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Annual Progress & Services Report

June 2015

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 mix of services.

The organizational unit responsible for programmatic implementation of the CFSP is the Child Welfare Services, overseen by Associate Director Mark Dalton. 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)

The goal of the Community Partnership for Protecting Children (CPPC) model in Maine is to transform the child welfare agency and communities to better serve vulnerable families and their children and to reduce abuse and neglect through the development a statewide community child welfare system. At its essence, CPPC is a collective impact model, designed with the understanding that the traditional child welfare model cannot- and should not- be the sole structure responsible for keeping children safe. As such, the model depends on the investment and involvement of the community.

What began as a successful pilot program in 2005 in Portland has now expanded to include the communities of Biddeford, Portland, South Portland, Westbrook, Lewiston, Auburn and Bangor. Through four (4) core strategies (Family Centered Practice, Policy and Practice Change, Neighborhood Networks and Shared Decision Making) community partners in the collaboration - including the OCFS- work together towards the following goals:

1. Reduce the likelihood of abuse and neglect among children in target communities;
2. Reduce the likelihood of re-abuse of children who have previously been reported for CPS services;
3. Reduce the rate of serious injuries to children; and
4. Increase the stability of families in the CPS system and community.

CPPC partners identify and support families earlier by decreasing risk factors and increasing protective factors through the use of Preventative Family Team Meetings, local collaborative work and other neighborhood-driven activities. As an active partner in the collaboration, OCFS has developed an earlier intervention position of a Prevention Social Worker within the scope of OCFS child welfare work to liaison with the community and to work directly with families most *at-risk* for experiencing first time or repeat maltreatment. The OCFS is committed to working with and empowering communities to ensure that children and families grow up healthy, productive and safe.

The Child Welfare Steering Committee (formerly PIP Steering Committee) was implemented in September, 2005, and currently comprises membership from child welfare, court improvement, treatment foster care, guardians-ad litem, community intervention, Attorney General's Office, Maine Children's Trust, birth parent, kinship provider, Maine Coalition to End Domestic Violence, Tribal Child Welfare, Family Violence Project, Edmund N. Ervin Pediatric Center, CPPC, and Early Childhood Services. One of the barriers to full participation for several group members is that resources are limited across all agencies and being able to

have consistent participation in this group has been difficult. However, the group receives agency documents for review and feedback and is able to do this electronically as well as participate in the meeting through teleconferencing. The purpose of the group is to inform and engage with community partners about the Child and Family Services Review process and to solicit input in efforts currently underway to improve outcomes for children and families. In general, this group meets monthly and there is a commitment to provide the group with specific topic related information that the group and/or OCFS believes is needed for further review and feedback by a diverse stakeholder group.

Child Welfare Steering Committee

Name	**Affiliation/Title**
Theresa Dube	Office of Child and Family Services- Quality Assurance/Federal Plan Program Manager
Mark Dalton	Office of Child and Family Services- Associate Director, Child Welfare
Grace Brace	Office of Child and Family Services- Deputy Director
Bette Hoxie	Adoptive and Foster Families of Maine- Director and Foster Parent
Robert Blanchard	Office of Child and Family Services- Associate Director, Operations Unit
Linda Brissette	Office of Child and Family Services- Resource Family Program Manager
Christine Hufnagel	Community Concepts Alternative Response Program
Jan Clarkin	Maine Children's Trust- Executive Director
Kristi Poole	Office of Child and Family Services- Title IV-E & Adoption Program Manager
Christine Alberi	Child Welfare Ombudsman
Jean Youde	Edmund N. Ervin Pediatric Center, Maine General Medical Center- Programs Coordinator
Dulcey Laberge	Office of Child and Family Services- Youth Transition Program Specialist
Angie Bellefleur	Office of Child and Family Services- Associate Director, Policy & Prevention
David McCluskey	Community Care – Program Director.

Name	Affiliation/Title
Nora Sosnoff	Attorney General's Office, Assistant Attorney General- Chief of the Child Protective Division
Kristen Gefvert	Administrative Office of the Courts- Court Improvement Plan Coordinator
Elizabeth McCullum	Administrative Office of the Courts- CASA Director
Debbie Dembski	Grandparent LCSW Sexual Assault Center staff member
Lauren Dembski	Parent
Spence Baird	Grandparent/citizen
Debra Dunlap	Community Partnership for Protecting Children, Southern Maine Senior Director
Glenda Hamilton	OCFS Administrative Assistant
Jill Downs	Maine Head Start State Collaboration Office Coordinator
Valerie Winocour	Parent

Name	Affiliation/Title
Jon Heath	Family Violence Project, Director of Education Programs
Evelyn Lewey-Dore	Tribal Child Welfare Caseworker (recently joined the group)
Debi Frances	Tribal Child Welfare, Human Resource Penobscot Nation (recently joined the group)
Lynn Carter	Maine Coalition to End Domestic Violence Rural Grant Program Coordinator

Assessment of Performance

Data used in this Assessment of Performance was pulled from the most recent ACF Summary Data-CFSR 3 Statewide Data Indicators (October 2014); OCFS Management Report;
and Me. CFSR data from 2009-2014:

- 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

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 in data submitted in the yearly APSR's (2010-2015) which were derived from the OCFS management reports:

Year of APSR	72-hour timeframe
2010	75.5%
2011	85.3%
2012	85.5%
2013	82%
2014	77%

2015	82%

It should be noted that in January 2015 the 72-hour Report was modified to include first contact with all victims within 72 hours.

The data collected through the case review process, although pulled from a significantly smaller sample of investigations, would indicate that Maine has been challenged in sustaining this standard as evidenced by the following table:

Me. CFSR Round	Item 1
Round 1: 11/2009-10/2010	65%
Round 2: 11/2010-10/2011	61%
Round 3: 11/2011-10/2012	79%
Round 4: 11/2012-10/2013	72%
Round 5: 11/2013-10/2014	75%
5-Year Average	**71%**

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.
- Late response time by out of home investigators.
- DHHS caseworkers do not go out until the last day of the 72 hours (the due date) and then there is something that delays the visit and they are not timely.
- 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 to locate families to initiate the assessment.

Factors that have impacted the capacity for timely assessments has been the significant staff vacancies for direct line caseworkers over the course of the last couple of years coupled with an increase in the number of children remaining in foster care which has diverted resource and staff time. Strategies that have been put in place that should support there being a change in meeting this standard include a Retention & Recruitment Specialist position that will focus on recruiting appropriate personnel and an increase in the funding for ARP's. District management will need to be focused on this area and utilizing the tools available to them to monitor performance. This issue has also been identified in the DHHS Strategic Plan so is the focus of both OCFS and the larger DHHS management team. The Child Welfare Associate Director provides monthly update reports in this area to the Commissioner.

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 ongoing progress made in this area as evidenced by following graph:

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%
5-Year Average	**74%**

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

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 ongoing quality case review data reflects that OCFS has sustained strength in this area fluctuating between 96%-100%.

Me. CFSR Round	Re-entry into foster care
Round 1: 11/2009-10/2010	96%
Round 2: 11/2010-10/2011	96%
Round 3: 11/2011-10/2012	97%
Round 4: 11/2012-10/2013	100%
Round 5: 11/2013-10/2014	100%
5-Year Average	**98%**

The ACF Summary Data- CFSR Round 3 Statewide Data Indicators (October 2014) 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.

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 has continued to be a challenge for OCFS and the data from the last four rounds of the qualitative case reviews bears this out:

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%
5-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 appropriate addressing of safety issues, particularly around substance abuse and domestic violence.

- Visits moving to unsupervised when not appropriate given the ongoing issues. This also includes the home environment not being assessed prior to visits starting up.
- Out of home parents not assessed despite the child having contact.
- Lack of assessment of safety and risk leading up to trial placement home, often children are just placed back home without a reassessment of the family home and situation.
- 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.

This is clearly an area OCFS needs to be focused on. The CFSP included 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. There was also a decision made at the Commissioner level to have key areas of concern addressed through implementing statewide PIPs targeting those areas, safety through the life of the case was one selected for this level of focus. Maine is looking to implement a Rapid Safety Feedback model to provide real time case review feedback to district staff and management teams to ensure that safety is being evaluated first and foremost in the work.

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

The data collected through the case review process, although pulled from a significantly smaller sample of investigations, would indicate that Maine has been challenged in meeting this standard although the trend line is clearly indicated an upward movement in meeting the standard as evidenced by the following table:

Me. CFSR Round	Repeat Maltreatment (formerly Item 2)
Round 1: 11/2009-10/2010	76%
Round 2: 11/2010-10/2011	80%
Round 3: 11/2011-10/2012	83%
Round 4: 11/2012-10/2013	87%
Round 5: 11/2013-10/2014	89%
5-Year Average	**83%**

The ACF Summary Data- CFSR Round 3 Statewide Data Indicators (October 2014) reflect that Maine no longer meets the national standard related to recurrence of maltreatment. The national standard is 9.0%, 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 Rapid Safety Feedback Model will positively impact the challenges we face related to recurrence of maltreatment.

The 2015-2019 CFSP does include 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 (October 2014) 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 90% threshold, and while had been trending up, the last round evidenced a drop in performance in that smaller sample of cases:

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%
5-Year Average	**78%**

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 5 review cycles:

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%
5-Year Average	**79%**

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).

This was an area that required a larger cohort group be reviewed in order to demonstrate meeting the PIP goal. One factor that impacts this area would be the lack of documentation related to why a goal would be extended beyond what might be considered an appropriate timeframe. Key strategies in the CFSP that will address this is streamlining caseworker workflow, strengthening the Family Team meeting process, implementing effective Permanency Review Teams and Family Share Meetings all of which will require caseworker

attention and time to adequately document these activities. As noted in the Review of Goals for 2014-2015 section of the APSR (starting on page 43:

- The strategies related to strengthening the Family Team meeting and Facilitated Family Team Meeting process are in the process of being implemented;
- Permanency Review Teams are regularly occurring in each district;
- Family Share Meetings: While implemented in each district the data indicates that they are not being consistently held:

Baseline (removals between 7/1/13-12/31/13)	**Q1 (removals between 1/1/14-3/31/14)**	**Q2 (removals between 4/1/14-6/30/14)**	**Q3 (removals between 7/1/14-9/30/14)**	**Q4 (removals between 10/1/14-12/31/14)**
12%	33%	31%	38%	47%

It should be noted that the Family Share goal for Year 1 of the 2015-2019 CFSP has been met- that goal was set at 16%.

The percentages above reflect the overall cohort of removals and when any Family Share meeting was found in the system. QA had conducted quarterly reviews to determine if the guidelines are followed, for example are meetings being held within 5 days of child removal, and adhering to this aspect of the guidelines has consistently been a challenge for staff and the data would reflect this occurring much less frequently than what the data presents above. The challenges presented have included staff not entering these meetings correctly so they aren't captured in a data pull, meetings being held in conjunction with Family Team Meetings which is not an appropriate setting for the meeting and district staff not being clear as to which program area is responsible for holding the meetings- child protective or children services. The new worker pre-service training includes a video of the Family Share Meeting and process. Districts have developed action plans to address the challenges and are expected to revise the plans if/when the data reflects little change in the outcome; this is managed by the child welfare management team. The SMT Accountability Plan also includes steps related to meeting this requirement.

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 last cycle 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 in the 2009 CFSR. 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:

ACF Data Indicator	**National Standard (NS)**	**Maine Data**
Permanency in 12 months for children entering foster care	40.4%	24.7 NS not met
Permanency in 12 months for children in care 12-23 months	43.7%	40.2% NS not met
Permanency in 12 months for children in care 24+ months	30.3%	26.8% 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. Strategies developed that should positively impact Maine's performance in these areas include:

1. All adoption cases will be reviewed to identify barriers that are impacting permanency and solutions will be developed to move the children forward in terms of permanency.
2. There will be a review of all youth to identify those where it would be appropriate to move them towards adoption and determine the barriers to achieving that goal for those youth.
3. Strengthening through additional training and support of the Facilitated Family Teaming process and Permanency Review Teaming process.
4. Redevelopment of the Family Reunification Program.

The quality case review data indicates a steady rise in performance over the course of 4 review cycles but a marked drop in the last period covering 11/2013-10/2014, with the exception of Item 10-OPPLA:

Me. CFSR Round	Item 8- timely reunification
Round 1: 11/2009-10/2010	65%
Round 2: 11/2010-10/2011	64%
Round 3: 11/2011-10/2012	69%
Round 4: 11/2012-10/2013	79%
Round 5: 11/2013-10/2014	63%
5-Year Average	**69%**

Me. CFSR Round	Item 9- adoption
Round 1: 11/2009-10/2010	44%
Round 2: 11/2010-10/2011	38%
Round 3: 11/2011-10/2012	63%
Round 4: 11/2012-10/2013	62%
Round 5: 11/2013-10/2014	30%
5-Year Average	**46%**

Me. CFSR Round	Item 10- OPPLA
Round 1: 11/2009-10/2010	50%
Round 2: 11/2010-10/2011	57%
Round 3: 11/2011-10/2012	83%
Round 4: 11/2012-10/2013	79%
Round 5: 11/2013-10/2014	86%
5-Year Average	**70%**

A possible explanation for the drop in performance is the increase in the number of children 0-5 years old entering custody with multiple risk factors including substance abuse, domestic violence and serious injuries. Coupled with practice drift surrounding the permanency review teams, facilitated family team meetings and quality family team meetings leading to delays in achieving timely permanency. We recognize this drift and have been working with Casey to help bring fidelity in all these practices which includes training and coaching in these practice areas over the course of the next year.

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.

Trends that were highlighted through the case review indicated that barriers to meeting this 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 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).
- Outside of visits what is being provided to demonstrate reunification is the goal.
- Lack of progression of visits. If the child has been in foster care 1 year and we are still having supervised visits this is demonstrating that concerted efforts are not being made to reunify.
- The goal of reunification was in place for a long time without achievement, concurrent plan or change in goal despite concerted efforts failing. Sometimes parents would be doing 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.
- 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.

While not a specific focus at this point, key strategies in the CFSP that will continue focus in this area is streamlining caseworker workflow, strengthening the Family Team meeting process, implementing effective Permanency Review Teams, Family Share Meetings and finalizing policy to support concurrent planning. There are also expectations related to supervisory oversight in terms of developing a formal supervisory review protocol of child and family plans.

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 data when we dropped to 86%. The data has ranged from 86%-100%, with the 5-year average reaching 95% 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%
5-Year Average	**95%**

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 OCFS remained challenged in this area for Rounds 1 & 2, there has been steady improvement in the last 2 rounds of reviews. The data has ranged from 63%-85%, with the 5-year statewide average reaching 77% 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%
5-Year Average	**77%**

The CFSP includes strategies that should improve this practice and include sharper focus on consistently implementing Family Share meetings, evaluating the current Fatherhood projects statewide with the goal being providing access statewide for fatherhood initiatives. There are both district plans and SMT plans to increase the use of Family Share Meetings in the next year. These plans have been sent to all staff and follow up meetings will occur within district to ensure these meetings are taking place. There has been a challenge with the fatherhood work as the contract holder who was responsible for statewide coordination of this work failed to meet the deliverables of the contract work. OCFS is looking to build internal capacity with support from private partners to support his work.

In response to increased demand, additional funding has been allocated to the support the Supervised Visitation program, both for the last contract period as well as for the contracts beginning July 1, 2015. The contracts are held regionally versus district based which will facilitated more consistent statewide practice as well as allow greater flexibility in funding following the need. Providing more focus is needed to ensure that if supervised visits are warranted that these decisions are reviewed on a regular basis in order to ensure that visitation between a child and his or her parents is of sufficient frequency and quality to promote their relationships.

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 experienced a significant drop in performance in the review period 11/2013-10/2014 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%
5-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 work Maine had done through its PIP related to implementing the Signs of Safety approach provided Maine with tools to better engage families and encourage the use of informal supports throughout case activities which allows for those connections to be maintained. In the winter of 2013 the decision was made to end the contract with the organization providing support related to implemented Signs of Safety (SOS). At that time OCFS leadership and staff identified key components of the SOS work that would be woven into the training unit which would transfer into building stronger connections and engagement with families. This included strengthening the Family Team Meeting and Facilitated Family Team Meeting process which is included in the Review of Goals for 2014-2015 (starting on page 43) update.

