A Report of the Child Protective Services Oversight Committee

January 1993

January, 1993

Commissioner Jane Sheehan
Department of Human Services
State House Station #11
Augusta, ME 04333

Dear Commissioner Sheehan:

As Chairman of the Oversight Committee which was established by your predecessor, Rollin Ives, I am very pleased to transmit our Report. The members of the Committee are available to assist with any clarifications or other activities which might be helpful to you and your staff.

As you are aware, the Legislature furthered the establishment and expanded the role of the Oversight Committee via ***H.P. 1633 - L.D. "Resolve, to Ensure Protection and Family Support for Maine's Children"***. In accordance with this legislation the final report will be submitted to the Maine State Senate and House of Representatives.

Please feel free to contact me should you require added information.

Sincerely,

John Rosser, Ed.D.
Chair

A Report of the Child Protective Services Oversight Committee

January, 1993

Additional copies may be obtained from
National Child Welfare Resource Center
for Management and Administration, Publications
Edmund S. Muskie Institute of Public Affairs
University of Southern Maine
96 Falmouth Street
Portland, Maine 04103
207-780-4430

January, 1993

John L. Martin
Speaker of the House of Representatives
Maine State Senate
State House Station #3
Augusta, ME 04333

Dear Speaker Martin:

Enclosed please find a copy of The Report of the Oversight Committee on Child Protective Services as authorized by ***H.P. 1633 - L.D. "Resolve, to Ensure Protection and Family Support for Maine's Children"***. Additional copies are available for distribution to appropriate Joint Standing Committees.

Members of the Oversight Committee are available to meet with Joint Standing Committees as may be needed and desired by you.

Please feel free to contact me should you require added information regarding this Report.

Sincerely,

John Rosser, Ed.D.
Chair

January, 1993

Senator Dennis L. Dutremble
President of the Senate
Maine State Senate
State House Station #3
Augusta, ME 04333

Dear Senator Dutremble:

Enclosed please find a copy of The Report of the Oversight Committee on Child Protective Services as authorized by ***H.P. 1633 - L.D. "Resolve, to Ensure Protection and Family Support for Maine's Children"***. Additional copies are available for distribution to appropriate Joint Standing Committees.

Members of the Oversight Committee are available to meet with Joint Standing Committees as may be needed and desired by you.

Please feel free to contact me should you require added information regarding this Report.

Sincerely,

John Rosser, Ed.D.
Chair

Membership of the Oversight Committee

John Rosser, Ed.D. **Chair**	Executive Director, The Spurwink School
Harvey Berman	Director of Program Operations, The Spurwink School
William Davis	Director, Institute for Study of At Risk Students, University of Maine
Dale Douglass	Superintendent of Schools, Brunswick
Cliff Goodwin	Former Foster Parent who has maintained 99 foster children, currently Vice President C&O Bakery Foods Inc., Auburn
Frances Loring	Representative of the Maine State Nurses Association
Bette Manchester	Principal, Bowdoin Elementary School
Robert Moore	Attorney in the law firm of Pierce, Atwood, Scribner, Allen, Smith & Lancaster; former Legal Counsel to the Governor
Rejea Pare	Children's Clinician, Tri-County Mental Health Center
Lawrence R. Ricci, M.D.	Director, Diagnostic Center for Child Abuse, Mid-Maine Medical Center, Waterville
Steve Roberts	Deputy Chief of Police, Portland Police Department
Robert Rowe	Director, New Beginnings
Tony Scucci	Executive Director, Franklin County Children's Task Force
Jane G. Smith	Executive Director, Samantha Smith Center; former Caseworker and Administrator, Department of Human Services
Anita St. Onge	Assistant Attorney General, Human Services Section
Paul Vestal	Director, Advocates for the Developmentally Disabled

---

Helaine Hornby	Director, National Child Welfare Resource Center for Management and Administration, Edmund S. Muskie Institute; Consultant to the Committee
Alfred Sheehy	Research Assistant, National Child Welare Resource Center for Management and Administration, Edmund S. Muskie Institute; Consultant to the Committee

Abbreviations

AFCARS	Adoption and Foster Care Research System
AFDC	Aid to Families with Dependent Children
BCFS	Bureau of Child and Family Services
BCSN	Bureau of Children with Special Needs
BMS	Bureau of Medical Services
CAN	Child Abuse and Neglect Council
CRP	Children's Response Program
CWLA	Child Welfare League of America
CWTI	Child Welfare Training Institute
DHS	Department of Human Services
DMHMR	Department of Mental Health and Mental Retardation
DOC	Department of Corrections
DOE	Department of Education
DPCA	Diagnostic Program for Child Abuse
DPHN	Division of Public Heath Nursing
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ICC	Interdepartmental Coordinating Council
IFPS	Intensive Family Preservation Services
MFPA	Maine Foster Parents Association
MCTF	Maine Childrens Trust Fund
NCANDS	National Child Abuse and Neglect Data System
NCPCA	National Commission for the Prevention of Child Abuse
PHP	Preventive Health Program (The delivery vehicle in Maine for EPSDT services)
SCAN	Suspected Child Abuse and Neglect
TQM	Total Quality Management

Table of Contents

Chapter 1

Executive Summary and Recommendations

In September 1991 two tragedies befalling Maine infants shocked the State's citizens and moved the Legislature to action. The first involved the suffocation death of a 2½ month old boy whose autopsy revealed two broken legs and 20 rib fractures. The second involved the rape of a 6-month old girl, whose mother had been arrested on drug charges, by a 17-year old substitute babysitter. In both cases there were prior alerts to the Department of Human Services that infants may be in jeopardy. In both cases the State's actions or failures to act could not avert the tragedies.

While no agency charged with protecting all of a State's children from maltreatment can fulfill its mission successfully in 100 percent of the cases, all caring citizens, including those caseworkers and administrators who are directly responsible for maintaining children's safety, constantly seek answers as to how we can do better.

It is in that spirit that the State Legislature, early in 1992, mandated the creation of an Oversight Committee and requested a report and ultimately a comprehensive plan from the Department of Human Services about how it can more effectively provide protective and family support services. (See Appendix A for "Resolve, to Ensure Protection and Family Support for Maine's Children," L.D. 2297.) This document constitutes the report of the Oversight Committee.

