Maine

CHILD WELFARE SERVICES OMBUDSMAN

14TH ANNUAL REPORT • 2016

CHILDREN'S OMBUDSMAN

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The 2016 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

CHRISTINE E. ALBERI, Esq.
Executive Director, Ombudsman

I am pleased and honored to present the fourteenth annual report of the Maine Child Welfare Ombudsman, and the fourth of the agency, Maine Child Welfare Ombudsman, Inc. We are an independent non-profit solely dedicated to fulfilling the duties and responsibilities laid out in 22 M.R.S.A. §4087-A. Our program provides Ombudsman services to individuals involved with the Maine Department of Health and Human Services, Office of Child and Family Services (OCFS). Specifically, the Ombudsman has the authority to investigate complaints concerning the handling of child welfare cases whether or not the children involved have entered foster care.

The Ombudsman and OCFS have worked in partnership this year to improve policy and practice in child welfare cases. As in past years, the majority of cases handled by OCFS assured the safety of children and were handled in accordance with OCFS Child Welfare Policies.

The Ombudsman was invited this year, along with other stakeholders, to participate in an initiative to revise Child Protective Intake policies. In 2015 Child Protective Intake referred 18,615 calls for intervention by Child Protective Services into a family situation. OCFS is working on a comprehensive new policy to ensure even higher accuracy in determining which families are in need of assistance at the outset.

In addition to receptiveness to case specific recommendations, the Ombudsman has also seen a high degree of responsiveness to statewide recommendations made, such as an increased focus on transition planning for children in foster care to ease the hardship of moving from one placement to another. In general, OFCS staff and management are very receptive to recommendations by the Ombudsman.

I would like to thank both Governor LePage and the Maine Legislature for continuing to support the Maine Child Welfare Ombudsman as an important part of an alliance of many individuals and organizations that work together help protect Maine's most vulnerable children.

Sincerely,

Christine Alberi
Child Welfare Services Ombudsman

WHAT IS *the Maine Child Welfare Services Ombudsman?*

The Maine Child Welfare Services Ombudsman Program is contracted directly with the Governor's Office and is overseen by the Department of Administrative and Financial Services.

The Ombudsman is authorized by 22 M.R.S.A. §4087-A to provide information and referrals to individuals requesting assistance and to set priorities for opening cases for review when an individual calls with a complaint regarding child welfare services in the Maine Department of Health and Human Services.

MERRIAM-WEBSTER ONLINE
defines an *Ombudsman* as:

1: a government official (as in Sweden or New Zealand) appointed to receive and investigate complaints made by individu als against abuses or capricious acts of public officials

2: someone who investigates reported complaints (as from students or consumers), reports findings, and helps to achieve equitable settlements

The Ombudsman will consider the following factors when determining whether or not to open a case for review:

1. The degree of harm alleged to the child.
2. If the redress requested is specifically prohibited by court order.
3. The demeanor and credibility of the caller.
4. Whether or not the caller has previously contacted the program administrator, senior management, or the governor's office.
5. Whether the policy or procedure not followed has shown itself previously as a pattern of non-compliance in one district or throughout DHHS.
6. Whether the case is already under administrative appeal.
7. Other options for resolution are available to the complainant.
8. The complexity of the issue at hand.

An investigation may not be opened when, in the judgment of the Ombudsman:

1. The primary problem is a custody dispute between parents.

2. The caller is seeking redress for grievances that will not benefit the subject child.

3. There is no specific child involved.

4. The complaint lacks merit.

The office of the Child Welfare Ombudsman exists to help improve child welfare practices both through review of individual cases and by providing information on rights and responsibilities of families, service providers and other participants in the child welfare system.