Relative notification when children enter foster care is also key in ensuring that families are informed timely 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 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 support that we provide notification to some relatives however not to the extent that we should be confident that we are meeting 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. While it is evident Maine is progressing in the area of preserving connections, we will continue this work and we will be supported through the strategies in the CFSP. OCFS is implementing Lexis Nexus as a diligent search tool. Staff managing this process will be housed in Central Office.

<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.

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 as evidenced in the table below:

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%
5-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.
- Lack of efforts to go beyond identification and actually contact paternal and maternal relative resources.
- 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 (not re-assessing a relative's current circumstances).
- Discounting a relative completely because they are not a placement option.

As evidenced in the last five APSR's, Maine has ranged between 36%-42% of children entering custody being placed with relatives from the onset. In the past year (3/1/14-3/1/15) the data reflects that of the 939 children entering foster care 40% were placed with relatives at the onset of their foster care experience and 82% have remained with the relative during this timeframe.

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 have 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. That works includes presenting material gained through the Fatherhood Conference to all district staff, as well as collaborating with the Director of the Menswork Program to restart the Fatherhood Workgroup. The data is clear that we need to strengthen the consistency related to providing relative notification letters to all known relatives. Districts are expected to update district action plans related to this measure in order to move toward complying with the law/policy.

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 and maintaining at 70% for rounds 4 & 5:

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%
5-Year Average	**65%**

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

- Parents not being invited to activities outside of visitation and services such as medical and dental appointments, school events (sports, PTC) or other important events in the child's life.
- If above not offered/invited documentation to reflect why this would not be appropriate. This is often not documented.
- 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.
- 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).

The data supports the need to continue work in this area. The CFSP will support this work specifically through the Fatherhood initiative, strengthening the FTM process, and consistent implementation of Family Share meetings which facilitate relationships between birth and resource parents. 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. There is also a plan to provide staff training on Family Team Meetings. Please the Review of Goals for 2014-2015 (starting on page 43) for the update.

The data indicates that we do need to do a better job on ensuring that Family Share Meetings are occurring and occurring within 5 business days of when a child enters foster care. The following table illustrates the first four data queries of children being removed from their family and whether a Family Share meeting was held at any point - the following was found:

Baseline measure	Q1	Q2	Q3	Q4
12%	33%	31%	38%	47%

The QA unit has conducted quarterly reviews of a smaller sample of these removals to determine if the Family Share meetings are happening within 5 days of the child(ren) being removed. The data indicates that when these meetings happen they are generally within 10 days of when the child entered custody.
While it is clear the agency needs to strengthen this work, it should be noted that the agency did meet its first year goal for compliance related to Family Share, that goal was 16%, we reached 37% which is the established Year 4 goal.

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 improvement in this area, trending up primarily in rounds 3 & 4 and dropping slightly in round 5 of the reviews, as evidenced in the table below:

Me. CFSR Round	Item 12
Round 1: 11/2009-10/2010	32%

Round 2: 11/2010-10/2011	26%
Round 3: 11/2011-10/2012	52%
Round 4: 11/2012-10/2013	63%
Round 5: 11/2013-10/2014	60%
5-Year Average	**48%**

Three key strategies that were developed at the time of the 2009 CFSR were implementation and training on fact finding interviewing, embedding the tenants of signs of safety in practice and improving supervision. Combined it was believed that caseworkers would better be able to engage with families, children, informal and formals support and obtain key information related to assessing the needs of the child, family and resource parents. Of note is that within rounds 3 & 4 of reviews there was demonstrated progress in this area which would coincide with the timing of when these new processes were in place and more ingrained in the day to day work of caseworkers and their supervisors. It is clear that more work needs to be done in this area and it is believed that the CFSP will support this continued work through strengthening of Family Team Meetings, Foster Care Redesign and increased funding for supported visitation and ARP.

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 following data was obtained through an August 2014 phone survey of 77 randomly selected youth:

- 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.

In a September 2014 survey of youth and CASA/GAL 61% of youth reported having been notified of and invited to attend their court hearings. Some youth provided additional feedback related to Judicial proceeding, including several who knew about court hearings but reported not being invited to attend them.

The ongoing quality case review data reflects that OCFS has made some improvement in this area, trending up primarily in rounds 3 & 4 and dropping slightly in round 5 of the reviews, as evidenced in the table below:

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%
5-Year Average	**57%**

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.
- If there is no 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.
- Parents who are incarcerated or out of state have no efforts made at all (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.
- 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.

One of the key strategies in the CFSP was strengthening Family Team Meetings and facilitated Family Team Meetings. In the fall of 2014 a survey was conducted with child welfare staff to ascertain what was working and not working related to FTMs. The responses reflected that staff didn't feel confident around facilitating or preparing for family team meetings. This information was shared with child welfare leadership and a training plan was developed and is in process of being implemented through work with Casey Family Services. Please see the Review of Goals for 2014-2015 (starting on page 43) 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 strengthening of Family Team Meetings, Fatherhood Initiative Work, continued support and training related to OCFS Fact Finding Protocol.

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.

The following data was obtained through an August 2014 phone survey of 77 randomly selected youth:

- 91% of youth surveyed reported having been visited by their caseworker each month for the 4 prior months;
    - 84% reported that these meetings were either helpful or very helpful.
    - 88% reported feeling that they had the opportunity to tell their caseworker about important things going on in their life.

Youth provided feedback in relation to how the caseworker could do things different or done more of to better support/help the youth. Feedback included:

- Caseworkers often have to find the answers and get back to the youth in time versus being able to provide the answer when asked the question.
- There are too many worker changes.
- Youth would like to see their workers more often.
- The team focusing more on the youths behaviors versus what she would like to have happen.
- Youth feel that the adults are talking about the youth but not directly at the youth sitting in the meeting.
- FTMs are not helpful when decisions are made but then there is no follow up to make sure those things do happen.

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%
5-Year Average	**60%**

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

- Particularly in 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) that explore 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.
- Narratives are at times copied and pasted from month to month.

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 management report 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. 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.

Documentation Policy was developed and implemented in September 2014. By January 2015 all district staff had been trained on documentation which was completed through collaborative work between the Training & Policy Team and QA Unit. The next step will be to conduct a QA review of documentation to assess if staff are implementing the elements of documentation in their work, followed by planning to address any challenges found through the review process.

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%
5-Year Average	**32%**

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

- Not seeing the fathers as frequently as needed.
- Not discussing important issues related to reunification as they come up in a case.
- Diligent efforts were not made to have face to face contacts outside of one phone call.
- When most of the face to face contacts were done in a different location outside of the home.
- When there is no discussion of services, time frames, safety, well-being, and permanency of the children.
- When there is DV and mom and dad are not interviewed alone.
- Out of home parents are not met with.
- Caseworkers documented as a face to face contact with parents when the worker drops by a visit that is happening between the parent and child and not seeing them separately from that visit.

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.

The CFSP will support the work needed in this area including the work on developing statewide Fatherhood Groups and strengthening and improving on the Family Team Meeting process.

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 3 rounds of reviews, reaching a 5-year average of 89%:

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%
5-Year Average	**89%**

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 established an Educational Stability Workgroup to determine how big an issue educational instability is 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.

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 was rated a strength in 83% of the cases reviewed, below the 90% goal for the review.

Maine law- **22 MRSA 4063 A.1** stipulates that the *"Department shall ensure that a child ordered into its custody receives an appointment for medical exam by a licensed physician or nurse practitioner within 10 working days after the department custody of the child commences".*

In July 2014 the QA Unit conducted a review of a random selection of 201 children entering foster care between January-March 2014. The purpose of this study was to assess how well the Department was following this law as there have been questions raised by community providers on this issue. As part of this review, QA reviewed the Macwis record (Medical Screen, Narrative log from the date of entry through 6 months following entry) to determine if the records supports the appointments being made 1) within 10 days (to be clear- we are looking at whether or not the appointments were scheduled within 10 days NOT were the children seen within 10 days) and 2) children being seen by a medical provider within 6 months of entry into foster care. QA Specialists also interviewed the District Program Administrator, District Supervisor and Caseworker to obtain their input as to the following:

1. Are initial health exams scheduled within 10 days? If so by who, caseworker, resource parent?
2. If not, what are the barriers to ensuring that these appointments are scheduled within that 10 days? For example: Workload issues, Resource parents schedule and caseworkers are unaware of when the appointments are scheduled, lack of providers to see the children within a short timeframe.

The outcome of this study found:

- In 70% of the cases reviewed, there was no documentation of medical appointments being made within 10 days of the child's entry into care.
- In 61% of the cases reviewed, the record supported that child were seen by a medical provider between 10 days – 2 months from entry into foster care.
- In 29% of the cases reviewed it could not be determined if the child was seen by a medical provider.

Trends from staff survey as to barriers to being in compliance with this law include:

- Lack of clarity on policy and law.
- Workload issues.
- Lack of awareness of the law.
- Scheduling conflicts with the medical provide and resource parents.
- Resource parents living outside of the immediate area covered by the Spurwink, PREP or Key Clinic requiring significant travel time.
- Role confusion as to who is responsible for setting these up, i.e. assessment worker, permanency worker.
- Many interviewees thought it would be helpful to have this expectation be on a checklist of tasks to complete.

- Overall lack of follow up to ensure that appointments are scheduled and occur. Follow up at all levels (i.e. caseworkers, supervisors, PA's, APA's).
- Delays due to the need for child to change medical providers because of location of placement.
- For those areas covered by PREP, Spurwink, Key Clinic the general process is for the case aids or support staff to make the initial referral to the medical program. Delays in this area could be a result of the caseworkers not notifying the support staff when a child enters care in a timely manner and/or not receiving the needed Court Orders to begin the process.

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 but a slight drop in round 5. 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%
5-Year Average	**79%**

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

- When the dental and medical needs are not documented.
- When the providers are unknown.
- When there is no documentation to reflect that the child has ever been seen for medical or dental care.
- Lack of assessment and addressing of all the children's health needs in in-home cases.
- Lack of addressing specific health needs of child in a timely manner (such as medical care not being provided in a timely manner); this is particularly impacted by placement moves.
- Passport Medical Screen is often significantly out of date.

Through the fall of 2014 Maine worked on developing a Child Health Assessment (CHA) Protocol which was implemented in February 2015. The priority of the CHA Protocol is to ensure that all staff follow the law regarding medical services for children in the care and custody of OCFS. Program Administrators will ensure that all staff knows the law around medical, dental, mental health and developmental screening for youth in child welfare custody. In the spring of 2015 a study by QA will be conducted to determine the level of compliance in using this protocol with next steps determined following that review to ensure full compliance.

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 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%
5-Year Average	**77%**

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

- In-home cases where it was not clear that a child's mental health needs were adequately being met.
- 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 policy with regards to certain medication is not being adhered to.

Since the 2009 CSFR Maine had continued to work towards improving the work conducted to assess and address children's mental health needs. Many of the policies and practices cited in the CFSR remain in place with the challenges related to policy not being fully implemented. The CFSP will support this work related to consistent implementation of policies and procedures.

The 2015 reorganization included the creation of a clear Children's Behavioral Health Team. There are ten Behavior Health Program Coordinators and three clinical social workers housed across the state in District Offices, Juvenile Corrections offices and the two Juvenile Corrections Facilities. The Behavioral Health Coordinators provide consultation and collaboration activities with community providers, families, child protective colleagues, Psychiatric Hospitals, etc. on treatment services, behavioral health resources, youth transition, and evidenced-based treatment modalities. Over the past year they provided Trauma-Informed Training to child protective colleagues; became part of adoption units across Districts; and attended Permanency Review meetings and Adoption meetings regularly. The clinical social workers primarily focus on youth who are detained in the Juvenile Corrections Facilities doing crisis intervention work and ensuring that the behavioral health needs of these youth are addressed in the most effective and least restrictive manner.

Systemic Factors:

In completing the Assessment of Performance, OCFS recognizes that there are likely gaps in our collecting and providing data related to systemic factors. OCFS has a plan to more fully assess these areas and determine what is necessary data to obtain and should be able to provide a more comprehensive assessment in the 2016 APSR submission.

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. CFS 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 5 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 and produces 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 report, informing as well as supporting the work functions of internal and external stakeholders.

Maine DHHS continues to maintain a federally-compliant SACWIS system. MACWIS remains stable and is still considered one of the most successful systems in Maine State Government. The MACWIS system receives ongoing maintenance, with 5 certified release deployments during 2014, continuing to meet all new federal requirements.

OCFS Information Services has been actively working with OCFS management, internal business users, other DHHS partners, and community representatives as well as OIT MACWIS support to plan and develop for the incorporation of requirements from the Fostering Connections to Success and Increasing Adoption Act of 2008 and the Preventing Sex Trafficking and Strengthening Families Act. OCFS has redesigned business processes and recoded programming to convert current multiple resources into one Family Resource which will provide licensed and unlicensed services. This functionality will be released late spring 2015.

OCFS continues their contract for the 8th 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 2014 and into 2015 ROM will upgrade Maine's ROM Reports Service Model. This model will provide technology updates, enhanced reporting functionality and allow for a range of new administrative tools for OCFS staff customizations. Maine OCFS continues to work with the ROM Director and team in replacing, modifying, eliminating and or phasing out reports from the ROM Core Model to successfully align with the changing CSFR outcome measures.

APS Healthcare continues to have the contract with the State of Maine's Department of Health and Human Services 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 Children's Behavioral Health Services of OCFS.

As part of the Maine ASO Behavioral Health Utilization Review Program they provide eligibility verification, utilization management services including: 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 and transitional services and reportable events.

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 although the qualitative case review found Maine was trending upward in this area during the last 2 rounds of reviews.

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.

- There is no FTM for both parents.
- 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.
- Parents who are incarcerated or out of state have no efforts made at all (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 as to how the information from that meeting was shared with the youth at another time.
- 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.

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. In the fall of 2014 a survey was conducted with child welfare staff to ascertain what was working and not working related to FTM's. The responses reflected that staff didn't feel confident around facilitating or preparing for family team meetings. This information was shared with child welfare leadership and a training plan was developed and is process of being implemented through work with Casey Family Services. Please see the Review of Goals for 2014-2015 (starting on page 43) 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 strengthening of the Family Team Meetings, Fatherhood Initiative Work, continued support and training related to OCFS Fact Finding Protocol.

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").* In March 2015 OCFS was notified that the state audit of foster care and adoption assistance were completed, there were no audit findings.

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. All of these audits included a review of court activity being timely.

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. Maine does conduct quality case reviews and, while data specific to compliance in filing TPRs is not specifically extracted to speak to the TPR process, the outcome of Item 5 may be the closest link to Maine's continued compliance in establishing the appropriate goals which would include adoption and filing a TPR to reach that goal.

The quality case review data indicates a fluctuation in performance over the course of 5 review cycles:

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%
5-Year Average	**79%**

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 an extra chance).
- 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).

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. At that time the Statewide Assessment and stakeholder interviews commented that courts across the State did not consistently allow the caregiver to be heard in the hearings, although there did appear to be differing opinions on whether caregivers were provided the opportunity to be heard in court.

One of the PIP action steps was to review randomly selected cases for court notification compliance. This review of 417 cases was conducted and reported out in Quarter 7 (April – June 2012) of the PIP and the following was found:

- In 77% of the cases reviewed there was documentation of written notification being sent to caregivers of court hearings.
- In 81% of the cases reviewed it was evident that there had been either written or verbal communication to the caregiver.

This data was disseminated to Management who developed a message to districts as well as to individual district Program Administrators related to need to ensure these notifications are being sent and that they are sent in a timely manner.

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. A major component to that is Foster Care Redesign which is being overseen by the OCFS Deputy Director in recognition of the importance of this development. The goal is to make sure that all families who care for youth get the supports needed to care for those youth. The second goal is to not pathologizes youth in order to get services.
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 full blown case reviews using the ACF review instrument or focused reviews based on agency need for data.
4. District staff has access to reports provided by the Data and QA Teams although it does seem apparent that not all staff has the same level of access and this is likely based on district staff preferences. This is an area that needs to 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.

In the past year OCFS implemented a 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, the Associate Director of Child Welfare, the Associate Director of OCFS Operations and OCFS Deputy Director, all who are present and are available at the debriefings. 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 has 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 childs entry into foster within 30 days;

- Ensuring 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.

