decreased parental capacity due to drugs and/or alcohol, sleep related deaths and maltreatment such as Abusive Head Trauma and	Yes	Held North, Central and South	Dr. Laurence Ricci and Dr. Jennifer Hayman medical experts on child abuse and neglect.	Full Day	OCFS Staff Alternative Response Teams Resource Parents

Sentinel Injuries.					
Office of Child and Family Services (OCFS) Orientation Training The OCFS New Employee Training is designed to inform new employees within OCFS of the various aspects of OCFS. The OCFS mission statement is reviewed as well as other major DHHS offices. The OCFS organizational charts and staff roles are reviewed stressing that OCFS is all one team working together for the children and families of Maine. Statistics of the populations served are reviewed as well as confidentiality, where to find policy and law, professionalism, and the work environment. Retention and recruitment efforts being done within OCFS.	No	Held in House	Policy & Training Team Staff Recruitment & Retention Specialist	6 hours Held every other month	OCFS Staff
Mandated Reporter Training This training is to provide training for OCFS staff and Child Abuse and Neglect Council staff to become trainers for the community on mandated reporting. Topics covered are what is mandated reporting, what are the laws around mandated reporting, indicators of abuse and neglect and how to report abuse and neglect to OCFS.	No	Held in various locations throughout Maine	Policy & Training Team Staff Child Abuse and Neglect Councils staff	3 hours held as needed	Child Welfare staff Community Partners
Adoption Process This training focuses on the process of adoption from working with the child, birth family, adoptive families, and others involved. The history of adoption and were we are today and the paperwork process of legalization.	Yes	Held at the district offices	Policy and Training Team Staff	3 hours	Child Welfare staff
Documentation This training provides instruction to staff on how, when and what to document when working with children and families.	No	Held in the district offices	Policy and Training Team Staff Quality Assurance Staff	6 hours	Child Welfare Staff
Supervisory Training – Putting the Pieces Together This training covers the three main areas of effective supervision (Administrative, Educational, and Supportive Supervision) that, while related, are also distinct and that each	Yes	Held throughout the State	Policy and Training Team Staff	54 hours	Child Welfare Staff

is an important component or piece of the bigger picture puzzle of child welfare supervision. Each module emphasizes self-reflection and application to the unique circumstances of each supervisor.					
Facilitated Family Team Training This training focuses on returning to the fidelity of the FFTM model (team decision making). It explains why this model works, what is looks like and how to best use this model when considering removal of children from their homes using court action.	Yes	Held throughout the State	Outside Consultation group Policy and Training Team Staff	6 hours	Child Welfare Staff
Rights of Recipients Training This training goes over the Rights of Recipients of Mental Health Services who are Children in Need of Service. The training provides rights violations examples staff may encounter and Disability Rights also talks about their role when they get involved. Ellie talks about her role as grievance coordinator and what a grievance is and what she will be doing if a grievance is filed by anyone. Different situations around treatment are also discussed.	Yes	Held throughout the State	Policy and Training Staff Disabilities Rights Center	4 hours	Child Welfare Staff
Abusive Head Trauma and Safe Sleep Experts from the field discussed the intricacies of Abusive Head Trauma and the need for safe sleeping environments. Participants' gained knowledge and skill to increase their confidence in having discussions with families about these two important topics.	Yes	Held throughout the State	Policy and Training Staff Dr. Ricci – Child Abuse Medical Expert	6 hours	Child Welfare Staff
Leadership Academy for Middle Managers The goal of this training is to enhance the ability of middle managers to apply leadership skills for implementation of sustainable systems change to improve outcomes for children, youth and families	No	Held in Southern Part of the State	Muskie Consultants	36 hours	OCFS Managers
Leadership Academy for Supervisors The LAS provides a high quality, proven training experience for	No	Held on line with some face to face consultation	Policy and Training Team	36 hours over a 9 month period	Child Welfare Staff

experienced supervisors in an accessible format, two-thirds in a self-directed approach to meet supervisor's busy schedule. The LAS is a 9 month blended learning program. The core curriculum for supervisors consists of the six on-line modules corresponding with the NCWWI Leadership Model. Learning activities include pre-learning in preparation for each of the six modules as well as instructor led real-time discussion sessions for graduates of each module.			Muskie Consultants		
Partnering for Success – CBT+ This training is an initiative between OCFS, Sweetser, and the National Center for Evidence Based Practice in Child Welfare (NCEBPCW) that we will work together to ensure sustained, accessible, evidence based therapy to children and families through shared communication and joint ownership for successful outcomes. Maine applied to the (NCEBPCW) and was selected as an implementation site to participate a in a three year project that will focus on ensuring children are receiving evidence–based Cognitive Behavior Therapy with an added component of Trauma Focused CBT together forming (CBT+). CBT+ is evidenced based and shown to work.	No	Held in house	Out of State Consultants	22 hours	Child Welfare Staff Children's Behavioral Health Staff Private Mental Health Agency
Transition to Independence – TIP This training is based on the Transition to Independence Process (TIP) Model an evidence supported model of working with transition age youth with emotional/behavioral difficulties (EBD). Training is a skills based approach of engaging with young people, listening to them and then helping them be successful in their goals. The skills are transferable to the young person to help them make decisions, avoid risky behavior and manage conflict in a healthy way.	Yes	Held in house	Out of State Consultants	? - Dulcey will know	Policy and Training Staff, Youth Transition Staff
Mock Trial This training gives caseworkers the opportunity to practice testifying in regard to a mock case in court with legal interns acting in the roles of the attorneys.	No	Held in house	AAG's Office	6 hours	Child Welfare Staff
Social Work Ethics	Yes	Held in house	Policy and Training	6 hours	LSW's who are conditionally