To arrive at its findings and recommendations, the Committee met on the average of twice a month throughout 1992. As detailed in Appendix B, the Committee received oral and written testimony from citizens and professionals of every governmental agency, organization and interest group relating to child protection and foster care; its members visited regional offices and job shadowed workers; its consultants interviewed caseworkers, supervisors, managers and community agencies in every region of the state, as well as central office; and its consultants surveyed caseworkers and supervisors and reviewed hundreds of pages of agency documents and data. The Committee also sought examples of effective programs and initiatives in other states and in specific Maine communities to serve as program models.

From this extensive review the Oversight Committee has drawn the following major conclusions:

1. ***Both the Governor and Legislature must publicly acknowledge a state of emergency in the State's ability to protect children.***

The State's financial shortfalls, necessitating staff reductions and furlough days, has created a crisis in the child protective system. The Oversight Committee strongly affirms that all state services are not of equal priority. Protecting children should be exempted from across the board cuts in times of financial hardship. At present, legitimate reports of abuse cannot be investigated and proper follow-up cannot be provided where abuse has been found.

2. ***The Department of Human Services cannot, nor should be expected to, solve this problem alone.***

Solutions to the problems in the child protective system require a multi-disciplinary, multi-level and coordinated response involving the law enforcement, education, mental health, medical, voluntary and social service communities. Implicit is the need for extensive "cross-training" to facilitate cooperation and coordination among these groups.

3. ***People working in the field do not have the resources available to them to get the job done.***

Resources lacking include adequate staffing in the Bureau of Child and Family Services; public recognition, on the part of leadership, of low worker morale and the need for increased staff support; modern office technology and automated case management systems; increased financial support for multi-disciplinary coordination (e.g., joint law enforcement-DHS investigations, SCAN Teams, interagency intervention/treatment agreements); and increased financial support for preventive, early intervention, and treatment services. BCFS workers face additional difficulties caused by the lack of an adequate number of specialized treatment providers and a lack of experts of all types (medical, mental health, mental retardation, child development, etc.) willing to go to court or able to be effective in court.

4. ***DHS, other state agencies such as the Departments of Mental Health and Mental Retardation, Corrections, and Education, as well as cooperating private providers, must continue to strive to make better use of federal funding options.***

Increased utilization of federal funds will allow the child welfare system to increase available resources despite the current fiscal crisis in Maine.

5. ***The Governor and the Legislature must acknowledge that investment in a comprehensive system of support for children and their families is necessary to prevent the need for larger investments in the future.***

A comprehensive system must encompass a continuum of services ranging from preventive to treatment services and must include supportive services designed to alleviate family stresses that lead to child abuse.

These conclusions permeate the recommendations made throughout the report.

Child Welfare in Perspective

The problems facing child protection in Maine must be viewed in a broader national context. Maine is not alone in its inability to protect children. The U.S. Advisory Board on Child Abuse and Neglect also concluded in 1990 that:

> ...child abuse and neglect in the United States now represents a national emergency. In spite of the nation's avowed aim of protecting its children, each year hundreds of thousands of them are still being starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled. The scope of the problem merits the declaration of a national emergency. The United States spends billions of dollars on programs that deal with the results of the nation's failure to prevent and treat child abuse and neglect.[1]

[1] "Child Abuse and Neglect: Critical First Steps in Response to a National Emergency," The U.S. Advisory Board on Child Abuse and Neglect, August, 1990, p. vii.

The Advisory Board recommends that all citizens of the nation, including elected officials, acknowledge the emergency and take responsibility for it; that the president at the national level and all governors at the state level provide leadership in addressing the struggle to protect the states' children; that the coordination of services become more than a mantra but an operating principle; that state and federal agencies learn more about child maltreatment by collecting information and evaluating data about service effectiveness; that child protection be recognized as a profession and the people working in the field receive proper education and training; that the quantity and quality of treatment programs be expanded; that more emphasis be placed on prevention and early intervention, including greater private sector involvement; and that the courts be accorded the resources and training to promptly and fairly resolve the cases coming before them. (See Appendix C for a complete list of U.S. Advisory Board recommendations.)

Many of these national themes are mirrored in the Oversight Committee's findings and recommendations.

Major Issues Facing the Child Welfare System

It is important to consider Maine's child protective services program, administered by the Bureau of Child and Family Services within the Department of Human Services, in the context of the broader child welfare system.

Increase in service demand: Child welfare is in a state of emergency because there has been a steady increase in demand for services without a *corresponding* increase in supply. The demand has been created in part by public education about the existence of child abuse and neglect and the passage of mandatory reporting laws throughout the country, including Maine, which require people who come in contact with children, such as doctors, teachers and law enforcement personnel, to report suspected abuse to the state agency vested with the responsibility for protecting children.

The symptoms of the emergency in child protection include the following: Nationally, between 1981 and 1988, reports of abuse and neglect rose 82 percent to 2.2 million. In Maine, reports rose 80 percent between 1984 and 1990 wherein 16,680 referrals were received. Nationally, by 1990, deaths directly attributable to child abuse rose to 1,383, a 57 percent increase since 1985. That same year in Maine there were three deaths identified as directly attributable to child abuse. While Maine had fewer identified

deaths that year per one hundred thousand children than the nation at large, the Oversight Committee emphasizes that zero deaths attributable to child abuse is the only acceptable goal for this state.

In Maine, *a full 64 percent of all abuse reports come from professionals who are mandatory reporters* compared to a national average of 49 percent of abuse and neglect referrals originating with mandatory reporters. Maine professionals are diligent in fulfilling their responsibilities to report, even if the State does not have the capacity to respond. The largest source of reports in Maine are educators (23 percent), followed by social service staff (18 percent), and medical professionals (10 percent). When the State does not respond to the satisfaction of the professional reporter, feelings of hostility and ill will are generated which damage the agency's reputation in the community and subsequently hamper its ability to do its work.