Districts were expected to develop action plans to address the areas of challenge based on the quarterly reports and update those as new data was reported to them. In reviewing the data it seemed apparent that these plans were not updated consistently as districts receive the new data as there was little improvement in all but one of these areas in the past year. As a result, 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. This plan is not to replace the district plans but to ensure that SMT is actively monitoring and supporting positive progress and sustainability. This includes steps that each layer of management will take to actively monitor this work is being done.

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. Following discussions with the Commissioner's Office, the decision was made to have a statewide PIPs focused on the key areas that the state was struggling with and was evident in the 5-year CFSR results. The key areas identified were safety through the life of the cases, case planning with children and families and frequency and quality of contact with children and parents. This was discussed with the District Management Team in January 2015 and April 2015 and it was agreed that the areas needing improvement will be able to be managed through use of the action plans already in place (relative notification, Family Share, voice recording, FFTM) and initiatives being developed, i.e. Rapid Safety Feedback model. Based on the next year of review and oversight, there may need to be additional planning required to meet these measures if progress is made without more focused oversight and planning.

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 is 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 will be moving towards 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.
    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 developed a Questions & Answer database for the CFSR and finding appeals and 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.
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 full 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. In the next year the process will need to be strengthened in terms of a defined sampling methodology and a process to eliminate cases prior to the case review month if/when there are case participants not willing to participate in the interview portion of the review. The long term goal, depending on our resources, is to increase the sample size for review.
   c. The 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 Steering Committees that allow stakeholders 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. The Child Welfare Steering Committee (formerly PIP Steering Committee) is a group of stakeholder consultants for OCFS in terms of preparing for the CFSR; following up on PIP progress and preparing for the CFSP. This group meets monthly.
   b. District staff has access to reports provided by the data and QA team. It seems that not all staff has the same level of access and this is likely based on district staff preferences. This is an area that needs to 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 the fall of 2014 a survey was conducted of district staff to assess how this process was going. The results of that survey reflect inconsistency related to the frequency and quality of Quality Circles being held. It has been determined that districts need better guidance on the use of these forums to address larger systemic issues.
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 explored a couple of alternative methods for assessment such as Structured Decision Making and the Eckerd Model which will expand the OCFS QA role. OCFS is working with the developers of the Eckerd Model as, structurally, Maine is poised to adopt this type of review model given its current QA system. A Memorandum of Understanding has been signed by Maine DHHS Commissioner and the Eckerd program to begin this collaboration.

Staff and Provider Training:

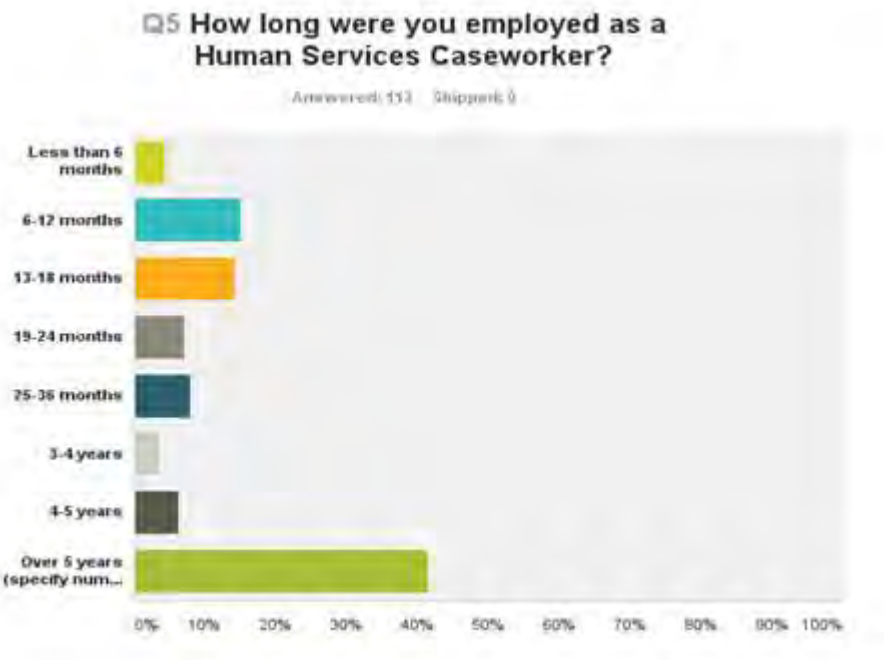
Item 26 Initial Staff Training- (How well is the staff and provider training system functioning statewide to ensure that initial training is provided to all staff who deliver services pursuant to the Child and Family Services Plan (CFSP) that includes basic skills and knowledge required for their positions) 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 2014 there were 6 rounds of New Worker Trainings conducted with 87 new workers participating.

OCFS was given access to the training curriculum used by Muskie and although some of the material is being utilized much of it will be changed to reflect current child welfare practices, policies and the State's implementation plans.

Similar to national workgroup retention rates, Maine has been challenged in keeping staff however is seeing an improvement in this area. The overall caseworker turnover rate in 2012 was 32.47%, in 2013 it dropped to 31.615, dropping again in 2014 to 27.01%. .

Please also see the below information about length of time employed at OCFS at time of separation. This is a self-report.



In February 2015 an anonymous survey was disseminated to 93 new workers, those who had been hired since looking for 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 caseworker 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.*

Maine OCFS was approved to receive TA from the National Resource Center for Organizational Improvement (NRCOI). The TA provided assistance in developing a plan to have delivered a supervisory training for staff who supervises front line child welfare caseworkers. The ongoing goal is 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 to the Supervisory Plan are the following:

- Provide trainings that encompass the "real" work that they and their staff do on a an everyday basis;
- Include topics that touch on the strength and challenges they each bring to the work;
- Be held in training venues that allow for attendance and interaction; and
- Provide trainings that morph into sustainable practice and integration of service that meets the needs of the children and families we serve.

OCFS staff, led by the Policy & Training Program Manager worked with Butler Institute to revise and deliver the curriculum *Putting the Pieces Together*. 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 retain front line workers and 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 indirectly affect the level of service offered through their impact on the direct service supervisees (Kadushin and Harkness 2002). Therefore, teaching supervisors the following:

- To understand their management style in relation to the agency's mission and to focus on agency goals and outcomes;
- To 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. The roll out of this training started in March 2015.

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 (as of 3/19/15)	2 lines vacated	2 promote

In addition to new worker trainings, ongoing trainings that were available in 2014 and the number of staff trained include:

TRAININGS	TOTAL STAFF
ICWA	60
PERMANENCY 2	68
Psychosocial Assessment Training	142
Adult Interviewing	15
Trauma	368
Legal	70
Commercial Sexual Exploitation and Human Trafficking	76
Failure to Thrive: Diagnosis, Treatment and Support	39
Medication Assisted Treatment	28
Adolescent Brain Development and Behavioral Health	18
Advanced Medical Indicators	20
Advanced Domestic Violence	39
Domestic Abuse - Perpetrator Mapping	44
Random Moment Time Study	16
Documentation	340
OCFS Orientation/Working Within OCFS	55
Technology (MACWIS and Dragon)	39

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 and has identified a need to revise and update the curriculum. A workgroup has been formed which includes district staff who are trainers of the current curriculum. The workgroup has met regularly since February 2015 with a goal of having this implemented in July 2015.

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 contracted agency, Adoptive and Foster Families of Maine (AFFM) and resource unit supervisors, it was determined that this assistance would be carried out through AFFM assuming responsibility for training one specific module of the curriculum whenever it was offered in district training on a statewide basis. AFFM 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.

The RFSS contract includes a requirement of on-going training provided to licensed resource families. AFFM 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.

The contractor throughout the year delivers or arranges for training to be delivered in resource family support group settings. The contractor also maintains a List Serve 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, specifically the Foster Care Redesign, increased funding in supervised visitation and ARP, the Fatherhood Group expansion and expansion of the CPPC program and/or OCFS support of community collaborative work. The assessment underway by the Prevention Team is expected to identify strengths and gaps in services across the state. The results of this assessment will be presented to the OCFS Executive Management Team who will then identify next steps for integrating preventative services into OCFS.

Item 30 (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 district from its former placement within the Intervention and Coordination of Care 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 our 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 our services as well as to establish measureable performance outcomes.

There are ten Behavior Health Program Coordinators and three clinical social workers housed across the state in District Offices, Juvenile Corrections offices and the two Juvenile Corrections Facilities. The Behavioral Health Coordinators provide consultation and collaboration activities with community providers, families, child protective colleagues, Psychiatric Hospitals, etc. on treatment services, behavioral health resources, youth transition, and evidenced-based treatment modalities. Over the past year they provided Trauma-Informed Training to child protective colleagues; became part of adoption units across Districts; and attended Permanency Review meetings and Adoption meetings regularly. The clinical social workers primarily focus on youth who are detained in the Juvenile Corrections Facilities doing crisis intervention work and ensuring that the behavioral health needs of these youth are addressed in the most effective and least restrictive manner.

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

- The YLAT
- The Child Welfare Steering Committee (formerly the CFSR Steering Committee)
- Maine Child Abuse Action Network

- Maine Youth Transitions Collaborative
- Moving Forward Initiative
- The REACH Workgroup
- The Community Partnerships for Protecting Children
- The Maine Child Death and Serious Injury Review Panel
- ARP Coalition
- TNT
- Child Advocacy Center Advisory Board
- Citizen Review Panel

OCFS can continue to demonstrate that the federal reports are routinely shared in the Child Welfare Steering Committee, which includes a representative from the tribal community, 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 of Children's Behavioral Health is 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 a Children's Behavioral Health Team, Finance Team, and Contracted Services Quality Assurance Team (CSQA).

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 our 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 our 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 our accounts, appropriations, and allocations. We will be clear on the role associated with quality oversight of services and the role of financial coordination.

The CSQA team will be leading quality improvement activities that will focus on the review of services across OCFS. A majority of the work will be monitoring the provision of Maine Care services in conjunction with our partners from Division of Licensing and Regulatory Services (DLSR), Maine Care and Audit/ Program Integrity. The work of this unit will complement the child welfare quality assurance tasks currently established within the office.

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
- REACH Workgroup
- 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

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 unchanged. 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. This new process of approving 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 Family Standards Policy and procedures combine the inquiry, informational, application, and home study process. These standards include age, health/functioning, background checks (including criminal history), and physical plan requirements (including a fire inspection and water test) in addition to a home study. 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 their ability to work 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.

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.

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 Family 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 motor vehicle registries and child abuse registries are also checked.

All adult members of the home 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. By policy, 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. Within 30 days of placement of a child in an unlicensed home, the caregiver is required to 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. There was a study conducted in the spring/early summer of 2014 that showed there was a wide variance in terms of practice and expectations. Casey Programs has been part of this work and has agreed to provide both hands on and technical support to bring Maine's PRT work back in line with the original model. This work plan should take place during the summer of 2015.

The Department contracts with the University of Southern Maine and with Adoptive and Foster Families of Maine to sponsor Community Conversations in locations across the state. These conversations are built upon the belief that recruitment is a community endeavor. These community conversations involve facilitated discussions between attendees (including educators, members of the community mental health provider profession, members of the legal profession, resource families, birth families, and Department staff) and youth panel members and adults who provided permanency to the youth. The discussions lead to insight gained by attendees into the needs of children and youth in their communities for permanency. The youth sharing their stories are often youth who have participated as members of the Youth Leaders Advisory Team (YLAT). YLAT has worked with youth on developing their strategic sharing skills and the youth are well prepared and supported in sharing only the information about their history which they feel comfortable in sharing. These youth are strong advocates and partners with the Department in its diligent recruitment efforts.

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. The Recruitment RFP has been completed and a community provider selected with services projected to begin in July 2015.

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.

Since the 2009 there was a drop in the usage of the available websites but Maine now reports that after two years of underutilization of the AdoptUsKids website by Maine OCFS staff, we have progressed in our effective use and efficiency as a state. This is due mainly to a shift back to each district having an adoption specific unit and supervisor. We have recommitted to the need for adoption units and adoption specific training.

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 are declining:

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

This does appear to be a nationwide phenomenon as adoptive placement requests for children in the care of another state being placed in Maine has also declined:

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

Review of Goals for 2014-2015 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. 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.

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 past five APSRs the data indicates 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 4 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 Intervention and Coordination of Care, Program Administrator, Unit Supervisor and Quality Assurance Specialist.*
- *Expansion and continued support of Alternative Response Programs through increased funding, renewing the Request for Proposals and providing training for staff.*
- *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%

Progress through May 2015:

✓ In December 2014 work was done by the OCFS Operations Unit to collect and analyze the Worker Workload Report in order for the agency to have a better sense of the distribution of cases among units

and program areas. That report was discussed at the March 2015 District Management Team Meeting. There was agreement that we could not redistribute staff at that point that data collection over the next couple of quarters will help in later decision making.

- ✓ Districts have been reviewing staffing patterns and case/assessment volume to re-purpose staff into practice areas of great need. We will also have better data once we have some months looking at caseload sizes.
- ✓ 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. Following discussions with the Commissioner's Office, the decision was made to have a statewide PIPs focused on the key areas that the state was struggling with and was evident in the 5-year CFSR results. The key areas identified were safety through the life of the cases, case planning with children and families and frequency and quality of contact with children and parents. This was discussed with the District Management Team in January 2015 and April 2015 and it was agreed that the areas needing improvement will be able to be managed through use of the action plans already in place (relative notification, Family Share, voice recording, FFTM) and initiatives being developed, i.e. Rapid Safety Feedback model. Based on the next year of review and oversight, there may need to be additional planning required to meet these measures if progress is made without more focused oversight and planning.
- ✓ Draft policy has been created related to how OCFS engages with Child Advocacy Centers. 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. This policy will be disseminated for comment/feedback and will be reviewed by the Executive Management Team (EMT) for final approval.
- ✓ The Alternative Response Programs have had a significant increase in service ability/delivery in FY15. The FY15 budget increase has provided nearly 3 times as many families to be served statewide. In FY15 an estimated 6668 families were served Statewide compared to 2766 in FY15 and 1613 in FY14.
- ✓ In January 2015 OCFS modified the 72-hour Report to reflect data pulled is for <u>all</u> victims being seen within 72 hours, not just the first victim seen.

<u>Data Updates:</u>

Management Report Data 72-hour Report (4/1/14-4/1/15)	CFSR Item 1: Timeliness of initiating investigations of reports of child maltreatment (4/1/14-4/1/15)
82%	**73%- Met Year 1 Goal**

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

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 last four Me. CFSR cycles strength noted in this area ranged from a low of 34% in 2010 to a high of 48% in 2013. The last two 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 4 years:

- *Continued support and training opportunities of the OCFS Fact Finding Interview protocol.*
- *Review/revise and strengthen Family Team Meeting Policy and Facilitated Family Team Meeting Protocol.*
- *Training on Family Team Meetings and Facilitated Family Team Meetings.*
- *Develop district repeat maltreatment written action plans based on data standards.*
- *Implementation and Utilization of the Family Stabilization Program.*
- *Develop a formal a 90-day supervisory review protocol of child and family plans.*
- *Review/reassess elements needed to strengthen the OCFS Management Reports.*
- *Management review of the components of the Signs of Safety and creation of a written action plan on how to move forward with the key elements of safety informed practice.*
- *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%

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%

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%

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

<u>Progress through May 2015:</u>

- ✓ The Family Team Meeting Policy, which includes the Facilitated Family Team Meeting protocol, was reviewed and disseminated in June 2014.
- ✓ In the fall of 2014 a recommitment to the Facilitated Family Team Meeting process was made by OCFS Management and each district identified dedicated facilitators for these meetings. Concurrently work was done with Strategic Consultants, Casey Family Services to develop and implement training for the facilitators that was rolled out in the spring of 2015.
- ✓ 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. In the fall of 2015 all staff will be trained in FTMs.