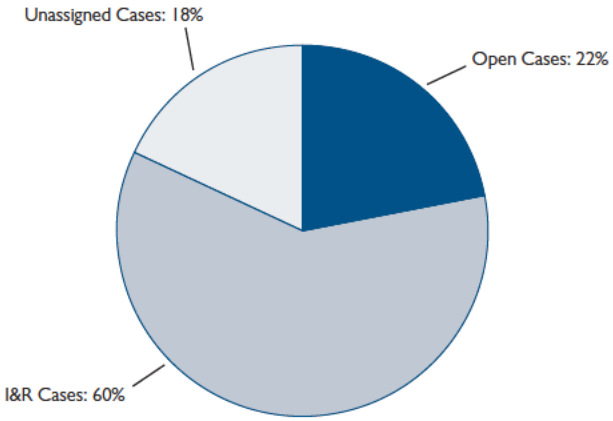
More information about the Ombudsman Program may be found at
http://www.cwombudsman.com

DATA
from the Child Welfare Services Ombudsman

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2015, through September 30, 2016.

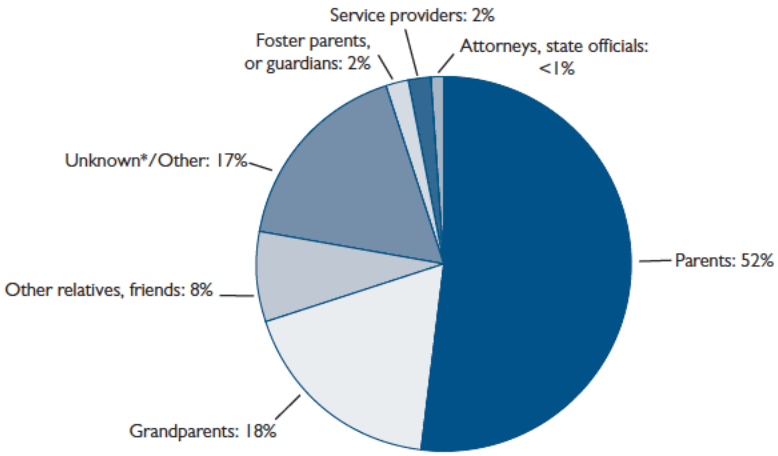
In Fiscal Year 2016, 512 inquiries were made to the Ombudsman Program, a decrease of 17 inquiries from the previous fiscal year. As a result of these inquiries, 114 cases were opened for review (22%), 307 cases were given information or referred for services elsewhere (60%), and 91 cases were unassigned (18%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Our new scheduling protocols allow each caller an opportunity to set up a telephone intake appointment.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



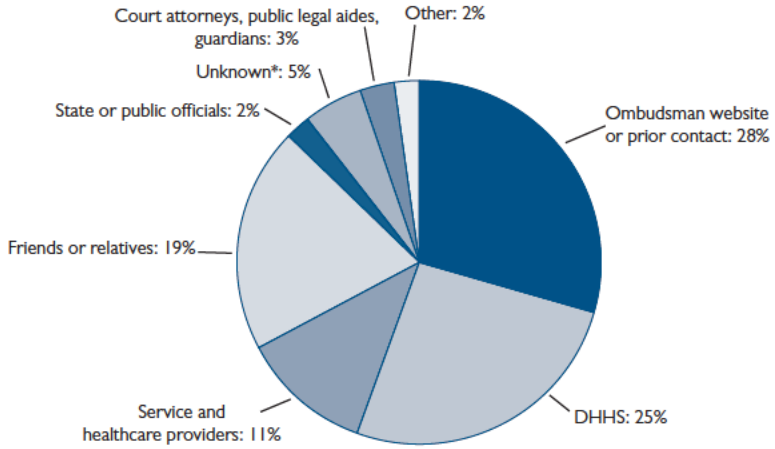
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2016, the highest number of contacts were from parents, followed by grandparents, then other relatives/friends.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