Alterations in family structure: Child abuse has been exacerbated by the erosion of the two-parent family as we traditionally knew it, and the failure of our society and the social service system to adapt to changes in family structure. As observed by the U.S. Advisory Board, "the increased complexity of child maltreatment is matched by the complexity of recent, dramatic changes in family and community life" including family structure. The number of divorces in the United States tripled between 1960 and 1980. The birth rate among unmarried women has more than doubled since 1950. While the number of single parent families has expanded dramatically, the social service system and our society in general have been slow to make changes to accommodate the needs of these families. Female headed single parent families face further difficulties. Working women still earn, on average, less than their male counterparts. Single parent families suffer even more when absent parents fail to provide necessary child support resources. Many abuse reports stem from a non-related man living in the home. They also result from estranged parents fighting over the children and alleging abuses by the other spouse or their new partners. The stresses of raising children alone may contribute to both neglectful and abusive behavior. In Maine, for children in state custody who are currently living in their own homes, twice as many live in one-parent homes as two-parent homes.

Increase in family violence: One of the most serious precursors of child abuse is familial violence or spouse abuse. Most often, this is expressed as violence against women. At the Diagnostic Program for Child Abuse (DPCA) in Waterville, 50 percent of mothers report being battered. This violence damages children in many ways:

- Children in homes where domestic violence occurs are physically abused or seriously neglected at a rate1500 percent higher than the national average in the general population.
- Lenore Walker's 1984 study found that mothers were eight times more likely to hurt their children when they were being battered than when they were safe from violence.
- Children in homes where domestic violence occurs may "indirectly" receive injuries. They may be hurt when household items are thrown or weapons are used. Infants may be injured if being held by their mother when the batterer strikes out.
- Older children may be hurt while trying to protect their mother.
- Approximately 90 percent of children are aware of the violence directed at their mother.
- Some of the emotional effects of domestic violence on children include: taking responsibility for the abuse; constant anxiety (that another beating will occur); guilt for not being able to stop the abuse or for loving the abuser; and fear of abandonment[2].

It is well documented that child abuse is an intergenerational problem; violence begets violence. Though many parents who were abused as children do not abuse their own children, many do. For example, at the Diagnostic Program for Child Abuse, 60 percent of parents report child abuse (in the form of parent abuse, spouse abuse, etc.) in their own childhoods. We cannot protect the next generation of children unless we effectively protect the current generation.

Rise in poverty and unemployment: In very recent years the downturn in the economy, particularly in states such as Maine, has spawned increased unemployment, poverty, and homelessness, factors which elevate the likelihood of abuse. According to the U.S. Advisory Board, while "child maltreatment occurs in all socioeconomic and cultural groups, poverty makes child maltreatment much more likely." The rural nature of Maine adds additional stresses to families. Observes the U.S. Advisory Board, child maltreatment occurs much more frequently when families under stress lack support from their neighbors and are socially isolated. Often sources of help or services related to family problems are far from the families who need them.

[2] National Women Abuse Prevention Project, *Effects of Domestic Violence on Children.*

Limited service access: To access services through the child protection system, families must pass two stages: their case must be accepted for investigation and, once investigated, must be substantiated for abuse and/or neglect. In Maine, the percentage of cases accepted for investigation has declined steadily throughout the past several years: from 43 percent in 1986, to 31 percent in 1988, to 27 percent in 1989, to 25 percent in 1991. The percentage of cases substantiated in Maine is 53 percent, markedly higher than the national average of 35 percent, but lower than Connecticut (75 percent) or Massachusetts (55 percent). Thus, what started in 1990 as over 16 thousand referrals of possible abuse/neglect resulted in only 2 thousand families receiving intervention.

Unfortunately, as many people testified before the Oversight Committee, the child protective system has become the major access point to the child welfare services system, not only for abused and neglected children, but for many at-risk children and families. Kamerman and Kahn (1989), after doing an extensive empirical study, report, "child protective services have emerged as the dominant public child and family service, in effect 'driving' the public agency and often taking over child welfare entirely. Even though child protective services often make referrals to other agencies, most of the families that are screened out will likely not receive the help they need to address their problems. It is not until the situation becomes very serious that the state intervenes. Consequently, many children seen by child protective services have already been traumatized."

The numbers of children in Department of Human Services custody, including those living in their own homes and those in substitute care, has declined in recent years: from 1,832 an 1986 to 1,763 in 1991, a 4 percent decline. If children can be protected safely at home without Department of Human Services custody, this is a good sign. However, the agency does not keep data on the numbers of children who are reabused or reenter the system, an important performance indicator being monitored by other states. Thus, we do not know whether the decline in services represents a failure to protect or a triumph of prevention and early intervention approaches.

Changing role of caseworker: Both nationally and in Maine the child welfare program is undergoing an identity crisis which is characterized by two ironies. First, social workers no longer do social work. The result of an overburdened child welfare system has been the enactment of many laws and rules to govern who the system serves, how it deals with crisis, and when and how the court should be involved. We have seen a massive shift of workers nationally to the investigatory, as opposed to the helping, function. They spend their time investigating reports, identifying perpetrators, collecting

evidence, and taking cases to court. In short, child protection has been transformed from a social service system to a quasi criminal justice function in which a very small percentage of families actually receive services. Maine has resisted separating the investigative function from the service function except in the case of charges of abuse in institutions. This means the same worker has to be quasi-cop and helper. The Oversight Committee recognizes the contradictions inherent in this dual role and suggests that the Department revisit the question of separating the roles. The Committee also recommends using law enforcement more consistently throughout the state to investigate the potentially criminal aspects of assaultive and abusive behavior perpetrated against children, freeing up caseworkers to do social work.

The second irony characterizing child welfare is that while professionals in the field now broadly acknowledge the connection between the various public systems serving children with problems--mental health, juvenile justice, education and child welfare--there is near paralysis in the ability to develop a truly coordinated, rational system in which children who need services get served and interagency turf battles vanish. In Maine the greatest difficulties appear to involve children who have serious emotional and/or mental health problems, but are denied access to services because they fail to demonstrate a performance-based educational need. We have observed children moving laterally among the systems and unfortunately, vertically from foster care to juvenile justice to adult homelessness and/or adult corrections.