- ✓ In the fall of 2014 the OCFS Management Report was modified to include the measures specifically related to managing the CFSP. This new Report will be disseminated to the Senior Management Team on a quarterly basis to help in tracking of compliance related to CFSP measures.
- ✓ In August 2015 the SMT group will begin to identify strategies and develops plans to implement a 90-day supervisory review protocol of child and family plans. These are expected to be implemented no later than 12/30/15.
- ✓ The family stabilization services, supported visitation and ARP, have received increased funding to better support the work.
- ✓ 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. During the upcoming year a protocol to address the gaps in collection of medical history will be developed and implemented.
- ✓ Signs of Safety: In December 2013, the OCFS ended the contract with Connected Families who to that point had been the training partner to Maine. 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 supports and formal supports to address safety goals
    - Quality FTM's and FFTM's
    - 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, Danger, 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

A written plan needs to be developed on how the agency is going to move forward with this practice.

Data Updates:

CFSR Item 3: Assessing risk & safety concerted related to the child in their own home or while in foster care. (4/1/14-4/1/15)
49%- Exceeding Year 1 Goal

CFSR Item 17: Agency appropriately addressing the physical health of the child including dental needs. (4/1/14-4/1/15)
78%- Did Not Meet Year 1 Goal

CFSR Item 18: Agency appropriately addressing the mental/behavioral health of the child. (4/1/14-4/1/15)
82%- Exceeding Year 1 Goal

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 4 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.*
- *Redesign Documentation methodology and policy.*
- *Annual Family Team Meeting and Facilitated Family Team Meeting trainings for all staff.*
- *Management review of the components of the Signs of Safety and creation of a written action plan on how to move forward with the key elements of safety informed practice.*
- *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, CQI 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%

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%

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%

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%

Progress through May 2015:

- ✓ OCFS has explored a couple of alternative methods for assessment, Structured Decision Making and the Eckerd Model. OCFS is currently working with the developers of the Eckerd Model as, structurally, Maine is poised to adopt this type of review model given its current QA system. Eckerd will provide training and support to effectively implement this model to fidelity.
- ✓ Continued support and training opportunities of the OCFS Fact Finding Interview protocol. There are no planned trainings for Fact Finding Interviewing; however it is on the ongoing training need list. Currently we go through the protocol during new worker training, with opportunities to role play and delve into the seven steps. The new worker checklist also requires new workers to observe interviews, read interviews, listen to interviews and discuss with their supervisor.
- ✓ In the spring of 2014 a workgroup was convened to review and draft Documentation Policy, there was statewide and program-wide representation in this group. Policy was developed and implemented following by statewide training. Trainers of the policy included Training Specialist and QA Specialist, this training occurred in each district, training all staff, between November 2014-January 2015. The workgroup has committed to reconvening quarterly to assess how districts are responding to the policy/training and addressing any questions or challenges as they come up. The QA unit is prepared to

conduct a case review targeting the documentation and assessing if what was is in policy and what was trained has strengthened the documentation in our records.

- ✓ With the completion of work done related to documentation (policy and training), the next steps in the upcoming year are to look at supervisory workload and streamline social work activities further by looking at administrative tasks that should/could be done elsewhere in our system.
- ✓ A process of annual training on Family Team Meetings and FFTM will need to be developed following the statewide rollout in the fall of 2015 (please see Goal #2).
- ✓ Supervisory Training Development: Maine OCFS was approved to receive TA from the National Resource Center for Organizational Improvement (NRCOI). The TA provided assistance in developing a plan to have delivered a supervisory training for staff who supervises front line child welfare caseworkers. The ongoing goal is 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 to the Supervisory Plan is 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.

  OCFS staff, led by the Policy & Training Program Manager worked with Butler Institute to revise and deliver the curriculum *Putting the Pieces Together*. 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. The roll out of this training started in March 2015.

- ✓ Signs of Safety: In December 2013, the OCFS ended the contract with Connected Families who to that point had been the training partner to Maine. 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 supports and formal supports to address safety goals
    - Quality FTM's and FFTM's
    - 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, Danger, 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

  A written plan needs to be developed on how the agency is going to move forward with this practice.

- ✓ Over the past several months the fatherhood work has been slowed down due in large part the contract that was held by a community provider was not renewed. The agency employed a person who was in charge of coordinating fatherhood work throughout the state. The OCFS has begun discussions with our partners at Casey to support Maine in developing more internal capacity to coordinate the fatherhood work. We sent a staff person to the New England Fatherhood Conference in March to begin this internal capacity building.

Data Updates:

CFSR Item 3: Assessing risk & safety concerted related to the child in their own home or while in foster care. (4/1/14-4/1/15)
49%- Exceeding Year 1 Goal

CFSR Item 14: Frequency and quality of caseworker visits with child. (4/1/14-4/1/15)
65%- Exceeding Year 1 Goal

CFSR Item 15: Frequency and quality of caseworker visits with child. (4/1/14-4/1/15)
40%- Exceeding Year 1 Goal

The data from the voice recording studies would demonstrate steady improvement in this area although not reaching the Year 1 goal of 100%.

	Statewide total of voice recordings found
Baseline (6/1/2013-12/31/13)	64%
Q1 2014 (Jan-March)	62%
Q2 2014 (April-June)	77%
Q3 2014 (July-September)	78%
Q4 2014 (Oct.-Dec.)	79%
Q 5 (Jan.-March 2015)	82%

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 4 years:

- *Implementation and Utilization of the Family Stabilization Program.*
- *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.*
- *Forming CPPC in Biddeford, 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.*
- *Annual Cops & Caseworker Training*

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.

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

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%

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

Progress through May 2015:

- ✓ In the fall of 2014 a recommitment to the Facilitated Family Team Meeting process was made by OCFS Management and each district identified dedicated facilitators for these meetings. Concurrently work

was done with Strategic Consultants, Casey Family Services to develop and implement training for the facilitators that was rolled out in the spring of 2015.

- ✓ 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. In the fall of 2015 all staff will be trained in FTMs.
- ✓ Family Share Policy has been drafted and will need to be sent out to comment. Once that feedback is reviewed and any changes are made, the policy will be reviewed by the Executive Management Team for finalization.
- ✓ 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 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.
- ✓ CPPC: What began as a successful pilot program in 2005 in Portland has now expanded to include the communities of Biddeford, Portland, South Portland, Westbrook, Lewiston, Auburn and Bangor. CPPC partners identify and support families earlier by decreasing risk factors and increasing protective factors through the use of Preventative Family Team Meetings, local collaborative work and other neighborhood-driven activities. As an active partner in the collaboration, OCFS has developed an earlier intervention position of a Prevention Social Worker within the scope of OCFS child welfare work to liaison with the community and to work directly with families most *at-risk* for experiencing first time or repeat maltreatment. The OCFS is committed to working with and empowering communities to ensure that children and families grow up healthy, productive and safe.
- ✓ 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. This duo has conducted several trainings that have trained Child Advocacy Center staff and OCFS staff to provide Mandatory Reporting Training statewide. They have also trained all of the Opiate Clinics (except two) and some child care providers. Included in this next round of training is representation from the Maliseet tribal child welfare.
- ✓ The family stabilization services, supported visitation and ARP, have received increased funding to better support the work.
- ✓ Cops and Caseworker Training: Due to limited resources and time, this training was not able to be held in the past year. The decision has been made to remove this objective from the CFSP as there are numerous new trainings that will need to be held over the next several years that take priority over the Cops and Caseworker Training.

Data Updates:

Family Share: In the last 5 quarters of data from the Macwis query the data would indicate progress is being made in this area:

Baseline	Q 1	Q 2	Q 3	Q 4	Q 5
12%	33%	31%	38%	47%	90%

The qualitative data would indicate that the work that remains is to improve upon policy compliance related to having the meetings within 5 days of a child's entry into care as well as when children have a change in placement.

Facilitated Family Team Meetings: Total removals by district 4/1/14-3/31/15

District	% of FFTMs held
1	56%
2	70%
3	45%
4	73%
5	80%
6	58%
7	91%
8	42%
Statewide	**65%**

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. The most recent ACF data profile also indicates a upward swing in children reentering foster care in Maine that needs to be assessed, addressed and measured.

Objectives over the next 4 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.*
- *Implementation and Utilization of the Family Stabilization Program.*
- *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.

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

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

Progress through May 2015:

- ✓ In the fall of 2014 a recommitment to the Facilitated Family Team Meeting process was made by OCFS Management and each district identified dedicated facilitators for these meetings. Concurrently work was done with Strategic Consultants, Casey Family Services to develop and implement training for the facilitators that was rolled out in the spring of 2015.
- ✓ 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. In the fall of 2015 all staff will be trained in FTMs.
- ✓ 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 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. Following discussions with the Commissioner's Office, the decision was made to have a statewide PIP's focused on the key areas that the state was struggling with and was evident in the 5-year CFSR results. The key areas identified were safety through the life of the cases, case planning with children and families and frequency and quality of contact with children and parents. This was discussed with the District Management Team in January 2015 and April 2015 and it was agreed that the areas needing improvement will be able to be managed through use of the action plans already in place (relative notification, Family Share, voice recording, FFTM) and initiatives being developed, i.e. Rapid Safety Feedback model. Based on the next year of review and oversight, there may need to be additional planning required to meet these measures if progress is made without more focused oversight and planning.
- ✓ There was a meeting with our Casey partners to look at current fidelity to Permanency Review Tea's and a plan to bring Maine back in line developed for the Summer/Fall 2015.
- ✓ The family stabilization services, supported visitation and ARP, have received increased funding to better support the work.
- ✓ The OCFS Deputy Director and OCFS Adoption Program Manager are currently reviewing all the youth who are TPRd (577) to assess barriers and effectively plan to reduce those barriers.

Data Updates:

CFSR Item 5: Were appropriate permanency goals for child established in a timely manner. (4/1/14-4/1/15)
75%- Did Not Meet Year 1 Goal

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 4 years:

- *Foster Care Redesign and Implementation.*
- *Implementation and Utilization of the Family Stabilization Program.*
- *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%

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%

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

Progress through May 2015:

- ✓ In the fall of 2014 a recommitment to the Facilitated Family Team Meeting process was made by OCFS Management and each district identified dedicated facilitators for these meetings. Concurrently work was done with Strategic Consultants, Casey Family Services to develop and implement training for the facilitators that was rolled out in the spring of 2015.
- ✓ 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. In the fall of 2015 all staff will be 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.
- ✓ In the February 2015 SMT meeting a plan was made with goals and objectives related to compliance around relative notification compliance to meet and exceed this area of practice.
- ✓ The family stabilization services, supported visitation and ARP, have received increased funding to better support the work.
- ✓ The Foster Care Redesign is still underway. The goal is to make sure that all families who care for youth get the supports needed to care for those youth. The second goal is to not pathologize youth in order to get services.
- ✓ Multi-Ethnic Placement Act- We are currently in the process of reviewing submitted proposals for a foster and adoptive family recruitment service. As a result of a scoring process, a proposal will be selected and a contract will be negotiated with that service provider. Discussions will immediately ensue between OCFS and the provider agency to emphasize the need for focused efforts upon recruitment of families who can meet the diverse ethnic and cultural heritage of children in care. This will include targeted, diligent and child-specific recruitment of families who can promote the child's continued involvement and connection with his or her ethnic and cultural history. This contract is expected to be in place in the summer of 2015.

Data Updates:

CFSR Item 11: Were concerted efforts made to promote, support, and/or maintain positive relationship of child with parents. (4/1/14-4/1/15)
69%- Exceeding Year 1 Goal

Relative Notification						
	Q1 (8/2012-8/2013) T=198	**Q2 (12/2013-2/2014) T= 39**	**Q 3 (3/2014-5/2015) T= 43**	**Q 4 (6/2014-8/2014) T= 56**	**Q 5 (9/2014-12/2014) T= 147**	
Known grandparents	0	10%	7%	26%	**28%**	

Known adult relatives	8%	14%	12%%	21%	**22%**	

The data would indicate that, while we still remain extremely challenged in providing notification all grandparents and all known adult relatives, there is progress being made in this area.

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)*

- *Develop and disseminate the OCFS CQI Operational Plan.*
- *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 CQI Operational Plan, Associate Director Report, Case Review data and report.

Progress through May 2015:

- ✓ The CQI Operational Plan was developed and disseminated to the OCFS Middle Management Team on 4/28/14 with the expectation for further sharing with all staff. This plan can also be found on http://www.maine.gov/dhhs/ocfs/prov_data_reports.shtml
- ✓ By the fall of 2014 all eight Districts as well as Central Office had a functioning Quality Circle group. A survey was conducted to help us better gauge where we are in the quality circle implementation processes and any barriers or resource needs that quality circles may be encountering. All comments provided were kept completely confidential and only trends identified will be compiled and reported. The results of that survey reflect inconsistency related to the frequency and quality of Quality Circles being held. It has been determined that districts need better guidance on the use of these forums to address larger systemic issues.
- ✓ Throughout the past year the QA Unit has continued to work on strengthening the case 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;
  - Group training with QA staff of the OSRI through the CFSR Portal made available by ACF;
  - Participating in group meetings with ACF Regional Staff;
  - Developing a Questions & Answer Database related to CFSR items to assist in managing inter-rater aspects of review; and
  - Regular phone and email contact between the QA Program Manager who oversees this process, and the Boston Regional ACF representative.

Current Services Supporting the CFSP Goals

Family Stabilization Program (FSP): The Family Stabilization Program was a preventative service designed to provide assistance to parents of children who are at risk for experiencing abuse or neglect. As a preventative measure to counteract this serious health and safety risk, the Family Stabilization Program was considered as an early intervention strategy to identify families in Maine who were either currently involved with or at risk of becoming involved with the child welfare system, due to abuse or neglect concerns. The program was partially implemented through an increase in funding for the Alternative Response and Supported Visitation services. OCFS determined that increased funding with Maine Children's Trust could positively impact more families than the proposed warm line. OCFS recognized that there were Warm Line services available within the state that could meet the needs that had been outlined within the request. There was also an increased need identified for consistent state wide prevention services so the funds that had been allocated for the Warm Line were reallocated to the MCT.

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.

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 three days of removal. In addition, FFTMs are convened in cases where a placement change is being recommended but is against the wishes of the current caregiver. Initially each district identified two staff lines (primary and backup) with their roles in the office being solely the facilitators of these FTMs, however due to the significant challenges Maine has faced with staff vacancies and recruitment most districts have discontinued the practice of having two staff lines and, in some instances, districts have had to utilize the FFTM staff to carry cases due to operational need.

Maine Children's Trust (MCT): 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 round 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.

Community Partnership for Protecting Children: Please refer back to page 3 for description.

Signs of Safety (SOS): A key strategy for implementation of Signs of Safety has been the ongoing access to Dr. Andrew Turnell and/or Connected Families, Dr. Turnell's designee to work with Maine. In December 2013, the OCFS ended the contract with Connected Families who to that point had been the training partner to Maine. 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 FTM's and FFTM's.
- 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.

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.

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, has occurred to plan for orientation for fathers, support groups, outreach to OCFS staff and other educational options. In March of 2014, Maine sent a team to the annual conference in Rhode Island to continue to support and spread this work throughout the state. The team agreed on the importance of spreading this work and will begin having quarterly meetings to begin the work of implementing fatherhood groups across the state. Over the past several months the fatherhood work has been slowed down due in large part the contract that was help by a community provider had not been renewed. The OCFS has begun

discussions with our partners at Casey to support Maine in developing more internal capacity to coordinate the fatherhood work. A district Assistant Program Administrator attended the New England Fatherhood Conference in March 2015 to begin this internal capacity building.

"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.

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.

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.

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 (MCED): The MCEDV provides support for domestic violence advocates (DV-CPS Advocates). These DV-CPS advocates are placed in a 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.

In the past year the work has continued with Commissioners visiting three of the tribal communities to hear the testimony from those impacted by decisions made by state child welfare. The Commissioners will release their final report with recommendations in June 2015.

Three workgroups have continued to meet to address various elements that could be foreseen at this stage in terms of communication needs and strategies, developing strategies for obtaining additional funding resources and for archiving the work of the TRC process/work and outcomes.

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 on dual initiatives 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 parents1 timely access to services and to make services more accessible.

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 new 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 is ready to implement its demonstration project as an opportunity to improve services available to the children and families of Maine.

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 choose the *Putting the Pieces Together Curriculum* and we have contracted with the Butler Institute, CO to provide train the trainer training, which began rolling out to all child welfare supervisor staff in March of 2015.