Training is offered to LSW's who are conditionally licensed from both OCFS and OADS. The training goes over in detail the Code of Ethics for Social Workers and work is done around Values and the Responsibility Standards. Ethical dilemmas are discussed as well as how to use a decision making model for analyzing the dilemma and finally how to use a resolution model to assist in deciding how we determine the best course of action.			Team Staff		licensed from OCFS and OADS
Ethical Decision Making for Social Workers This training is offered to Social Workers from both OCFS and OADS and is a requirement for social work license renewal. The training goes over the Code of Ethics for Social Workers. Social Work Values are covered and different scenarios are worked through with a specific dilemma resolution model. Trainees also take a set of the standards from the Code of Ethics and summarize them for the group and give examples from their work.	Yes	Held in house	Policy and Training Team Staff	4 hours	Fully licensed LSW's from OCFS and OADS
Advanced Domestic Violence Victim Focus This training focuses on the domestic abuse survivor's experience during a child abuse assessment. Using a mock case, they highlight methods/procedures that enhance safety and encourage accountability. This training focuses on partnering with the non-offending parent to promote efficient, effective and child-centered outcomes. As well as, intervening with perpetrators of domestic abuse through accountability to reduce risk and prevent further harm to children and adult survivors.	Yes	Held in central location in Maine	Maine Coalition to End Domestic Violence Policy and Training Team Staff	6 hours	Child Welfare Staff Community Partners
Advanced Domestic Violence Perpetrator Focus This training brings into focus the Domestic Abuse Offender's Choice to be Violent. They explore the differences between men's and women's violence. Community leaders, working in this field, share their lessons learned. Participants acquire an understanding of and an opportunity to practice with David	Yes	Held in central location in Maine	Maine Coalition to End Domestic Violence Policy and Training Team Staff	6 hours	Child Welfare Staff Community Partners

Mandel's latest tool, Mapping Perpetrator's Patterns. Participants learn to maintain their focus on abusive behavior.					
Drug ID, Impairment Recognition This training gives an overview of drugs and paraphernalia recognition. It highlights key indicators of drug impairment and gives tips on how to document. It covers current drug trends and briefly facilitates a discussion about youth who may be under the influence. The presentation also includes discussion around worker safety when working with someone who may be under the influence	Yes	Held North, Central and Southern part of state	MDEA Retired Policy and Training Team Staff	6 hours	Child Welfare Staff Community Partners
Youth Voice/Child Plan Training Training covers how to engage young people in being part of their case planning. Young people will be a part of this training and will discuss how to get buy-in and understand the goals of young people vs our goals for them. The new child plan and FTM's are also discussed in this training.	Yes	In districts	Policy and Training Team Staff partnered with Muskie and Youth	2 hours	Child Welfare Staff
Problem Sexual Behavior, Adolescents This training covers adolescent problem sexual behavior and research that states recidivism isn't as high as has been thought in the past. It also covers how important positive treatment approaches are with youth who have had problem sexual behaviors. It provides information about planning for safety when siblings are living in a household together and there has been problem sexual behavior.	Yes	Central location in state	Dr. Sue Righthand Policy and Training Team Staff	6 hours	Child Welfare Staff Community Partners
IMPACT New users receive a brief training on the IMMPACT system which is the ME CDC system that a child's immunizations are stored. OCFS office assistants and case aids are IMMPACT users and there are at least two in each office.	No	Adobe Web Conferencing	Policy and Training Staff	2 hours	Child Welfare Staff

2016 Trainings to be rolled out based on feedback from the districts:

- **Advanced Fact Finding Interviewing Training**
  - This training will be a multi-day practice seminar where staff will build on and advance their fact finding interviewing knowledge and skill by refreshing their knowledge of the 7 step interviewing protocol and then critique their own and their peers work. Each participant will bring examples to share of each step and will engage in a constructive feedback process.

- **FTM Training**
  - This training will enable participants to build their skills in facilitation, team building and planning through the life of a case. The training will focus on strategies of how to help a family move through a case making progress by using the FTM model.

- **Motivational Interviewing**

  This training will cover the Motivational Interviewing techniques that build upon eliciting and working with the individual's consideration of potential change. In the field of Child Welfare, this method can be used to assist reluctant clients in determining their true interest and drive to change or stay the same, in turn allowing the worker to make accurate assessments related to child safety and to make specific referrals to services based on the client's readiness to do meaningful work.