Promising Responses

The Oversight Committee has studied the responses to the crisis in child welfare and the changing character of the system. It has observed both procedural and substantive responses, many of which provide encouragement. At the national level, the U.S. Select Committee on Children, Youth and Families has held numerous hearings and published their findings, bringing public attention to the problem. National commissions such as the U.S. Advisory Board on Child Abuse and Neglect and the National Commission on Children chaired by Governor Rockefeller of West Virginia, have published detailed reports with far-reaching recommendations. There have been numerous efforts to change the system through coercion, using class action lawsuits. The Children's Rights Project of the American Civil Liberties Union has been particularly active in the child welfare arena, bringing major change in Louisiana, Washington, D.C. and Connecticut. There continues to be substantial private investment in pilot projects and reform strategies by

foundations such as the Edna McConnell Clark Foundation, the Pew Charitable Trust, the McDonald's Foundation, and the Annie E. Casey Foundation. The Homebuilders model, one of the major family preservation initiatives, for example, has received extensive support from the Edna McConnell Clark Foundation. A very important prevention and early intervention initiative, Healthy Start, receives substantial funding from the McDonald's Foundation.

In Maine, no less than nine studies have been published since 1983 including those of the Legislature's Joint Standing Committee on Audit and Program Review. The studies have recommended changes in legal processes, staffing levels, training, service availability and interagency coordination, among others. Most have called for a more comprehensive and rational system. One of the most important advances throughout this decade, both nationally and in Maine, has been an increased involvement of community professionals and even volunteers in the detection, diagnosis and treatment of child abuse. Once a highly confidential and specialized field of service, child abuse and protection has enjoyed both public scrutiny and wider professional involvement through guardians ad litem, multi-disciplinary teams, foster parent organizations, and, in general, a community-level capacity to respond. The Oversight Committee endorses this trend and, in this report, makes recommendations for its continuation and expansion.

The Oversight Committee found a number of positive elements and initiatives by the Department of Human Services to improve the Child Protective Services system which are referenced throughout this report. Some of the most encouraging are as follows.

1. The Childrens' Response Program (CRP) is a cooperative effort between DHS and the Portland Police Department. Since July 1992, the CRP has responded to 61 referrals: 19 were open protective cases, 37 were handled by the CRP and 5 became new CPS referrals with none screened out. A similar program in Lewiston responded to 40 referrals between July and September of 1992.

2. The Bangor Regional DHS Office is currently developing a Children's Response System to serve northern Penobscot County in conjunction with the Penobscot County District Attorney's Office. The project will receive referrals from Penobscot County police and area social service and child abuse prevention agencies.

3. The Lewiston Regional DHS Office and the Lewiston/Auburn YWCA have cooperated in the formation of a Family Mediation Project. The Project Director and seven YWCA staff have participated in 22½ hours of training provided by the Maine Court Mediation Service.

4. DHS is exploring the possibility of expanding Family Preservation Services in Maine. In October 1992, DHS and the Child Welfare Training Institute presented a conference to discuss a planning strategy for expanding this service in Maine.

5. Working in conjunction with the Muskie Institute at the University of Southern Maine, DHS has established the Child Welfare Training Institute which delivers a 20-day preservice training program to new workers, inservice training to experienced workers, foster parent training and supervisory and management training. An expansion of these programs is currently under development.

In addition to these specific instances, during interviews with DHS staff and providers the Oversight Committee discovered:

1. A heartfelt commitment to the safety of children and families on the part of Bureau of Child and Family Services staff at all levels of the organization;

2. An equally deep commitment to children and families on the part of community service providers, schools, law enforcement agencies, substitute care providers, and citizens as well as an equally deep concern that too many children are being hurt by our collective inaction;

3. A disturbing sense of cynicism regarding the public will to substantially improve the service system for children and families.

It is within this context that the Oversight Committee presents its findings and recommendations. We recognize that the implementation of these recommendations will involve more than the good will and hard efforts of the Department of Human Services. It will involve a public recognition that, without these changes, children will continue to be hurt and families will continue to be neglected. In difficult economic times the elec-

torate must set priorities which focus on the neediest people. Protecting the safety of children must be one of those priorities.

A word about cost. While members of the Oversight Committee are highly cognizant of the State's financial crisis, we were instructed to conduct this review with the welfare of children in mind. We weighed the recommendations in relation to cost and used that consideration as a guidestick but never as a veto mechanism. Further, this report contains recommendations which will increase revenues flowing into the state to offset some of the added costs.

RECOMMENDATIONS

Following is a list of recommendations that appear throughout this report together with their page references.

Child Protective Services

1. **DHS should fully investigate every allegation of abuse and neglect which meets current screening standards to determine if the child(ren) can remain safely in the home either with or without the provision of services.** *(page 40)*

To make this recommendation possible, the following steps are required:

A. **DHS should seek, as priority one, to have Childrens Emergency Services workers and Child Protective Services workers exempted from furlough days. DHS should seek, as priority two, to have Childrens Services workers exempted. This change will allow more time for current staff to perform the functions they are being paid to perform.**

B. **DHS should reinstate the case aides and paralegals whose positions have been cut due to budgetary pressures. In addition, DHS should seek authorization for 12.5 additional case aides and 5 paralegals to meet a standard of one case aide for every two units, and one paralegal for every region.**

C. **If, after one year, implementation of the recommendations above do not allow for the investigation of all legitimate allegations of abuse, DHS should seek authorization to hire 10 additional caseworkers including 8 Child Protective Services workers and 2 Childrens Services workers.**

2. **DHS should determine after 1 year if the Children's Response Programs in Portland and Lewiston (in which the police check into low priority abuse/ neglect allegations) should be continued and/or expanded into other communities throughout the state.** *(page 42)*

3. **DHS should establish an Information and Referral Service in cooperation with the expanded Child Abuse and Neglect Councils or other organization designated in each county to plan for coordinated services.** *(page 42)*

4. **DHS should not screen out abandoned teenagers who meet the intake criteria for abuse and neglect. These teenagers are often chronically, episodically homeless and are beginning a life pattern of episodic homelessness. Unless increased attention is paid to this group of Maine citizens, the prospect of them remaining on the welfare rolls throughout their adult lives weighs heavily as a possibility.** *(page 43)*

5. **Child abuse investigations, in which there is a reason to believe a crime has been committed, should be jointly investigated by law enforcement and DHS. The role of law enforcement is to determine if an arrest is warranted, and/or to facilitate a six-hour hold in order to protect a child who is at immediate risk of serious harm. The role of the DHS caseworker is to assess the risk to the child and the needs of the family. Whenever possible, these investigations should be conducted by established teams. These teams should meet regularly, train together from both child protective and law enforcement perspectives, and develop their mutual roles to have maximum impact.** *(page 43)*