OCFS staff, led by the Policy & Training Program Manager worked with Butler Institute to revise and deliver the curriculum *Putting the Pieces Together*. 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.

We are still in the process of developing a plan to grow and sustain our Supervisory Academy.

Evaluation

Moving Forward

OCFS contracted with Hornby Zeller Associates to serve as the lead agency and Evaluator for this *Initiative.* Over the past five years, Moving Forward has seen notable successes:

- The Moving Forward Initiative in Maine expanded from three partner agencies serving young adults as part of this learning collaborative to five partner agencies. Additionally, other agencies located in other parts of the state have been trained in the TIP Model by Maine's Certified TIP Trainer.
- The Moving Forward Initiative hired peer mentors to support young adults receiving services through this *Initiative* as well as to provide life skills classes for youth based on their interests.
- The *Moving Forward Initiative* completed TIP Fidelity Reviews with partner agencies and based on feedback, began providing booster TIP trainings at monthly Learning Collaborative meetings.
- The *Moving Forward Initiative* continues to work with other state agencies, such as Department of Education, Department of Adult Services, and Department of Labor, focusing on improved transition services to youth involved in systems.
- Young Adults have told us they have benefited from these services and supports such as improving their own personal well-being, returning to and completing school, finding employment, obtaining housing and making connections.
- Young adults have been and continue to be actively involved in this Initiative at all levels.

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 for FY 2015 contract period, it should however be noted that OCFS is currently in the process of identifying priority services which promote retention of well-trained and supported resource parents. In that process, OCFS is reviewing training and supportive services currently provided to both kinship and non-relative families, as well as determining how to better align OCFS and contracted agency-delivered services. This process will result in identifying specific service delivery areas which may best be delivered to resource parents by each entity, depending upon factors identified during this review process. This process of review may result in a need to amend the Resource Family Support Services contract during the FY15 contract year.

Performance Standards/Goals

Performance Goal A: All new resource families will have access to a trained mentor statewide.

Performance Measure A: 100% of applicant or newly licensed resource families statewide will have access to a trained mentor.

Performance Strategies A: The Provider will develop a pool of trained mentors that will be available to new resource families as requested.

Data Collection A: The Department will survey district resource supervisors quarterly to determine access and availability of trained mentors upon request of newly licensed or applicant resource families.

Performance Goal B: All resource families will have access to a support group statewide.

Performance Measure B: 100% of all resource families will have access to support groups statewide.

Performance Strategies B: The Provider will ensure there is a support group available that meets the

needs of the resource families in each county.
Data Collection B: The Provider will provide a list of all support groups that exist statewide. The Department will survey quarterly resource unit supervisors to determine whether the resource family's needs are being met in this area.

Performance Goal C: The Provider and district offices will have a productive and collaborative relationship.

Performance Measure C: 100% of District PA's will report satisfactory collaboration with the provider.
Performance Strategies C: The Provider will meet quarterly with each district and respond to specific issues in a timely manner.
Data Collection C: The Department will survey District PA's quarterly to assess satisfaction level with provider.

Performance Goal D: The array of resource assistance offered by the Provider to support Resource Families increases the Resource Families' ability to meet child's needs from time of placement through permanency.

Performance Measure D: 65% of respondents of surveyed Resource Families and Kinship Families will report an increase in their awareness of supports and services offered by this Provider- outlined in Rider A. Resource Families surveyed are Adoptive, Foster, Kinship (licensed and non-licensed), and Permanency Guardians that participated in the Session 5 component of the fundamentals training, Kinship Issues training, or are families that were identified by the Department for this Provider to support
Performance Strategies D: The Provider will receive names and contact information from the Department of newly identified Resource Families and Kinship Families at least quarterly. Provider will respond to individuals requesting support and services and support within 24 hours. The Provider will deliver supports and services outlined in Rider A which increases the resource families' understanding of active supports available to Resource and Kinship Families.
Data collection D: The Provider will develop an annual survey methodology to measure impact of provider's delivery of supports and services outlined in Rider A.

Performance Goal E: Training of Session 5 Component of the Resource Family Introductory training provided to Resource Families and Kinship Families increases families' ability to meet child's needs by increasing the families' developmental responses to grief and trauma, allegation prevention, and ways to support positive behaviors.

Performance Measure E: 90% of Resource Family Introductory Training participants in Session 5 will report an increased understanding of all 5 objectives (changes that can occur within the personal ecosystem when a child is placed in the home, developmental responses to grief and trauma, allegation prevention strategies, acceptable vs non-acceptable discipline techniques according to Department policies, and the use of resiliency techniques when supporting a child's behavior.). The families measured are those who during the contract year participated in the Resource Family Introductory Training and the provider agency delivered the session 5 component.

Performance Strategies E: The Provider will deliver session 5 component of the Resource Introductory Training to Resource Family applicants which increase the resource families understanding of a child's developmental responses to grief and trauma, allegation prevention, and ways to support positive behaviors.

Data Collection E: The Provider will conduct a pre-test/post-test with training participants to measure the increase of understanding.

Performance Goal F: Training of Kinship Issues in Foster Care and Adoption provided to Kinship Resource Families increases family's ability to meet child's needs by increasing the families' understanding of the joys and stresses of being a kinship caregiver, issues pertaining to reunification and permanency, navigating child welfare systems and identifying resources within those systems, and the differences of being a licensed kinship home vs. being a non-licensed kinship home.

Performance Measure F: 90% of Kinship Issues in Foster Care and Adoption training participants will report an increased understanding of all 5 objectives (the joys and stresses of being a kinship caregiver, issues pertaining to permanency, navigating child welfare systems and identifying resources within those systems, differences of being a licensed kinship home vs. being a non-licensed kinship home, and the importance of family share meetings to support reunification). The families measured are those who during the contract year participated in the Kinship Issues in Foster Care and Adoption Training and the provider agency delivered training.

Performance Strategies F: The Provider will deliver Kinship Issues in Foster Care and Adoption training to Resource Family applicants which increases the resource families understanding of the joys and stresses of being a kinship caregiver, issues pertaining to reunification and permanency, navigating child welfare systems and identifying resources within those systems, and the differences of being a licensed kinship home vs. being a non-licensed kinship home.

Data Collection F: The Provider will conduct a pre-test/post-test with training participants to measure the increase of understanding.

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.

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 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 serve 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.

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.

The Child Protection Assessment Policy is currently undergoing revisions to incorporate current practice, 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.

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, day 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 we utilize the OCFS Mental Health Program Coordinators and Clinical Caseworkers 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 will be 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.

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 following performance measure:

   Over the course of the quarter, 90% of families will have a reduction in the number of interventions necessary, or no interventions, to address unsafe behaviors during visits.

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:

   Over the course of the quarter, 80% of families will exhibit positive parent-child interactions during scheduled visits as measured by the Quality of Visitation Scale.

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.

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

Supporting 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 OCFS 2015 realignment included the creation of a clear Children's Behavioral Health Team, separate and district from its former placement within what was formerly the Intervention and Coordination of Care Team (now Child Welfare Services). The Children's Behavioral Health Services Director will be assisting with policy development, provider engagement, and improvement of all behavioral health services. The Director will be working closely with the resource coordinators to amend our 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 our services as well as to establish measureable performance outcomes.

There are ten Behavior Health Program Coordinators and three Clinical Social workers housed across the state in District Offices, Juvenile Corrections offices and the two Juvenile Corrections Facilities. The Behavioral Health Coordinators provide consultation and collaboration activities with community providers, families, child protective colleagues, Psychiatric Hospitals, etc. on treatment services, behavioral health resources, youth transition, and evidenced-based treatment modalities. Over the past year they provided Trauma-Informed Training to child protective colleagues; became part of adoption units across Districts; and attended Permanency Review meetings an Adoption meetings regularly. The Clinical Social workers primarily focus on youth who are detained in the Juvenile Corrections Facilities doing crisis intervention work and ensuring that the behavioral health needs of these youth are addressed in the most effective and least restrictive manner.

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. This work could be supported by districts receiving a quarterly report of youth on antipsychotic medications as queried through Macwis and MaineCare, however running this data query has been problematic and the barriers will need to be assessed to determine the best way to collect and disseminate the information in a useful way for districts to utilize.

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.

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 72 hours 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 would be developmental screening 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 has taken a strong effort to prioritize placements of infants and toddler with relatives that supports 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 age 0-5 has decreased- 2012 (950); 2013 (848); and 2014 (763).

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 caseworkers participate on.

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
Linda Brissette	OCFS, Resource Family Program Manager
Kristi Poole	OCFS Title IVE & Adoption Program Manager
Marie Kelly	OCFS Regional Child Welfare Manager
Karen Dostaler	Assistant Attorney General
Lori Geiger	OCFS, Information Systems Program Manager

The workgroup has been tasked with researching current practice, policy and law to identify areas that need to be changed or enhanced due to this new piece of 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 2014 was 36.

During 2014, 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 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. OCFS has continued 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 REACH 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 her several of our policies, training tools, manuals and links to IV-E information. OCFS will continue to work collaboratively with the tribes on many issues/initiatives. It is recognized that OCFS needs to update its agreements with each of the tribes; however due to staff commitments and some changes in tribal staffing, this has not yet occurred. OCFS does share drafts and final reports related to the APSR and CFSP to the tribal community through the Child Welfare Steering Committee which includes a representative from the Wabanaki Coalition. In the last year that representative retired and there hasn't been a new representative identified who can participate in that group.

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 will be updated to include the new federal guidelines.

Tribal Representation	
Tribal Affiliation	**Contact Name**
Houlton Band of Maliseet	Laurie 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
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, 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 responding to the need to meet the federal goal of seeing children every month by developing the following strategies:

- Each district supervisor with case carrying workers will review the face-to-face contact report by the 15th of each month to identify those children that have not been seen in that month and develop a plan with the caseworkers for those children to be seen before the month's end. Each supervisor shall then send an e-mail to the Program Administrator to communicate how they have planned for the children to be seen.
- Supervisors shall engage in a preparatory supervision meeting with each caseworker each month to develop a plan for a face-to-face monthly contact, including the areas to assess and questions to use in that assessment. Supervisors will document this preparation in supervision notes.
- In terms of measuring the progress made, the frequency of the visit will be measured through the monthly management report. Quality will be measured by ongoing case reviews and at quarterly intervals; QA has the capacity to conduct reviews of face-to-face contacts with children on a large sample size of the most recent contacts if requested by management.

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 is evident through the increase in contacts made in the home which is at 90% (March 2015 OCFS Management Report). 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.

Adoption Incentive Payments

Maine has not received adoption incentive funds since 2010.

Targeted Plans within the CFSP

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

CAPTA Plan- See Appendix C

Foster and Adoptive Parent Diligent Recruitment Plan

The Department recognizes a need for diligent recruitment and several years ago began steps to identify how to meet this need. Efforts began to translate our recruitment and training materials to meet the cultural and linguistic characteristics of our diversified population. This is an ongoing goal, as we have assumed internal responsibility for recruitment and training needs. When we began diligent recruitment efforts in Maine, we were actively partnering with contracted providers who assumed much of the day to day implementation work.

With Department staff assuming these roles, staff encountered the demands of competing priorities involved in licensing of unlicensed kinship caregivers and non-kinship applicants who responded to general recruitment efforts. The Department recognizes that our earlier focus upon diligent recruitment has been reduced at a time the need for diligent recruitment has increased.

As a result of this identified need for diligent recruitment, the Department has issued a Request for Proposals for a recruitment service provider. OCFS will be contracting with a provider agency, and recruitment services are expected to be implemented during the summer of 2015. The addition of this significant OCFS service will allow for partnering between the provider agency and OCFS in diligent recruitment of families to serve children in need of this service. 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.

OCFS Foster & Adoptive Recruitment Plan:

1. A description of the characteristics of children for whom foster and adoptive homes needed:
    - We are 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.
- We will collaborate with our contracted Recruitment agency provider in also meeting with media partners to develop television, radio and print material for distribution.
- We understand the need to recruit diverse populations, including religious, GLBTA, racial, ethnic and cultural groups. We will assure that staff are culturally competent and that translation services are available.
- We need 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.
- We 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, drug-affected infants 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. 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 protocol.

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.

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.

Maine's *Rules Providing for the Licensing of Family Foster Homes* and *Rules Providing for the Licensing of Specialized Children's Foster Homes* requires the following from foster parents:

- Foster children receive preventative and ongoing medical, dental and psychological care in accordance with the directions from the physician and the Department;
- Foster parents shall request a medical history of child at the time of placement;
- Foster parents shall maintain a health record for each foster child, including medical history, examinations, medical and dental treatments, prescribed drugs and immunization records with the record accompanying the child if he/she moves from the home;

- No prescription medication will be administered to a foster child without an order from a licensed physician. Foster parents administering psychotropic medications must have received instructions regarding the administering and possible side effects in writing from either the prescribing physician or the pharmacist. Prescription medication must be kept in the original container labeled with the child's name, date, instructions, and physician's name.

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 72 hours 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 will be 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 insure 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.

Maine utilized a multi-systematic workgroup to identify a process to provide oversight and protocols to monitor the appropriate use of psychotropic medications for children and youth in the foster care system. The choice of the protocol and consent guidelines were based on the T-MAY (Treatment of Maladaptive Aggression in Youth) The Rutgers CERTs Pocket Reference Guide for Primary Care Clinicians and Mental Health Specialists Copyright© 2010 Center for Education and Research on Mental Health Therapeutics (CERTs), Rutgers University, The REACH Institute (Resource for Advancing Children's Health), The University of Texas Pharmacy, New York State Office of Mental Health and California Department of Mental Health.

Child welfare workforce and providers are trained on the appropriate use of psychotropic medications through this formalized protocol/consent worksheet that addresses a process that is comprehensive and coordinated for assessment, and treatment planning to identify children's mental health and trauma-treatment needs.

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.

Collaboration with partners in Children's Behavioral Health (CBH) ensures availability of mental health expertise and consultation regarding consent and monitoring issues by a board-certified child psychiatrist. In the spring of 2012, monthly consults between OCFS Medical Director, CBHS, and child welfare staff were implemented. These consults allow districts staff to review difficult cases involving psychotropic medications with children's behavioral staff and to ensure that the psychiatric needs for children in foster care are being appropriately managed. The Clinical Care Specialists had been working with the OCFS Medical Director to discuss the details of providing clinical consultation on an individualized level throughout our districts. Clinical Care Specialists attended a PA/APA meeting to discuss these details and to obtain feedback regarding needs.

A report of foster children on these medications has been developed and is provided quarterly by MaineCare. The report is distributed to the OCFS Caseworkers of the children so that ongoing oversight can occur.

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 D**

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 $940,000 annually for training costs.

See **Appendix E** 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

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 16,551,459. 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.	• Caseworker training through MECASA, *about 70 staff at this point have been trained.*	• 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	Screening tool and needs assessment being completed by Hornby Zeller. Will have screening tool by May?
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	Will work with LE at both the state and county level. Should think about who to involve in the workgroup from this discipline.
Report Annually to HHS total number of CSEC victims		• Way to capture this number	• DHHS	9/2017	
471 (a)(35) **Develop and implement protocols to:** locate missing foster Children, **determine what factors lead to the child's absence and address this**		• Develop Protocols • Screening tool • Way to document factors leading to the runaway	• DHHS • MECASA	9/2015	Further discussion on this topic needs to happen. Research in regards to common reasons leading to runaway.. ways to asses and

in future placements, determine if child was a CSEC victim during absence from care					capture this is needed.
Report this information to HHS		• Way to capture this number	• Macwis staff through AFCARS	9/2015	Macwis staff will develop a sub group to work on this. First workgroup to meet on 3/24
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	Have responded to Christie Morin's request to states to start discussions with them a the NCMEC

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 section 475(10)4 4 "** Caregiver is a foster parent or designated official at a child care institution, **in their standards for foster family**	This language is not in contract, policy or rules**.**	Policy or rules that permit this Designate an official who is in charge of applying the reasonable and prudent parenting standards	Linda Brissette Stephanie Barrett to join us next workgroup to speak about the residential programs	9/2015	**Linda states that there are rule changes and standards of Foster care that could be changed to address this, as well as contract changes that could include this information.** **Discuss with Steph steps to implement this in the residential**

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.		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			**settings.** Linda states that there are rule changes and standards of Foster care that could be changed to address this, as well as contract changes that could include this information Speak to Stephanie Barrett about this for residential, and Linda states that this could be incorporated into the foster parent training that already exists.