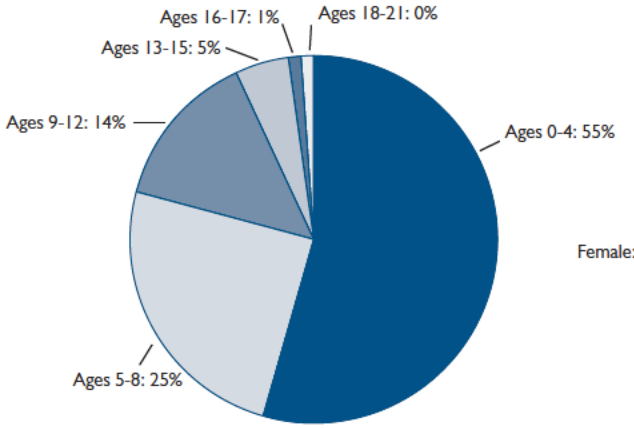
In 2016, twenty-eight percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty-five percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.

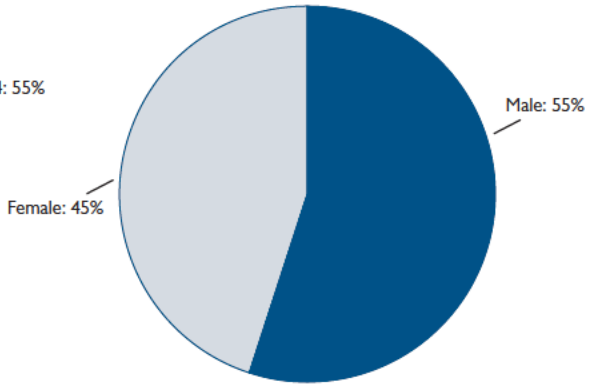


* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

WHAT ARE THE AGES & GENDER OF CHILDREN INVOLVED IN OPEN CASES?

The Ombudsman Program collects demographic information on the children involved in cases opened for review. There were 216 children represented in the 114 cases opened for review: 55 percent were male and 45 percent were female. During the reporting period, 80 percent of these children were age 8 and under.





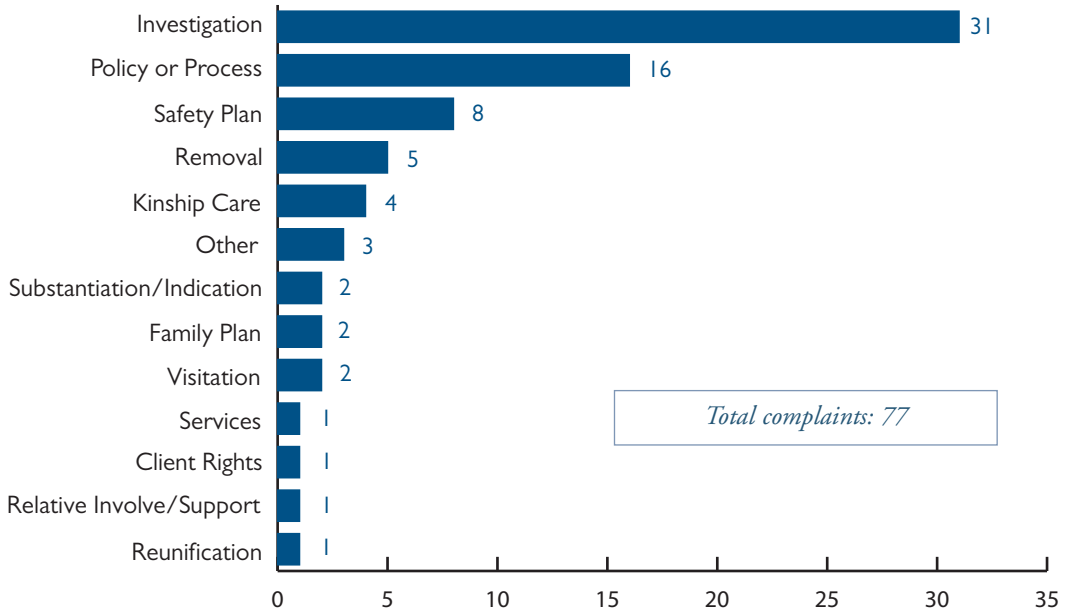
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT		CHILDREN	
DISTRICT #	OFFICE	CASES	NUMBER	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	4	4	4%	11	5%
1	Biddeford	13	13	11%	26	12%
2	Portland	9	9	8%	25	12%
3	Lewiston	19	19	17%	35	16%
4	Rockland	7	7	6%	10	5%
5	Augusta Skowhegan	11 14	25	22%	41	19%
6	Bangor	18	18	16%	31	14%
7	Ellsworth	9	9	8%	17	8%
8	Houlton	10	10	9%	20	9%
TOTAL			**114**	**100%**	**216**	**100%**