A. **Information sharing between law enforcement and DHS should be worked out in memoranda of agreement which aim at removing confidentiality barriers and promoting a cooperative effort.**

B. **In urban areas, one or more specific police officers should be assigned to work in the area of child abuse. In rural areas, either the sheriffs' departments or an expansion of the State Police Detectives assigned to do investigations for the D.A.'s offices should be assigned this duty. Thus, for all areas of the state there should be specific identifiable law enforcement personnel assigned to child protection.**

C. **Standard recommendations, standard reporting procedures, and standard policies should be developed between DHS and law enforcement *and followed.* An up-to-date DHS organizational chart with the proper chain of command and phone numbers should be supplied to all law enforcement agencies in the state.**

6. **SCAN Teams should be funded in all Maine hospitals. DHS should establish a formal liaison with each SCAN Team in order to gain the maximum benefit which the SCAN Teams represent. SCAN Teams should identify, report, assess and work with high-risk families.** *(page 44 & 136)*

7. **DHS should review its policy regarding the investigation of cases referred by mandatory reporters in which the reporter strongly affirms that the case should be investigated. DHS should give more weight to the professional judgment of mandatory reporters and always inform them of the disposition of their report.** *(page 45)*

8. **DHS should establish detailed working agreements with cooperating agencies and organizations such as District Attorneys, SCAN Teams, schools, and law enforcement agencies. The purpose of these agreements is to promote collaboration, respectful sharing of information, and/or joint decision-making. The Children's Response Program in Portland and the Central Maine Medical Center SCAN Team in DHS Region II provide excellent examples of formal cooperative agreements that have led to a strong working relationship at the community level.** *(page 46)*

9. **DHS should seek legislative amendment of 22 M.S.R.A. § 4002 to provide for a second standard of jeopardy to allow the court to order services in cases where the current jeopardy standard cannot be met but where there is clear danger to the child and family.** *(page 46)*

10. **DHS should examine its compliance with the confidentiality laws to make sure that communication is occurring as fully as allowed by law.** *(page 47)*

11. **DHS should work with existing Intensive Home Based Family Preservation Services Providers to strengthen the existing service network as it proceeds with implementing such services in-house.** *(page 47)*

Childrens Services and Substitute Care

12. **All children involved with the Department should have timely evaluations of medical, psychological, developmental, educational, and behavioral issues. Relevant evaluative information and medical records should be recorded and safeguarded in the Medical Passport and should be shared with foster parents for children entering substitute care.** *(page 56)*

13. **Child abuse evaluations, referenced above, should be conducted in diagnostic settings within limited timeframes to allow caseworkers to quickly learn what services the child requires. The Commissioner of Human Services should work with the Director of these services at Mid Maine Medical Center and other professionals to design such a system which would include at a minimum:** *(page 57)*

    A. **Psychological and substance abuse evaluations for parents;**
    B. **Medical/mental health evaluations for children;**
    C. **Child development evaluations;**
    D. **Educational evaluations; and,**
    E. **Parental capacity evaluations.**

14. **DHS should consistently recognize foster parents and other substitute care providers as a key component and integral members of the treatment and care team for children in substitute care. DHS and the Maine Foster Parents Association (MFPA) should reach an agreement concerning the specific expectations of substitute care providers, both as individuals and as members of the treatment team. All children entering substitute care should have a case plan which includes the caseworker, therapist, and the substitute care**

provider in order to better meet the needs of the child. The initial case planning stage should include the substitute care providers. *(page 58)*

15. **DHS, the Maine Foster Parent Association, and representatives of other substitute care providers should develop standards of care for placements at all levels of the substitute care system. This process should focus on developing detailed Quality Assurance Standards for substitute care placements. DHS should use a common assessment process to determine what level of care each child requires.** *(page 58)*

16. **DHS and the Child Welfare Training Institute should continue to expand training opportunities and support services for substitute care providers. DHS should continue to work with the Maine Foster Parents Association to develop a community-based substitute care provider support system which includes respite care as one component.** *(page 59)*

17. **DHS and the Maine Foster Parents Association should continue to develop an objective method for handling board rate discussions between DHS caseworkers or other Department representatives and substitute care providers.** *(page 59)*

18. **Caseworkers should be trained in the practical functioning of a foster home, and other substitute care facilities, in order to facilitate more cooperative working relationships between caseworkers and substitute care providers.** *(page 60)*

19. **DHS should emphasize the rehabilitation of children and families before beginning reunification efforts.** *(page 60)*

Personnel and Training

20. **See Recommendation 1A. We reiterate here that Children's Emergency Service, Child Protective Services and Childrens Services workers should be exempted from furlough days so that the staff of those units can receive proper supervision.** *(page 76)*

21. **BCFS should improve its capacity to provide clinical consultation and supervision to its workers.** *(page 76)*

22. **DHS and the Child Welfare Training Institute should expand clinical training resources for supervisors. These resources should include training within the CWTI, expanded utilization of offerings in the State University system, and use of other professional training facilities within the state.** *(page 77)*

23. **BCFS should explore the development of a formal system of mentoring among the casework staff. This system would create pairs or triads of caseworkers constituted according to experience, with experienced caseworkers paired with less experienced ones.** *(page 77)*

24. **BCFS should conduct a time study of caseworker functions to determine where and how workers currently spend their time and what functions could be performed by case aides, clerical staff and/or volunteers.** *(page 78)*

25. **See recommendation 1B. DHS should reinstate the case aides and paralegals whose positions have been cut with the shortsighted view that their elimination would have little or no effect on the ability of caseworkers to do their jobs. In addition, DHS should seek authorization for 12.5 additional case aides and 5 paralegals to meet a standard of one case aide for every two units, and one paralegal for every region.** *(page 78)*

As a part of the time study (recommended above) DHS should determine if additional clerical support is needed as well.

26. **The Governor, the Commissioner, and the BCFS central office staff can demonstrate their support for the line workers and supervisors by publicly acknowledging the difficulties the organization faces as a result of stresses created by turnover, furloughs and shutdowns, and the reduced workweek. Public acknowledgment of these stresses would be a large step in restoring the confidence of the regional offices.** *(page 78)*

Managers should also continue to address the question of agency image by implementing other recommendations in this report which help to remove the isolation of the agency and foster working agreements with other groups.