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				**9/2015**	

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 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	Used for youth as young as 12.	Youth transition policy and permanency policy changed to 14	Marie, Policy and Training unit (Dulcey)		Marie is looking at the APPLA permanency plans that have been in place for youth under 16. She will report back as this affects 25 or so children and then we can plan as to how to decrease the use of this moving forward. Again this can be addressed through the child case plan, the permanency section. Training may need to happen around this area of practice. Speaking with Karen Dostaler on 3/27 and we will discuss how to make this happen in the court system.

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). •**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:** 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	Legal summary and child case plan addresses this. Youth transition policy addresses this for youth 16 and older, now changed to 14				

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 (formerly age 16) (section 475(I) of the Act).	Currently the child assessment and plan policy require this for aged 12 and older youth Youth transition policy addresses this				

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.*	**Currently the age is 16. Youth transition policy addresses this.**	**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 individual who is considered by state law to be a sibling or who would be considered a	This is addressed in the Permanency Policy	Added relatives.	Kristi Poole, Gina, SMT, social workers	Immediately	**Policy changed to reflect this addition. Awaiting approval. Email has already been sent to staff with the added list of relatives that they should be contacting.** **Need sibling definition in policy**

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.					

Adoption and Guardianship Incentive Program- applies to state title IV-E agencies only

Section		**Needs to be in place**	**Key Informants**	**Time frame**	**Updates and next steps**
Renames the program "Adoption and Legal Guardianship Incentive Payments." •Reauthorizes at the current authorization level of $43 million for each fiscal year through 2016. •Creates new incentive categories that replace the old categories. Each fiscal year, a state is eligible for incentive funds in the following categories and award levels: **$**5,000 for improving the rate of foster child adoptions. $10,000 for improving the rate of older child adoptions and older foster child guardianships(age 14 and older) $7,500 for improving the rate of pre-adolescent adoptions and pre-adolescent foster child guardianships (ages 9-13**).** **$**4,000 for improving the	**Change the name of our program to reflect this change?**	Ways to measure if we meet the criterion to receive the incentive. Ways to communicate with staff the importance of meeting these guidelines so we can receive the incentive.	Bob Blanchard or designee	Fiscal year 2013-2015	*Meet with Bob to assess plans measurement

rate of foster child guardianships**.** •The base rate is the average rate for the immediately preceding 3 fiscal years or the rate for the prior fiscal year. For fiscal year 2014, states receive an amount equal to half the sum of the total award currently in effect and the total award under the new categories. Also provides a pro rata adjustment if insufficient funds are available. •Creates an incentive for timely adoptions finalized during any fiscal years 2013-2015 if the other incentive awards are less than the appropriation. A state may be eligible to receive an award for a fiscal year if the average number of months from removal to placement in a finalized adoption is less than 24 months**.** •Allows states to spend the incentives over a 36 month period instead of a 24 month period. •**The guardianship incentive is available for a child who leaves foster care to live with a legal guardian if either:** **O** The child was removed from the home pursuant to a voluntary placement agreement or judicial determination that continuation in the home is					

contrary to the welfare of the child, return to the home is not an appropriate option, the child demonstrates a strong attachment to the legal guardian, the legal guardian has a strong commitment to caring permanently for the child, and if over 14 years of age, the child is consulted regarding the legal guardianship arrangement; or Alternative procedure used by the state to determine that the legal guardianship is an appropriate option for the child.					

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**	**Look at the policy, address language changes.** **Send to SMT.**

Title IV-E Adoption Assistance Program savings reporting

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Modifies section 473(a)(8) of the Act to require title IV-E agencies to **calculate and report annually** the savings from the agency de-linking title IV-E adoption assistance eligibility from the Aid to Families with Dependent Children (AFDC) eligibility requirements, the methodology used to calculate the savings, how savings are spent, and on what services**.** Title IV-E agencies must use a methodology specified by the Secretary or may propose an alternative for the Secretary's approval. Title IV-E agencies must spend the savings on title IV-B and IV-E programs; 30% of which must be spent on post-adoption services, post-guardianship			Bob Blanchard	10/2014	

services and services to support positive permanent outcomes for children at risk of entering foster care. Two-thirds of the 30% must be spent on post-adoption and post-guardianship services. Title IV-E agencies must use the savings to supplement and not supplant any Federal or non-Federal funds used to provide any service under title IV-B or IV-E.					

New Chafee Foster Care Independence Program (CFCIP) purpose and increased appropriations beginning in 2020

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Increases the appropriation by $3m to $143,000,000 beginning in FY 2020 (section 477(h)(1) of the Act). Amends the purposes of the CFCIP at section 477(a)(8) of the Act to ensure that children who are likely to remain in foster care until age 18 have on-going opportunities to engage in "age or				9/2015	

developmentally-appropriate" activities.					

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 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 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					

Reports to Congress

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
HHS must report to Congress on children who run away from foster care and their risk of being sex trafficking victims, their characteristics, factors associated with running away, experiences while absent from care, and trends, among other things (section				**September 29, 2016**	

105 of P. L. 113-183). HHS must report to Congress on agencies implementation of and best practices for the case planning amendments in 475A (b), 475(1)(B), (D), and (5)(C) of the Act (section 113(e) of P. L.					

National Advisory Committee on the Sex Trafficking of Children and Youth in the United States

Section	Currently in place	Needs to be in place	Key Informants	Time frame	Updates and next steps
Within 2 years of enactment, HHS must establish and appoint a National Advisory Committee on the Sex Trafficking of Children and Youth in the United States to, among other things advise on practical and general policies on improving the national response to sex trafficking and develop best practices.				**2016**	

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 in foster care and youth formerly in care are consulted regularly throughout the year regarding the services and supports they receive through the Chafee Foster Care Independence Program. Their feedback of program strengths and needs are integrated into this State Plan as well as used to shape Maine's laws and policies to support these older youth.

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 2015.

Section II summarizes the administration of the Education and Training Voucher fund program for the academic school year 2014-2015.

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 15 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 is residing 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. The Program Administrator shall review the youth's request and make a final approval decision.
- Youth who have a signed V9 Agreement, and who, while in foster care would have been eligible for adoption assistance or permanency guardianship assistance prior to age 18, and are subsequently adopted through Probate Court between 18 and 21 may continue to receive V9 services with OCFS

approval. The youth must also continue to meet the other educational and employment eligibility criteria.

- Youth in foster care age 18-21 who have a signed V9 Agreement and who has 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 DHHS custody, 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:

- Help youth explore and find their permanency options and connections before exiting foster care.
- Transition plan with youth, beginning with a comprehensive assessment of youth strengths and needs, active participation of young people and their supports in case planning, and offering services/supports that that meets their individualized needs.
- Create a normalized growing up experience for youth in care that is comparable to 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 Maine's Chafee Independent Living Program is to ensure that all youth in care are prepared for a successful transition to adulthood. We do this by: assisting youth to have legally permanent family and lifelong 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 Youth Transition Workers, OCFS caseworkers, a contract with the University of Southern Maine's Muskie School, a contract with Jobs for Maine Graduates, therapeutic and non-therapeutic foster home parents, group home staff, transitional living programs, adult developmental services, and other contracted providers. These services are funded by a combination of federal and state funds.

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 resources.

Youth transition workers continued to carry cases and partner with caseworkers to carry out essential transition services with youth such as completing a comprehensive strengths/needs assessment with all youth in care at age 15 (Youth Transition Tool).

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.

Various OCFS Program Specialists and casework staff met with various contracted agency providers (therapeutic foster care and residential care). Planning continues regarding overall strategies to meet the transition needs of youth placed within various agencies. 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 Office of Child and Family Services and the Office of Aging and Disability Services (OADS) continued to meet to improve the transition process. We developed a statewide approach for convening early planning meetings for all youth served by OCFS and we continue to refine the Transition Protocol. This Protocol allows a youth who is eligible for adult services to remain on a V9 Agreement with OCFS to pay room and board costs, and for OADS to provide case management services until the youth can enter the Section 21 Adult Waiver Program.

Over the past year, Office of MaineCare Services implemented the Affordable Care Act Provision that allows youth who age out of foster care to remain eligible for coverage until the age of 26, effective 1/1/14. OCFS worked with USM Muskie 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 in FFY 2015.

ELIGIBLE POPULATION (FFY2015):

Number of youth in care **aged 15-21 on Oct. 1, 2014**:

AGES	FEMALE	MALE	TOTAL
Age 15	32	36	**68**
Age 16	37	33	**70**
Age 17	32	46	**78**
Age 18	23	24	**47**
Age 19	18	21	**39**
Age 20	16	9	**25**

TOTAL	158	169	327

Of youth **age 15-21**, the length of time these youth had been in care on **October 1, 2014:**

Length of time	# of youth	% of total
Less than 6 months	45	14%
6 months to 1 year	21	6%
1 to 2 years	48	15%
2 to 3 years	48	15%
3 to 4 years	29	9%
4 to 5 years	29	9%
5 to 6 years	18	6%
6 to 7 years	17	5%
7 to 8 years	9	3%
8 to 9 years	14	4%
9 to 10 years	7	2%
10 to 11 years	8	2%
11 to 12 years	10	3%
12 to 13 years	7	2%
13 to 14 years	2	1%
14 to 15 years	4	1%
15 to 16 years	4	1%
16 to 17 years	5	2%
17 to 18 years	1	0%
18 to 19 years	1	0%
TOTAL	**327**	**100%**

Estimated Eligible Population for 2015 (as of 2/1/15- youth currently in care):

AGES	FEMALE	MALE	TOTAL
14yo	35	28	63
15yo	30	38	68
16yo	33	34	67
17yo	36	40	76
18yo	17	30	47
19yo	14	15	29
20yo	15	14	29
TOTAL	**180**	**199**	**379**

As of 2/1/15, the number of youth placed in residential placements was 60 youth (16 % of the total 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. Young people in foster care aged 14 and

older, youth formerly in foster care, and adult partners from across the state contribute to this effort in various ways.
YLAT groups met monthly in six sites in Maine, from January 2014-May 2014 and September 2014-December 2014. Monthly meetings were held in Bangor, Rockland, Skowhegan, Augusta, Lewiston and Saco. Six meetings were held in Aroostook from January 2014 to December 2014 with 130 youth and 54 adult partners participating.

In 2014, 25 YLAT members presented 14 panel presentations and trainings to Guardians ad Litem, CASA volunteers, foster and adoptive parents, caseworkers, legislators, policy makers, agency staff, youth in care and employers.

Nine (9) Community Conversations were held across the state. In spring 2014, a panel of youth currently in care or extended care, alumni from foster care, adopted youth, and foster and adoptive parents spoke about their experiences in creating permanent family connections for older youth in care. In fall 2014, 2 events were held to discuss how being in foster care impacts a young person's experience of "normalcy," (the everyday opportunities and challenges of a typical teenager), and included a panel of current YLAT members, typically ages 14-18. Six more events focused on "normalcy" are scheduled for spring 2015.

In February 2014, 5 YLAT members provided testimony to the Maine Legislature's Joint Standing Committee on Health and Human Services (HHS) in support of LD 1683: **"An Act to Improve Degree and Career Attainment for Former Foster Children."**

YLAT members also served on the Maine Youth Transition Collaborative (MYTC) Advisory Committee and the New England Youth Coalition.

The 24th Annual Teen Conference for Maine's Youth in Care, was held on June 26th, 2014, at the University of Maine. Over 120 youth and adult partners came together with a theme of "Dream Big, Start Today!" A former youth in care from Maine was the keynote speaker, providing a presentation on adolescent brain development and how it affects young people transitioning out of foster care. Youth attended workshops in the morning on topics including leadership and strategic sharing, and took part in an experiential financial literacy fair in the afternoon.

Consultation and Collaboration:
The Office of Child and Family Services has a strong commitment to collaboration with youth, parents, community service providers, and various community stakeholders. We believe this ensures a coordinated approach to serving the needs of older youth in care by encouraging public and private partnerships to maximize limited resources.

Maine is involved in a number of collaborative efforts at the state and local levels and intends to continue these collaborations in the future. Some examples include:

Maine Tribes and Bands: In FFY 2015, 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 overall goal of MYTC is establishing lasting partnerships with public and private organizations and the business community focusing on Youth Leadership, Community Engagement, and Opportunity Passport. As part of the MYTC, over the past couple of years, The York County Collaborative has expanded geographically into Cumberland County and is now called the *Southern Maine Youth Transition Network*. 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.

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. A big focus of this group in 2015 is to complete a comprehensive needs assessment and count of homeless youth in Maine.

New England Youth Collaborative: Youth in care, youth formerly in care, and adult supporters (staff) from all New England states first met in January 2008. This Collaborative aims to improve outcomes for older youth in care by looking at ways New England States can collaborate and learn from each other in order to implement innovative and best 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. In 2014, the NEYC was focused on promoting normalcy for youth in care, as well as post-secondary education.

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 FTM's are to take place that include youth and their supports.

Maine continues to support permanency for older youth through legislation that allows for the *reinstatement of parental rights* for a parent when termination of parental rights was made at least 12 months prior. This allows youth in foster care to legally reunite with their parents who may over time have resolved the issues that caused the child to be unsafe.

OCFS continued to seek feedback from young people in care regarding the Youth Transition Policy and will continue in the upcoming year to look for ways to better support youth to be involved in their own case planning and court hearings.

DHHS continued to provide financial and in-kind support to *Camp to Belong Maine* (CTBM). Every summer since 2004, CTBM has allowed children and youth from across the state 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.

Post-Secondary--OCFS 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 workers and caseworkers continue to meet monthly with youth on V9 Agreements, and as part of their on-going support are connecting youth to the available supports, services, and community opportunities 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. MYTC is a recipient of an Aspen grant to further this work and is developing a comprehensive strategic plan focusing on the *Back on Track* model. The MYTC provides a navigator to help students and disengaged youth to bridge between high school and college by providing direct support to youth to ensure they are better able to succeed when being connected to relevant resources and supports.

In 2014, Maine passed legislation that will provide funding and navigator support to youth who age out of its 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.

Maine also continues to support a Tuition Waiver program for 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. 30 tuition waivers are available to freshman students per academic year to attend one of the state university system schools or one of the state community colleges. 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 the upcoming year, OCFS is looking to provide training and support to youth to help them feel better prepared to participate in their case planning, family team meetings, and court hearings.

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 3 years, with increasing numbers of youth participating, as well as a pilot in 2014-2015 in Cumberland County.

DHHS 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 2014, JMG provided training to 46 youth, and also included bringing in financial mentors for youth. OCFS intends to continue this contract for 2015.

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* 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. 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.

Goal 5: Increase housing options for older youth in care and youth transitioning from care.
Housing continues to be a challenge in Maine. OCFS continues to utilize state funds to pay for the housing needs of youth with a Voluntary Extended Care (V9) Agreement and staff work with landlords to help youth secure housing.

In 2014, OCFS entered into a pilot with the Maine State Housing Authority and New Beginnings, a local teen shelter, to utilize Family Unification Program (FUP) vouchers in Androscoggin and Franklin Counties to provide housing support to youth who exited foster care and who are homeless.

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 have experienced the child welfare system.

Goal 6: Improve the outcomes for youth placed in congregate and therapeutic foster care.
OCFS remains committed to youth being placed in the least restrictive environment possible to meet their safety needs:

- OCFS continues to work with providers to ensure best practices through contracting and site reviews.
- Maine continued to use the DHHS Intensive Temporary Residential Treatment (ITRT) process to review the appropriateness of youth placements in congregate care.

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 2014, OCFS also began completing the 21-yo Follow-up Surveys. OCFS will continue to look for ways to better 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.

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, aged 16 and older, who were reunified from Maine DHHS.
- Youth, aged 16 and older, who were adopted from Maine DHHS.
- Youth, aged 16 and older, who enter permanency guardianship from Maine DHHS.
- 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 degree.

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 Workers coordinate 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

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;

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

State of Maine Department of Health and Human Services
Office of Child and Family Services
Child Abuse Prevention and Treatment Act 2014-2015 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).