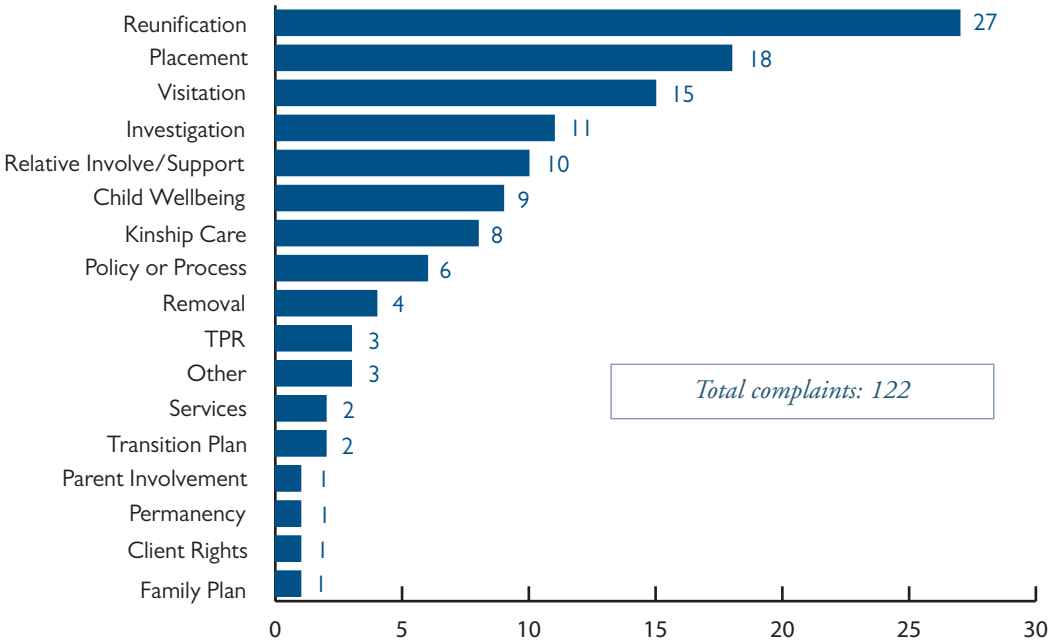
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 114 cases were opened with a total of 199 complaints. Each case typically involved more than one complaint. There were 77 complaints regarding Child Protective Services Units or Intakes, 122 complaints regarding Children's Services Units.

Area of Complaint: **CHILD PROTECTIVE SERVICES**



Area of Complaint: **CHILDREN'S SERVICES UNITS (FOSTER CARE)**



HOW MANY CASES WERE CLOSED & HOW WERE THEY RESOLVED?

During the reporting period, the Ombudsman Program closed 109 cases that had been opened for review. These cases included 204 complaints and those are summarized in the table below.

VALID/RESOLVED complaints are those complaints that the Ombudsman has determined have merit, and changes have been or are being made by the Department in the best interests of the child or children involved.