27. **DHS should develop a recruitment plan which may incorporate some or all of the following:** *(page 79)*

    A. **Re-implement or expand campus recruitment and student internships as an active recruiting tool if the field instruction units do not provide sufficient new recruits.**

    B. **Develop recruiting techniques for older workers.**

    C. **Expand the use of the caseworker trainee line. This will allow the agency to bring on potential caseworkers and allow the agency a full year to evaluate the future potential of the workers, as opposed to the six-month probationary period of an employee hired as a caseworker.**

    D. **Continue developing and testing the Field Instruction Units through the CWTI.**

28. **DHS should utilize the current personnel system as effectively as possible since attempting to change it will require a tremendous amount of time and resources and is unlikely to be successful.** *(page 79)*

29. **DHS should continue to develop all aspects of the Child Welfare Training Institute as planned. CWTI provides pre-service and in-service training to Bureau of Child and Family Services (BCFS) personnel, supervisory and management training, and is currently expanding training in the areas of professional development, foster and adoptive parent training, field instruction and training to day care providers. CWTI should also expand training opportunities for other substitute care providers, and continue to expand cross-training opportunities. In addition to expanding training opportunities within the Institute, CWTI should explore collaborative arrangements with other educational and training institutions (such as the Maine Criminal Justice Academy) within the state.** *(page 79)*

30. **The Department should take steps to formalize a procedure for adding cross-training to the CWTI as already initiated on a limited basis. In particular, DHS should continue to assure that the law enforcement officers and state police who will be assigned in each region to work with BCFS are identified and required to participate in the 20-day pre-service training program.** *(page 80)*

31. **The Bureau Director should actively coordinate the work of each bureau function such as purchase of services, licensing, regional operations and policy-making to assure that consistent messages are sent to the regions and that regional needs are heard and reflected in the decisions of central office.** *(page 94)*

32. **BCFS should actively pursue its plans to implement Total Quality Management.** *(page 94)*

33. **BCFS should develop an automated case record system, giving each worker the capacity to enter and retrieve client data directly. BCFS should consider using one office as a pilot site both to reduce start-up costs and to minimize disruption to the agency.** *(page 95)*

34. **BCFS should assure that one FAX machine per office exists. It should assure that sufficient phone lines are available to serve the public adequately and that voice mail is installed where it does not already exist.** *(page 95)*

35. **BCFS should review, update and codify the policy manuals governing all aspects of child protection and childrens services.** *(page 95)*

36. **BCFS should develop a system of accountability which provides the Commissioner and bureau director ongoing feedback about agency performance and which includes:** *(page 95)*

    A. **Defining performance measures for the agency.**

    B. **Defining performance measures for private providers of direct services.**

C. **Conducting periodic reviews of regional operations which include checks of compliance with agency policy through reviews of case records.**

D. **Generating reports quarterly and writing them up annually to report on progress in attaining agency goals.**

37. **DHS should request funding to enable the implementation of Administrative Review of Child Protective Services cases.** *(page 96)*

38. **The Child Welfare Services Ombudsman position and Office should be funded and reinstated.** *(page 97)*

39. **The Legislature (or Commissioner) should establish a permanent Oversight Committee whose primary purposes are to establish annual goals, provide an ongoing system of feedback to the Commissioner and Director of the Bureau of Child and Family Services, and review recent trends in national and regional systems. The Oversight Committee should provide an annual report to the Director of the Bureau of Child and Family Services, the Commissioner of Human Services, the Legislature, and the Governor. The duties of this committee complement the duties of the Child Welfare Advisory Committee. The Department should consider consolidating these functions under a single committee.** *(page 97)*

40. **The Commissioner should request funding dedicated to providing staff support to the Child Death Review Committee.** *(page 97)*

41. **DHS should advocate for the establishment of a task force to examine the Child and Family Services and Child Protection Act. The Task Force should be established jointly by the Executive Department and the Legislature's Judiciary Committee. Its goal should be to amend the Child and Family Services and Child Protection Act to expedite the Department's mission to support and strengthen families. Aspects of the law to be examined should include:** *(page 98)*

A. **Amendment of 22 M.S.R.A. § 4031, 4051 to allow the District Judge to change venue in order to facilitate Child Protective Hearings.**

B. **Amendment of 22 M.S.R.A. § 4002 to provide for a second standard of jeopardy to allow the court to order services in cases where the higher standard of proof cannot be met but there is still some danger to children and families.**

C. **The issue of rehabilitation and reunification keeping in mind federal mandates and shrinking resources.**

D. **The issue of children in need of supervision.**

42. **Legislation must be initiated to insure that the Department is allowed "standing" as a surrogate parent in the PET process.** *(page 98)*

43. **DHS and the Courts should examine ways to streamline procedures and establish alternative methods of resolving cases. One suggestion would be to use the current administrative case review process to resolve uncontested cases administratively.** *(page 99)*

44. **DHS and the Attorney General's office should continue to clarify decision-making in order to work effectively as a team. The process should include:** *(page 99)*

A. **Assuring that communication continues on a regular and ongoing basis.**

B. **Assuring that consultation is occurring prior to decision-making. This would require advance notice of decisions and communication to the Assistant Attorney General as to the Department's position well in advance of the scheduled proceeding.**

C. **Insure that the system to resolve conflicts is utilized to ensure that conflicts are not left unresolved.**

Interagency Relationships

45. **The Legislature should establish a Department of Children and Families and a Department of Health and Developmental Services.** *(page 104)*

46. **In the absence of such restructuring, the Governor should exert his leadership over the four commissioners who provide services to children to require a single, unified approach to the following:** *(page 104)*

    A. **Children who require residential care but do not have educational needs that cannot be met by the local school district.**

    B. **Children being served by more than one agency.**

    C. **Adolescents who are not in DHS care or custody but who move throughout the residential care system (emergency shelter care; community-based group care or group homes; and transitional living facilities.)**