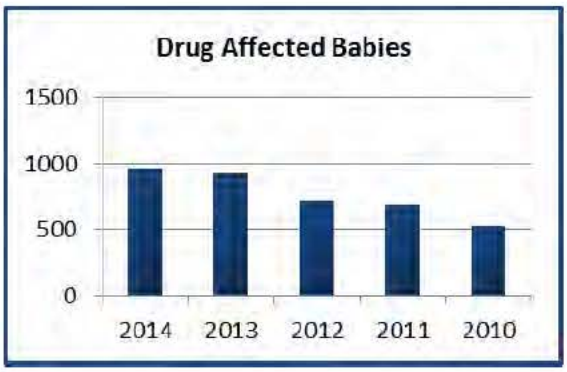
DHHS meets CAPTA Section 106 and CJA Section 107 grant requirements through a range of programs and supports in its agency child welfare work and through ongoing, strengthened, and increased inter-agency, intra-agency, interstate, intrastate, and multidisciplinary team work within our communities, supported by federal, state, and private resources, including parent partners and community members.

There were no substantive changes during 2014 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 2014 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.

These 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.).

During 2014, OCFS received 961 reports of drug affected babies and 927 reports were received in 2013, 720 in 2012, 668 in 2011 and 532 reports for 2010. Of the 961 reports received by OCFS in 2014; 4 were referred to appropriate Tribal Welfare staff, 30 were referred to Home Visitors, 106 were referred to a Contract Agency, 476 were assessed by OCFS child protective services and 328 were referred for Public Health Nursing services.



FINAL DISPOSITION	# REPORTS
Assign to Contract Agency	106
Child Protection Assessment	476
DAB - Completed Assessment	17
DAB - Refer to PHN	328
DAB- Referred to Home Visitors	30
Referred to Tribes	4
TOTAL	**961**

During calendar year 2014, there were 8944 reports assigned for assessment for child protective services involving 15,137 children as alleged victims of child abuse or neglect of those assigned 8913 were completed; 2377 were substantiated or indicated and 6536 were unsubstantiated. In 2014, there were 1908 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, 7987 reports were deemed "inappropriate" (screened out) during calendar year 2014, as they did not contain allegations of child abuse or neglect.

The number of children, under age 18, in State custody at the end of calendar year 2014 was slightly lower than last year. In 2014 the number ended up at 1,857 versus 1,908 for calendar 2013; 1,324 in 2012 and 1,471 in 2011. Although, the number of children in custody in Maine declined slightly from 2013 to 2014, the sharp rise from 2011 and 2012 is still evident.

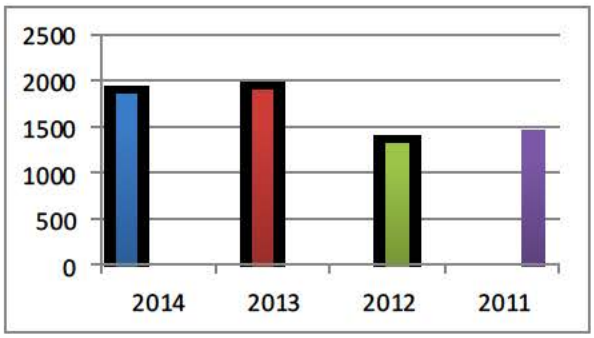


Table to left shows the # of children in custody at the end of each year.

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 2014. Therefore, this data is relative to the number already described in the previous paragraph; which was 1,857 but varied to a lower number by as much as 9% during the year. Maine does not currently track the data on out of court contacts between such individuals and children.

Incidences of previously abused children being victims of maltreatment in the system decreased by as much as 7% in 2014, 6.5% to 6.1%. During 2014, one hundred more children left foster care for permanent homes when compared to 2013.
In 2014, ten child deaths were either indicated or substantiated by DHHS and/or were a result of a homicide and although there was maltreatment involved in each case based on the definition, maltreatment may not have directly caused the death of the child.

Looking ahead, the Office of Child and Family Services is actively pursuing the use of a real-time quality assurance practice that will 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, a 'Rapid Safety Feedback' system. This system 'Eckerd' was first introduced in Florida and the results have been very positive. Eckerd describes the process as a true partnership between the field and QA that shares decisions and responsibility on cases and assessments.

OCFS experienced a more positive year for maintaining stable child protective staffing when compared with 2013 and 2012. The child protective caseworker statewide turnover rate was approximately, 27.01% for 2014, vs. 31.61% for 2013, and 32.47% for 2012 and for supervisors in 2014, it was 6.7% roughly the same. This trend in caseworker turnover is very similar to nationwide statistics. The 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]. 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.

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 2014 was within 72 hours approximately 86% of the time. Maine's goal of completing assessments within 35days 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 2014 on approximately 86% of completed assessments.

OCFS had 314 child protective caseworkers and 62 child protective supervisors conducting the work of intake, screening, assessment, investigation, and permanency work, noted below by geographical district office, at year end 2014.

District	Number of Caseworkers	Number of Supervisors	Number of CPS Assessments	Number Vacant Positions
1	44	9	1287	7
2	50	9	1250	1
3	46	9	1577	1
4	24	4	835	1
5	46	9	1624	3
6	41	9	1277	3
7	21	5	555	0
8	23	5	508	3
9	19	3	--	3
Total	**314**	**62**	**8913**	**22**

** 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 from end of year 2014.*
***Assessments completed are based on calendar year 2014.*

[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

Currently there are 26 child protective service personnel responsible for intake and screening and 144 child protective service personnel responsible for the assessment and investigation of reports. 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.

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 $34,091 to $46,218 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 is 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.

To further the effort for supervisory training and development, Maine OCFS was approved to receive TA from the National Resource Center for Organizational Improvement (NRCOI). The TA provided assistance in developing a plan to have delivered a supervisory training for staff who supervises front line child welfare social workers. The ongoing goal is 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 to the Supervisory Plan is 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.

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.

Maine's Citizen Review Panel

The Citizen Review Panel (CRP) completed their annual report for the period of 2011-2013 and this report was submitted to the Department for response (Attached Responses). In addition to this, the Panel also submitted a report in October 2014, titled *'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. 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. A portion of this plan is currently under legislative review under the title LD213. *(Attachments)*

The CRP will continue to report annually on their work, by summarizing the specific areas of the child welfare system they review, the recommendations resulting from those reviews, and OCFS' response to the Panel's recommendations. This strategy will help maintain a consistent method to meet the requirements of CAPTA, as well as, develop a stronger relationship with the Department.

Membership has been maintained and currently represents a broader spectrum of the community. The current membership is 18 and the majority of these individuals are attending regularly scheduled monthly meetings and all members are attending at least quarterly. Although, two members left during 2014 the Panel managed to recruit new disciplines to enrich their meetings; those that have been added are domestic violence, law enforcement, and public health nursing. The CRP is still actively seeking new members from other areas to support its ongoing work, and though the requirements for CRP membership, under CAPTA Title 1, Section 106, are somewhat broad, the group works conscientiously to follow the membership diversity guidelines provided by the State's Multidisciplinary Task Force under CAPTA Title 1, Section 107.

Maine's CRP held their Annual Retreat on October 7, 2014. The focus of the meeting was a revitalization process; the group reviewed CAPTA and CRP histories. The group also selected the topic of 'child welfare; recruitment and retention' and continues to put together meaningful meetings to that end. The CRP is hopeful to provide recommendations on how to help maintain a stable child welfare and resource family staff; by conducting a survey and putting together a focus group in order to show an evidenced based mechanism was used, which will give teeth to the recommendations that will eventually be put forth to the Department for response. It is also expected that the CRP will deliver a 'Thank You' message to all of Maine's child welfare

staff and may even send out a challenge to other organizations to do the same. The group motioned to post their 'Thanks' in various newsprint, newspapers, and websites, it is proposed to have these gestures of appreciation be coordinated with the national child abuse prevention month in April.

In May of 2014, the CRP Coordinator for Maine attended the National Citizen Review Panel meeting that was held in Atlanta, Georgia, hosted by the Georgia Citizen Review Panels.

Maine's Child Death and Serious Injury Review Panel

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 2014. These reviews were comprised of the following themes and trends; Abusive Head Trauma (AHT), Burns, Ingestions, Unsafe Sleep, and Significant Bruising and Fractures. Eight case reviews is relatively a small number in comparison to the total number of reports received by Child Protective Intake, however, it is important to mention that the Panel does examine each intake report that relates to child fatalities and near fatalities, which for 2014 amounted to more than 200 alleged serious injuries, ingestions and child deaths; these were only referral reports, which may or may not have been indicated or substantiated for abuse and/or neglect.

The Maine CDSIRP completed work on their annual report which consisted of accomplishments, case findings, and case recommendations, for the period of 2010-2013. The Panel looked at the rise of infants exposed to drugs in utero, the dramatic increase in drug ingestions in children, the mandatory reporting and failure to report, unsafe sleep environments, home birth, young adults formerly in protective placements that have harmed others and abusive head trauma (AHT); each of these topics is touched on in the 2010-2013 report included with this update. The group agreed that they will continue to summarize their annual work and then submit a complete report every 2 years, or biennially in order to meet the requirements for CAPTA. *(Attachment)*

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 the New England States are trying to address. Maine is hosting the 2015 Annual meeting to be held in Portland, ME on April 30 and May 1st; the theme of this year's group will be 'Abusive Head Trauma' and 'Mandatory Reporting'. *(Attached Agenda)*

The following is a quote from the previous Co-Chair of the Child Death and Serious Injury Panel:

"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." (Meister M.D., Stephen J.)

CAPTA funding continues to support the work of the Citizen Review Panel (CRP) and the Child Death and Serious Injury Review Panel (CDSIRP).

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.

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. For over 30 years, the Maine Coalition against Sexual Assault (MECASA) has represented and served Maine's sexual violence service providers. MECASA works toward ending sexual violence by providing public policy advocacy, assistance to Maine's sexual violence service providers, public awareness and prevention activities, and statewide training. MECASA's efforts include:

- Initiating and advocating for victim-centered public policy
- Providing support and assistance to Maine's sexual violence service providers and serving as a liaison between the centers and our statewide and national partners
- Reducing common myths and misperceptions about sexual violence through building and sustaining public awareness
- Providing expert training, statistics, and resources about sexual violence to organizations, groups, and individuals throughout the state

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.

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, 2014 and will end June 30, 2015 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.

Along with funding for continued support of Maine's Citizens Review Panels, CAPTA funds will also be utilized to support improved access to evidence-based parenting education programs for the parents in our communities, through the child abuse prevention councils of Maine. CAPTA funds will also be utilized for the development and implementation of a community-based physician education project. Key areas of this work will be mandated reporter training and prevention training, including "Safe Sleep" strategies for infants. CAPTA funds will continue to support mandated reporter education programs using a peer-to-peer training model and a formal program to train the trainers; this will allow individuals the opportunity to offer additional training in each of their respective regions of the State.

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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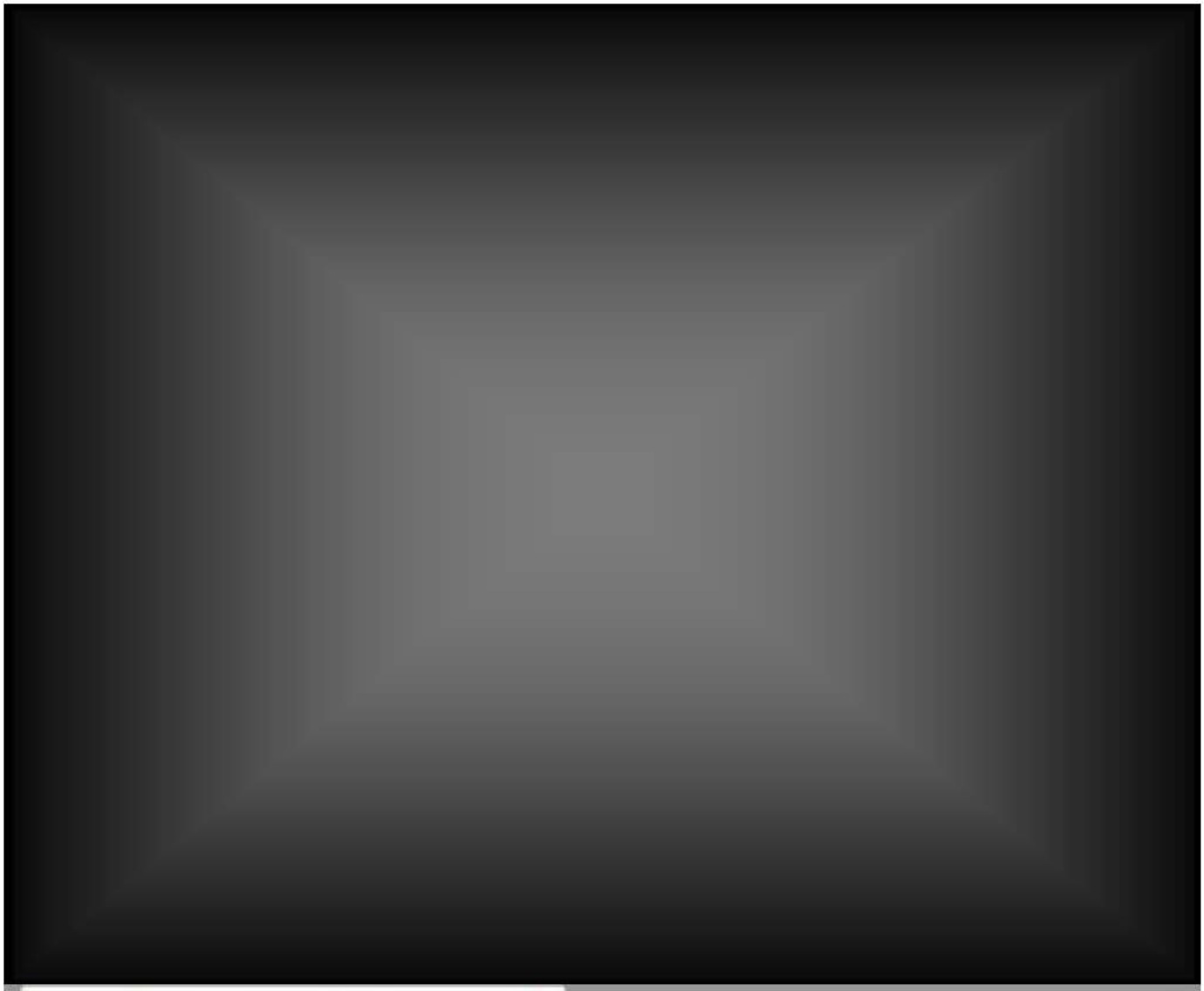

Department of Health and Human Services

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]

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"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)."[2]

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:

[2]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
Kimberly Day, LSW	Child Welfare Coordinator, School of Social Work
Marguerite DeWitt, MD	Office of Chief Medical Examiner
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
Stephen Meister, MD, *CHAIR*	Medical Director, Family Division, Maine CDC
Mark Moran, LCSW	Family Service & Support Team Coordinator, EMMC
Karen Mosher, PhD, *CO CHAIR*	Clinical Director, Kennebec Valley Mental Health
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Lawrence Ricci, MD	Director, Spurwink Child Abuse Program
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Win Turner	Panel Research, UMO, Ad Hoc member
Lt. Gary Wright	Maine State Police, CID II
Margaret Greenwald, MD	Chief Medical Examiner, Medical Examiner's Office
Chief Judge Ann Murray	Chief Judge, Maine District Court
Lyn Carter	Coordinator, Maine Coalition to End Domestic Violence
Elizabeth Neptune	Maine CDC, Office of Minority Health Manager
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

CHILD DEATH AND SERIOUS INJURY REVIEW PANEL MEMBERS 2011

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CHILD DEATH AND SERIOUS INJURY REVIEW PANEL MEMBERS 2012

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Denise Giles	Victim Services Coordinator, Maine DOC
Alan Kelley, Esq., DDA	Office of the District Attorney
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Ann LeBlanc, PhD	Director of State Forensic Service
Virginia Marriner	Director of Child Welfare Policy & Practice, DHHS
Stephen Meister, MD, *CHAIR*	Medical Director, Family Division, Maine CDC
Mark Moran, LCSW	Family Service & Support Team Coordinator, EMMC
Karen Mosher, PhD, *CO CHAIR*	Clinical Director, Kennebec Valley Mental Health
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Margaret Greenwald, MD	Chief Medical Examiner, Medical Examiner's Office
Lyn Carter	Coordinator, Maine Coalition to End Domestic Violence

CHILD DEATH AND SERIOUS INJURY REVIEW PANEL MEMBERS 2013

Luanne Crinion, RN, MSN	Public Health Nursing, DHHS
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Lawrence Ricci, MD,	Co-Director, Spurwink Child Abuse Program
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Stephanie Anderson, Esq.	Office of the District Attorney, Cumberland County
Louise Boisvert	Associate Director Intervention & Coordination of Care
Elizabeth McCullum, Esq.	Court Improvement, Family Division, Judicial
Christopher Gardner	Maine Drug Enforcement Agency, Special Agent
Jeffery Love, Sgt	Maine State Police, Major Crimes Unit North
Christopher Pezzullo, DO	Medical Director, Family Division, Maine CDC
Marie Hayes, Ph.D.	Professor UMO, Pediatrics, Psychiatry, Family, EMMC
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 and presented at each of the past fifteen annualNorthern New England Child Fatality Review Team Meetings.