VALID/NOT RESOLVED complaints are those complaints that the Ombudsman has determined have merit, but they have not been resolved for the following reasons:

1. ACTION CANNOT BE UNDONE: The issue could not be resolved because it involved an event that had already occurred.

2. DEPARTMENT DISAGREES WITH OMBUDSMAN: The Department disagreed with the Ombudsman's recommendations and would not make changes.

3. CHANGE NOT IN THE CHILD'S BEST INTEREST: Making a change to correct a policy or practice violation is not in the child's best interest.

4. LACK OF RESOURCES: The Department agreed with the Ombudsman's recommendations but could not make a change because no resource was available.

NOT VALID complaints are those that the Ombudsman has reviewed and has determined that the Department was or is following policies and procedures in the best interests of the child or children.

RESOLUTION	CHILD PROTECTIVE SERVICES UNITS	CHILDREN'S SERVICES UNITS	TOTAL
Valid/Resolved	2	5	7
Valid/Not Resolved*	19	20	39
1. Action cannot be undone	14	16	30
2. Dept. disagrees with Ombudsman	0	1	1
3. Lack of Resources	0	1	1
Not Valid	56	102	158
TOTAL	**77**	**127**	**204**

* Total of numbers 1, 2, 3

During reviews of the 109 closed cases, the Ombudsman identified additional complaint areas in 12 cases that were not identified by the original complainant. The 12 complaints were found to be valid in the following categories: 2 reunification, 6 investigation, 1 kinship care, 1 transition plan, 1 safety plan, 1 child wellbeing, and 1 trial placement. 10 of the complaints were unresolved because the action could not be undone and 2 were resolved by changes made by the Department.

POLICY AND PRACTICE
Recommendations

The Ombudsman and the Department of Health and Human Services, Office of Child and Family Services (the Department) have had a productive year in collaboration on policy and practice recommendations. When the Ombudsman's concerns are reported, the Department has agreed to recommendations to correct problematic areas of practice, such as transition planning, both in districts and statewide.

The 2015 annual report detailed recommendations both on kinship placements and relative involvement as well as recommendations on transition planning when moving a child from one placement to another. During the 2016 fiscal year, practice in both of these areas has improved and neither emerged as an outsized issue during the reporting period.

During the 2016 fiscal year the following were among the most important recommendations made to the Department:

1. ASSESSMENTS, SAFETY PLANNING AND ACTING TO PROTECT CHILDREN

When the Department receives a report of abuse or neglect that is appropriate for assessment, a crucial period of decision-making follows. The Ombudsman made recommendations this year regarding assessment policy, safety planning and intervention in situations where the Department had multiple involvements with families over several years.

A. BASIC ASSESSMENT PRACTICES. As in previous reports, compliance with assessment policy continues to be at issue. There has been some improvement in this area, however, and some of the Department's recent changes would not necessarily be reflected in this year's recommendations.

One of the cornerstones of an initial assessment of the safety of children is to quickly interview children and to visit the children at least once a month in the home while the assessment or case is open. In the majority of cases, social workers visit children quickly in the home or at school for initial interviews, and also make announced and unannounced visits to the home monthly, or when new information warrants a check on the children. Out of home children and adults who are not parents living in the home are also assessed. Unfortunately, regular face to face contact with children has been inconsistent in some cases. Lack of ongoing assessment, especially in cases where there is a long term safety plan or family plan, has been an issue as well in cases reviewed this year.

Department's Response: The initial interview of a child and subsequent interviews for new allegations should follow the Fact Finding Interview Protocol. All experienced protective workers, as defined by having two or more years of interviewing experience will be receiving a three day advanced interview training as a recognition that they have not received any formal interview training for several years.

One of the challenges this past year has been that caseworkers must interview all victims within 72 hours instead of at least one child victim. This can be challenging to meet given all the complexities of family units. Staff continues to improve this practice expectation with initial contacts made 80% of the time within 72 hours.