47. **The Governor and the Legislature should require that the Commissioners of Human Services, Education, and Mental Health and Mental Retardation give priority attention to the establishment of "mutual agreements and specific regulations" which would ensure the elimination of loopholes and inconsistencies in current state statutes and regulations involving children and youth which in fact allow for abdication of responsibility for needed services. Incentives must be provided and creative planning must occur to develop and implement "real" interagency cooperative agreements among all agencies serving children and youth.** *(page 105)*

48. **DHS should negotiate with the Department of Education, the Department of Mental Health and Mental Retardation, and other appropriate state officials concerning the responsibility for identifying and coordinating mental health services for children in need through the school system. Reimbursement for these services should come directly from DHS and the Bureau of Children with Special Needs.** *(page 105)*

49. DHS, in concert with the Department of Education, the Department of Corrections, and the Department of Mental Health and Mental Retardation should advocate for legislative action creating an entitlement to mental health services. State extension of this entitlement should be accompanied by state commitment to pay for it. *(page 106)*

A. **The four agencies should explore whether or not the Americans with Disabilities Act can serve as a method for providing mental health services to children who do not currently demonstrate an educational need. Additionally, the four agencies should explore P.L. 93-112 § 504 as another potential funding source for these services.**

B. **The interagency agreement should incorporate a broader definition of mental health needs based on the behavior of the child exhibited outside the classroom, in the community, and at home, in addition to the child's classroom performance.**

50. DHS should engage in more consistent dialogue between CPS staff and local school and police personnel, especially with respect to "cracking the system" to obtain services for children who are perceived to be at risk and in need of services. *(page 106)*

51. DHS and the Department of Education should encourage the establishment of widely available community-based parenting courses throughout the state. *(page 107)*

52. Over the last decade at least nine Maine studies have addressed improving services to children. The Commissioner of Human Services, who is also the Chair of the Interdepartmental Council, should take the lead in prioritizing the recommendations in this and other recent reports. This should be a joint effort of the Administration and the Legislature which should result in a multi-year plan to address the needs of children and their families.

The conclusion of this effort should be a Blaine House Conference on Children and Their Families convened by the Governor and the Legislature.

Participants should engage in dialogue about the Plan while selected members of the public, the Administration, and the Legislature should finalize a multi-year strategy. *(page 107)*

Finance Issues

53. **DHS should seek federal funds to strengthen the Child Abuse and Neglect Councils (or other designated coordinating organizations) by aggressively seeking to match state expenditures supporting these organizations. The support funds should include the requirement that the designated organizations be able to provide documentation to support the federal claims.** *(page 117)*

54. **DHS should seek to strengthen non-categorical finance for family support.** *(page 118)*

    Options for strengthening these financial supports include:

    A. **Developing a Medicaid "Rehab" option for DHS Child Protective Service clients, similar to that for the substitute care group, and opening Medicaid reimbursement to MSW level clinicians.**

    B. **Expanding use of the "Katie Beckett" funding to allow non-Medicaid eligible families whose child(ren) are in danger of out-of-home placement access to Medicaid supported in-home treatment.**

    C. **Expanding Medicaid Targeted Case Management to include community agencies which serve Department clients.**

55. **DHS should pursue full implementation of the Medicaid Ribicoff amendments.** *(page 120)*

56. **The Department should explore the design and development of a Medicaid "Rehab" option for therapeutic child care.** *(page 121)*

57. **DHS should explore matching Family Crisis Services expenditures ($1,311,022 in fiscal year 92, 85 percent state funded) through the Title IV-A Emergency Services Program. This program has been recommended for elimination in order to reduce state expenditures. DHS must advocate for the restoration of this program.** *(page 121)*

58. **DHS should pursue legislation to codify a requirement that federal funds generated by child and family programs remain available to these programs.** *(page 122)*

A Comprehensive System

59. **DHS should provide adequate base level funding for Child Abuse and Neglect Councils or other appropriate organizations in each of the 16 counties. Funding should be sufficient to enable each organization to hire a full-time executive director. In each county, the chosen organization should be defined as the vehicle for drawing together appropriate community representation to enhance cooperative, community-based attempts to address the issues of prevention, volunteerism, early intervention, combining of community resources, and the design of strategies to address such needs. In addition, the chosen body should design and implement the Information and Referral Service discussed in Recommendation 3, Chapter 2. DHS should have discretion in choosing the appropriate organization in each county to fulfill this role. This funding should be accompanied by specific outcome measures and evaluation criteria to allow the Department to closely monitor the performance of the chosen organizations.** *(page 132)*

60. **The sixteen coordinating organizations, with financial support from DHS, and technical assistance from Project Maine Families, should focus on creating and enhancing their organizational capabilities to enable them to fulfill their roles. These enhancements must include developing the capacity to measure outcome and evaluation criteria required by the Department of Human Services.** *(page 132)*

61. **DHS should initiate any necessary legislative changes required to allow the Child Abuse and Neglect Councils or other appropriate organizations to fulfill these roles.** *(page 133)*

62. **The fundamental goals of the Maine Children's Trust Fund (MCTF) should be reinstated, establishing the Trust's independence from any state agency. The role of the MCTF should be clearly defined, focusing on resource development. Strategies should include promotion of the tax check-off through an aggressive marketing campaign, and the exploration of opportunities to match these revenues through various private and public sector funders. The primary goal of the MCTF should be to build a substantial fund to create a self-perpetuating funding source for prevention focused activities.** *(page 133)*

63. **DHS should pursue statutory actions to reinstate the Board of Directors of the Maine Children's Trust Fund, with the intention of recreating the original intent and structure of the MCTF.** *(page 133)*

64. **DHS should take steps to insure universal prenatal care and to coordinate this program with the strengthening of existing home health visitation programs. DHS should establish a long term goal of strengthening this system to include the full implementation of the Healthy Start Model of home visitation, beginning at the prenatal stage.** *(page 134)*

65. **Recognizing the pressures and need to deal with "crisis" cases, especially when financial and human resource needs are limited, the Department can demonstrate its commitment to the value of preventive programs by designating a fixed proportion of available funds for preventive programs and activities.** *(page 135)*

66. **DHS should explore options for providing pediatric consultants to DHS through the American Academy of Pediatrics Maine.** *(page 136)*

67. **Project Head Start should be encouraged to take full advantage of legislation allowing local grantees to purchase program facilities. This will provide a level of stability which will enhance the Department's ability to expand the health and education components of the Head Start Program.** *(page 137)*