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.

> *"Intervening effectively in the lives of children and families who are affected by child abuse and neglect is not the sole responsibility of any single agency or professional group, but rather a collective community concern" (17)*

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.

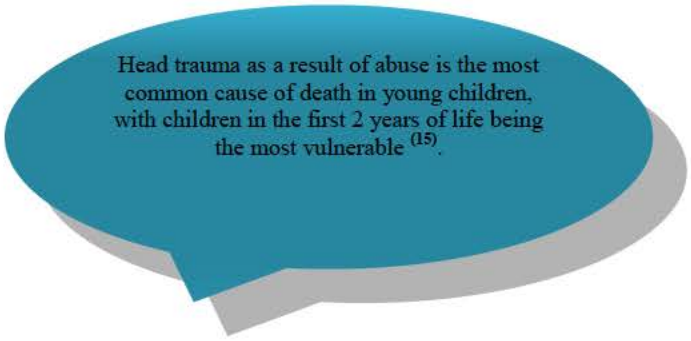
To ensure coordination of efforts in evaluating and developing a response to the challenge of our growing Drug Affected Baby (DAB) problem, we invited Attorney General William Schneider to our Panel meeting in July 2011, representatives from Maine's Office of Substance Abuse (OSA) also took part in this 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).]

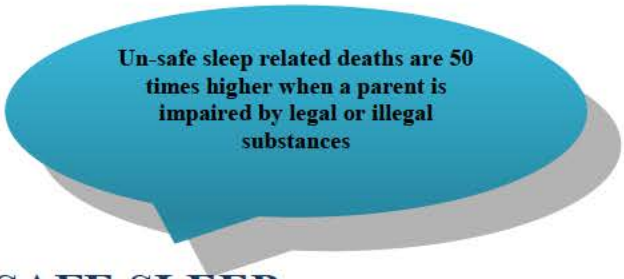
B. Substantial bruising or multiple bruises; [2013, c. 268, §1 (NEW).]

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 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

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

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.

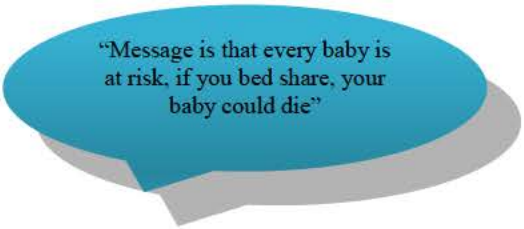
Finding: The Department is required to make decisions quickly. This does not coincide well with the resources of the Medical Examiner's office. In this particular case, the autopsy report had still not been completed even though the Department had already closed the case.

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.

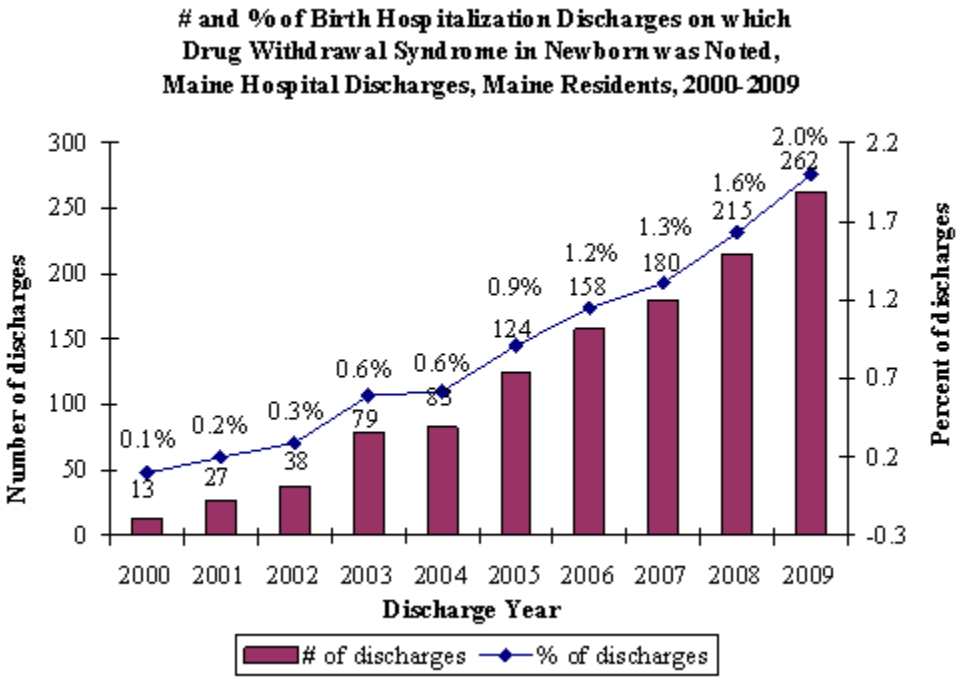
Kelley Bowden, RN discussed her work with hospitals

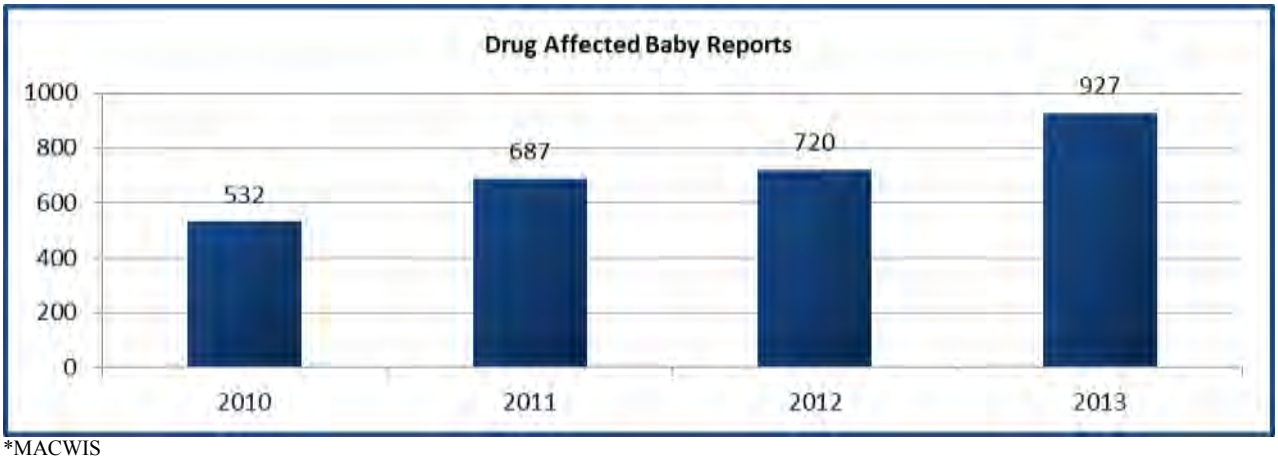
Reducing an infant's exposure to legal or illegal drugs, alcohol and tobacco would likely have a large financial benefit to the state. Not to mention the moral issue of protecting these infants who are more apt to suffer from the long term ill effects of exposure due to their small developing bodies.

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 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 knowledge 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 report 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 reach 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 its 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 report 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 regarding treatment and prosecution of the person responsible for the abuse, neglect or death. The persons making the recommendations shall take into account the nature, extent 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 in 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 standards. 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 photographs. [2001, c. 345, §5 (NEW).]

D. Designated agents of the department may take photographs of any subject matter 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.[3] 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:

[3]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

- 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
- 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:

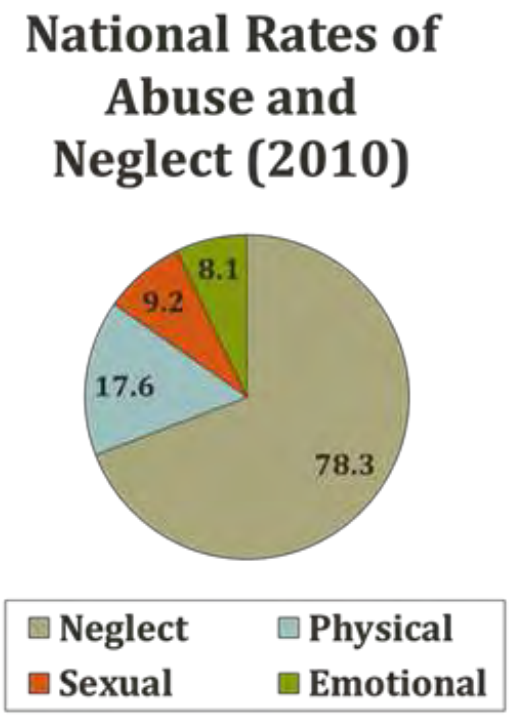
Planning around child safety, regardless of the model used, requires that the model be carefully understood and embraced by Department staff, as well as by the numerous stakeholders who participate in safety planning for children and are called upon to implement the practice. It also requires diligent 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.

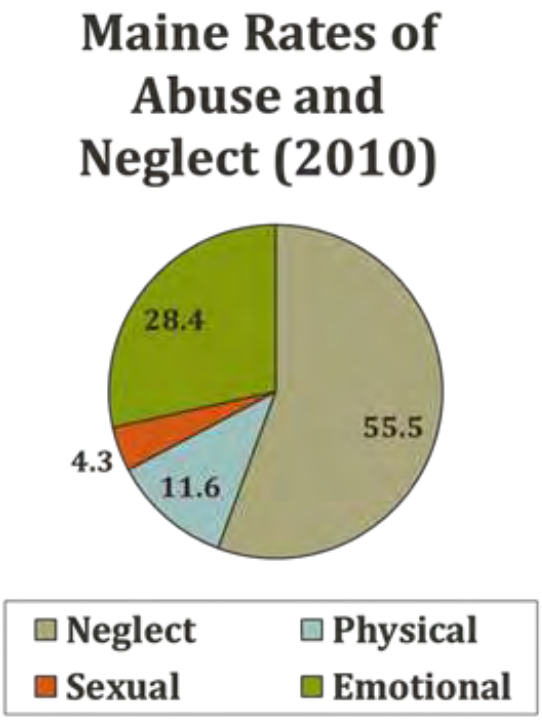
Child Welfare is a huge system with profound responsibilities in life and death matters. Any implementation of change in practice pattern will, by its nature, require careful planning, oversight, and ongoing expert supervision in order for it to be properly implemented and carry a reasonable chance for 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.





Child Welfare Information Gateway (2012). Child Maltreatment 2010: Summary of key findings. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Maine Department of Health and Human Services

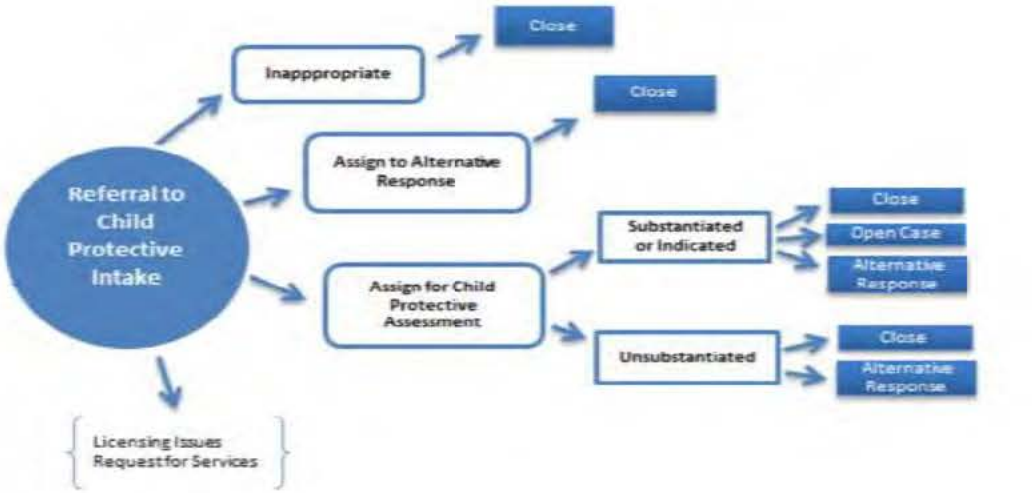
REFERRAL REPORTS

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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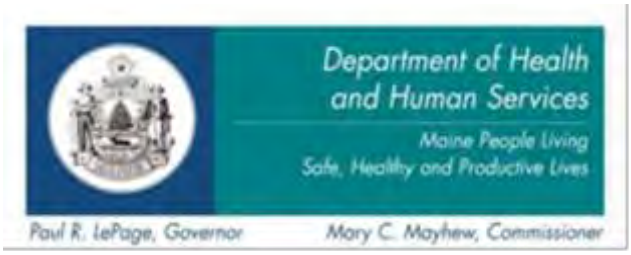

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Department Responses to the Citizen Review Panel Annual Report 2011-2013

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.

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[4].

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)[5] ,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.

[1] Comprehensive Assessments for Children Entering Foster Care: A National Perspective
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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
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?

[4] 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

[5] 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.

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 D
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 E- 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.	56 hours not including field instruction. Held every other month	New Child Welfare Staff Alternative Response Teams
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	4 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
Permanency Session II This Training is to inform staff on	Yes	Held in House	Policy & Training	12 hours	Child Welfare Staff

placement and educational stability by stressing the knowledge of the child's needs and developmental level. Policy around selecting placement and considering kin first is discussed explaining community based placements that are least restrictive. Different placement types are defined and a brief introduction to ICPC is covered. The fostering Connections Act is discussed and the procedure for school transfer is explained. Adoption and Permanency Guardianship are discussed.			Team Staff	Held Quarterly	Alternative Response Teams
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
Intake This training provides an overview of the Child Protective Intake Unit. Topics include writing a report of child abuse and neglect, mandated reporting, what makes a report appropriate verse inappropriate, how decisions on child abuse and neglect are made as well as learn how to make an Out of Home Investigation (OOHI) report, a Drug Affected Baby (DAB) report, a report to the District Attorney, and learn various databases that Intake uses to gather more information about a family's composition and demographics.	Yes	Held in House	OCFS Intake staff	6 hours Held monthly	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	Yes	Held in various locations throughout Maine	Policy & Training Team Staff Dr. Lawrence Ricci- medical expert on child abuse	6 hours Held Quarterly	Child Welfare Staff Resource Parents Community Partners. Alternative Response Teams

obtained, in light of what we know about the dynamics of child abuse and neglect.			and neglect.		
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	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 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.	Yes	Held in various locations in Maine	Policy & Training Team Staff Maine Coalition Against Sexual Assault staff	4 hours	Child Welfare Staff Community Partners Alternative Response Teams
Medication Assisted Treatment Training This training is to inform caseworker staff and Resource Parents the intricacies of medication assisted treatment with the intent of increasing knowledge and awareness of this form of treatment and decreasing myths.	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
Understanding the Dynamics of Sexual Assault This training is on the dynamics of	Yes	Held in various locations in	Policy & Training Team Staff	3 hours	Child Welfare Staff Resource Parents

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.		Maine	Maine Coalition Against Sexual Assault Staff		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
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	No	Held in various locations	Policy & Training Team Staff	3 hours held as needed	Child Welfare staff Community Partners

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.		throughout Maine	Child Abuse and Neglect Councils staff		
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 Delivered to each district Working on broadening this training to incorporate more information on Trauma informed adoption work.	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