The Department's policy is that the caseworker will make at least one purposeful face-to-face contact each month with the child in all cases. The average monthly face to face contact for children in care for the last Federal Fiscal Year (October 2015 to September 2016) is 94%.

As part of OCFS's strategic plan for the next two years one of the objectives is to increase effectiveness of the response to reports of child abuse and neglect through an improved assessment process. There are quarterly actions steps including additional trainings, such as motivational interviewing for all staff to improve ongoing assessment practice.

B. **SAFETY PLANNING.**

Safety planning was designed in policy to be a short term measure to protect children while the Department can complete an assessment of the children's safety. Parents sign an agreement, often requiring that the child or children move into a relative's home temporarily, while the social worker determines the level of safety in the home. Sometimes these safety plans can develop into longer term voluntary care agreements where children will reside outside the home, usually with relatives, while the parent voluntarily engages in treatment or counseling to address the issues that might place the children in danger. These types of plans can be very effective, avoiding court action and keeping children in the parent's custody.

However, safety plans, as distinguished from family plans with voluntary care agreements, are sometimes used in situations where they do not protect the children and delay necessary services and court intervention.

If the level of risk to the children is high, and the parents do not agree to the safety plan, or are continually violating, changing or constantly renegotiating the safety plan, best practice is to request a Preliminary Protection Order from the court instead of entering into another safety plan. There have also been several instances where the Department asked a parent to give up physical custody of a child, stating that this was necessary for the safety of a child and a petition would be filed in court to take custody, but then there was a long delay in filing a petition.

Parents' agreement to safety plans or longer term voluntary care agreements is often not true agreement, but agreement only to avoid court or to postpone the frightening prospect, from most parents' perspective, of children going into state custody. Parents can be put into a position where they lose their health insurance, housing, and other services because they no longer have physical custody of their children, but do not have the protections of having representation of an attorney and a judge involved to oversee the case. For children, these plans can delay permanency and at worst, put children in difficult or dangerous circumstances when parents decide to stop following the plan. Used properly, as they most often are, safety plans and voluntary care agreements can be beneficial to children and families.

Department's Response: As part of our teaming process, all safety plans are to be developed at an FFTM or if not possible within 5 days after creating a field safety plan. The purpose of this is to develop a safety network versus having only the parents' agreement that they not engage in particular behaviors. When created through the teaming process with the right people at the table, the safety plan will have checks and balances that lower the level of risk to the children.

The Department is collecting data to determine how many children are diverted from entering foster care through this FFTM and safety plan process and how many children are only delayed from entering foster care. The Department recognizes that when there is a delay, in addition to the issues raised above, the kinship providers are also experience increased out of pocket expenses with little financial assistance, creating hardship for many who are on a fixed income.

All FFTM facilitators and District backup facilitators and their supervisors will be receiving training this year to increase the effectiveness of FFTM's and safety planning. We are also engaging in ongoing discussions with the Courts and AAG's office about the use of safety plans and a workgroup is being developed to further discuss this practice area. The goal of the workgroup is to ensure safety planning is being done in the most effective way that provide practice clarity for staff and adequate supports to parents and their support network.

C. TIMING OF EFFECTIVE INTERVENTION.

In general, the Department, in an effort to preserve families and not intervene unnecessarily, does not take children into custody when unwarranted. The Ombudsman has made recommendations this year around several cases where the Department had multiple assessments of families over the course of several years. The same issues and patterns of behavior presented in each assessment. In subsequent assessments, information would come out that the situation in the previous assessment as understood by the Department, had not been accurate and parents had been in more difficult circumstances than was known at the time. The risk had continued for the children between Department involvements. Parents would improve their circumstances slightly due to the Department's involvement, promise to engage in services, and the assessment would be closed or referred to an Alternative Response Program. Then months later, another report would come in indicating that parents had not engaged in services or lessened the risk to the children.

A high frequency of Child Protective involvement and reports called into the Department, especially if the calls are from a variety of reporters, should alone raise serious concerns even if no findings of abuse or neglect had been made in previous assessments. If the history indicates that there were many opened and closed cases over the years, the previous cases should be reviewed carefully and there should be careful guarding against confirmation bias. Particularly with parents who have problems with chronic substance abuse, without treatment a parent is highly likely to relapse. Treatment is important for many other issues as well. The long term impact to a child is likely to be very high after years of ongoing neglect.

The Department should not hesitate to proceed with court intervention in cases where it appears likely that the pattern of abuse or neglect will continue based on the family's history and lack of engagement in services, particularly when parents are struggling with substance abuse or mental health issues, or both.

Department's Response: Using the new Federal definition of repeat maltreatment, which is a reoccurrence of child abuse or neglect within 12 months of the initial finding, the rate is 9.8% for the last fiscal year. There are those families where multiple reports are assessed with no findings. The new assessment policy will be finalized this quarter and all staff will be trained on the updated assessment and findings policies. This training and policy will include the importance of reviewing the history and considering the totality of the information known about a family in making decisions about current safety.

The Rapid Safety Feedback (RSF) process also ensures that the history is reviewed through an intense level, in the moment, quality assurance review for safety in assessments that score a high probability of having a bad outcome.

The Maine Enhanced Parenting Program is currently available in 5 of the 8 districts of the districts with the goal of increasing effectiveness of substance abuse treatment and parenting practices for parents with children aged 0 to 5. This will be made available in all areas of the State.

Training in the teaming process will lead to the increased successfulness of engaging families and their support networks in sharing responsibility for child safety both while OCFS is involved and after the Department's involvement ends.

The Department has engaged in ongoing conversations with our AAG's about immediate risk and when it is appropriate to go to court. Through our teaming process reboot, assessment and interviewing training for staff, the ongoing use of RSF and the development of a clear process for safety planning, we believe that decisions regarding child safety will be made in a timelier manner.

2. OLDER YOUTH WITH MENTAL HEALTH AND BEHAVIORAL ISSUES

The Department struggled with difficult circumstances in cases involving older youth with mental health and behavioral issues. These children, whether in state custody or with their biological or adoptive families, have limited options: the juvenile criminal justice system, residential treatment, therapeutic foster care, homeless shelters, or remaining in their homes with intensive in-home services. When in-home services are not working, often children are cared for by a patchwork of crisis centers, emergency rooms and homeless shelters, none of which are equipped to provide the care that these children need. Better trained, better funded home environments that can provide focused services tailored to each particular youth's needs would be highly beneficial.

Children will often stabilize in residential treatment, which results in discharge home to situations that are either unsafe or result in a return to behaviors that lead back to crisis and another residential placement. Every time a stay in residential treatment needs to be reapproved a stressful situation is caused for children, parents, and providers, and sets back a child's treatment.

It would be beneficial for the Department to develop clearer practice guidelines when assessment or permanency social workers are presented with parents who are unable to care for their child due to the child's serious mental health or behavioral issues. Decision-making in these cases is very difficult and the Department should proceed with caution. Parents should not be penalized for their children's issues, but children should also be taken into state custody when they are not safe due to these mental health and behavioral issues.

The same services in the children's mental health system are available to parents and the state if the children are in foster care. However, the Department has more expertise to help navigate the system. Most importantly, the Department has therapeutic foster homes available for children with serious mental illness or behavioral issues.

The Department can improve the response to these kinds of complex cases through more education and training. However, the children's mental health system is currently not equipped to effectively serve the apparently growing population of children with mental illness and behavioral issues that cannot be managed in the home. Therapeutic and other foster homes are not available to parents or guardians. Long waitlists exist for in-home therapeutic services that may prevent the need for hospitalization or residential treatment. Most agree that it is not in the majority of children's best interests to be in long term residential treatment. However, some need a longer term, stable living situation that is able to help prepare the child for a successful transition back into the home, foster home, or to adulthood.

Department's Response: OCFS believes that residential treatment is an appropriate placement for children on the continuum of placement options, although is intended to be intensive, short-term, temporary treatment. The goal of this service is to stabilize children who require this level of treatment that are unable to be safely managed in a community setting. The Department has made significant shifts in practice over the last 10 years in that children should not grow up in residential care.

Department Mental Health Program Coordinators and Clinical Care Specialists in each district office meet regularly with residential and community providers of services to ensure quality services and proactive planning for youth in residential placements. These staff also have a role to work with families, community providers, OCFS, residential treatment providers and KEPRO (Maine's Administrative Services Organization) around referral management and placement.

Children's Behavioral Health Services staffs maintain a 24/7 on call system for children that require emergency hospitalization to try to ensure youth are maintained within the State of Maine. They follow up with youth who have an extended stay in the hospital and can help navigate referrals for 30 day overlap case management services and Intensive Temporary Residential Treatment (ITRT) applications.

For youth in custody of the Department, monthly residential reviews are occurring on each youth to ensure that their needs are being met and discharge planning is ongoing. To ensure timely discharge planning, there is a secondary placement option available to resources families that commit to being a discharge placement and participate in the treatment process, including visitation, therapy and team meetings while getting reimbursed for their time. There is also an enhanced rate available for eligible treatment level foster parents who will accept placement of a youth out of a residential setting.

The Department can only intervene in circumstances where child abuse and neglect of a child exists. Children in the parental custody have access to similar supports and services as youth in care. Children's Behavioral Health Services staff and community targeted case managers are available throughout the state to assist parents in navigating and accessing the appropriate services for their children. The Department is committed to supporting children whose needs do not rise to the level of child abuse and neglect and is actively working to develop a prevention and community intervention tier as part of the continuum of services provided by the formal child welfare agency and community partners.

CONCLUSION

The above responses from the Office of Child and Family Services reflect an organization that is continually striving to improve practice and policy to both keep children safe and avoid taking children into custody. An ongoing focus around education and new policy will likely improve outcomes. OCFS and the Ombudsman continue to work collaboratively towards solutions.

ACKNOWLEDGMENTS

As the fourteenth year of the Maine Child Welfare Ombudsman program comes to a close, we would like to acknowledge and thank the many people who have continued to assure the success of the mission of the Child Welfare Ombudsman: to support better outcomes for children and families served by the child welfare system. Unfortunately, space does not allow the listing of all individuals and their contributions.

The staff of public and private agencies that provide services to children and families involved in the child welfare system, for their efforts to implement new ideas and provide care and compassion to families at the frontline, where it matters most.

Senior management staff in the Office of Child and Family Services, led by James Martin, for their ongoing efforts to make the support of families as the center of child welfare practice, to keep children safe, and to support social workers who work directly with families.

The Program Administrators of the District Offices, as well as the supervisors and social workers, for their openness and willingness to collaborate with the Ombudsman to improve child welfare practice.

The Board of Directors of the Maine Child Welfare Services Ombudsman, Ally Keppel, Allie McCormack, Maureen Boston and Virginia Marriner for their support and dedication to our agency.

Lastly, the Ombudsman would like to draw attention to the difficult, demanding, and often heartbreaking work that social workers do every day to help keep children safe and to reunite families. Social workers who help take children out of dangerous situations, help devastated parents to reunify with those same children, and sometimes see families through the heartbreaking termination of parental rights, receive little thanks for their work that is among the most important in our society. OCFS social workers should be acknowledged and thanked for their efforts to help and protect the vulnerable children in Maine.

CHILD WELFARE OMBUDSMAN

P.O. Box 2057 • Hope, Maine 04847 • 1-866-621-0758 • 207-213-4773

EMAIL: ombudsman@cwombudsman.com • WEB: www.cwombudsman.com