68. **The pre-school and school age Preventive Health Program should be supported in all public schools and all publicly supported pre-school programs. Formal links between PHP and BCFS should exist in all regions.** *(page 137)*

69. **Funding for early intervention activities should be available for non-Department of Corrections, non-DHS children who are in a high-risk environment and in need of group care or other services.** *(page 138)*

70. **DHS should invest in community resources to support at-risk families whose level of risk does not require Child Protective Services involvement. DHS should join in collaborative planning efforts with community service providers and the CAN Councils or other coordinating organizations to facilitate the strengthening of this service network.** *(page 138)*

Chapter 2

Child Protective Services

FINDINGS

- **Referrals to the Bureau of Child and Family Services (BCFS) have risen from 9,240 in 1984 to 16,334 in 1991, an increase of nearly 77 percent.**

- **In 1984, BCFS performed 5,240 Protective Studies, compared to 4,034 in 1991, a decline of 29 percent. Thus, DHS has reduced entry into the system at the same time reports are rising. The absolute number of children and families being served is declining.**

- **In 1991, DHS was unable to investigate 1,152 allegations of abuse and neglect which met intake standards but could not be assigned for investigation due to lack of available staff.**

- **DHS investigates 43 percent fewer children than the national average and has the lowest ratio of number of investigations to number of children in the population among the six New England states.**

- **Families who do not meet the DHS criteria for warranting an abuse investigation generally get no assistance at all with family problems.**

- **Teenagers who are runaways or whom their parents cannot control are consistently screened out.**

- **DHS and law enforcement do not consistently conduct joint investigations when there is reason to suspect that a crime has been committed.**

- **On a limited basis, DHS has begun to enlist the help of others, such as the Portland Police Department, to assist with cases to which it cannot respond, and hospital-based SCAN teams to identify and serve at-risk families. While promising, these efforts are scattered.**

- **While mandatory reporters such as nurses and teachers constitute a far higher percentage of all reporters in Maine than nationally, their reports generally go uninvestigated, creating ill will in the community and jeopardy to children.**

- **The current legal standard of jeopardy does not allow DHS to intervene with services before a family is in full-blown crisis.**

- **DHS' use of confidentiality laws appears to block communication with other professionals, to the detriment of clients, in cases where such communication would indeed be permitted.**

Discussion

The Department of Human Services is legally mandated to protect children from abuse, neglect, and exploitation which occurs within the family, to petition the court for a protection order when children are in circumstances of jeopardy, to give priority to family rehabilitation and reunification, and to promote early establishment of permanent plans for care and custody of children who cannot return to their families within a time frame which meets the child's needs. This includes:

- Assessing allegations of abuse and neglect to determine if children are in need of protection.

- Assisting parents to recognize and fulfill their responsibilities so that their children may remain safely in their own home.

- Providing care and services to children who have been removed from their own homes in order to promote their personal growth and development and preparation for healthy adulthood.

- Providing for and coordinating services so that, when families are rehabilitated, children can safely be returned to their own homes.

- Assuring permanency in an adoptive home or other permanent placement if the custodial family cannot be preserved without serious risk to the child.[3]

Within the Department of Human Services, the Bureau of Child and Family Services is the organizational unit which performs these functions. In this chapter we address these functions of Child Protective Services: Intake Screening and Assessment, Intake Study, and Continuing Protective Services. Much of the controversy surrounds these functions: who the agency screens in and out and what processes are used and services provided to those who are screened in.

Referrals and Screenouts

When the Department of Human Services receives a telephone call from either a mandatory reporter such as a school teacher or doctor, or a member of the public alleging a family problem, i.e., a referral, intake workers in each region gather facts to determine whether the problem presented is appropriate for a Child Protective Services intake study.

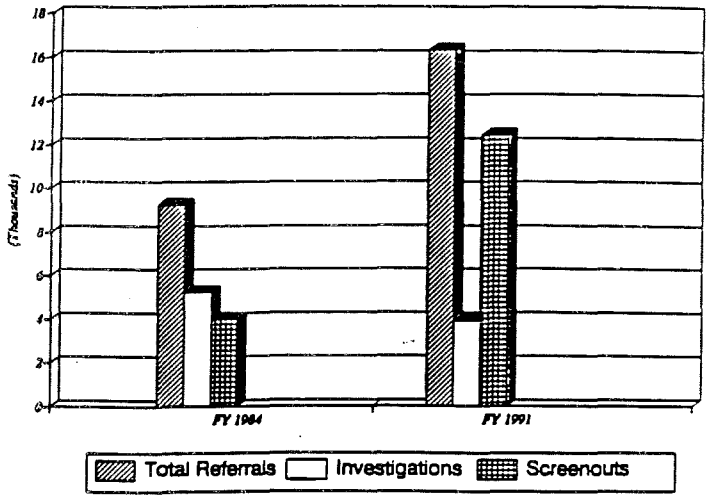
When calls come in after hours on the 800 line they are answered by Childrens Emergency Services in Augusta. If immediate action is required, an on-duty worker in the region is contacted. The Department defines a referral as any written or verbal request for Child Protective Services intervention in a family situation on behalf of a child in order to assess or resolve problems being presented. This decision-making process includes obtaining information from the initial reporter and locating and reviewing previous child welfare records regarding the family and alleged perpetrator. When the referral indicates an "immediate risk of serious harm" the intake worker immediately contacts the Child Protective Services Supervisor because these reports are supposed to be investigated immediately, at least on the same day they are received. All other valid referrals, i.e., those alleging risk of serious harm, risk of harm, or potential for abuse and/or neglect, are supposed to be delivered to the supervisor on the same day they are received. All reporters/referrants are supposed to be informed of the assessment decision.

[3] "FY 91/93 State Child Welfare Services Plan," Bureau of Child and Family Services, Augusta, ME, 1991.

The Department of Human Services records all reports as referrals and all reports that are not investigated as screenouts. Many other human services agencies do the same, while others record only referrals in which there is an abuse or neglect allegation. Even if Maine were to record more non-abuse related referrals than other states, and thus have a higher screenout rate, the other data here show that Maine conducts fewer abuse investigations on a per capita per child basis than all the other New England states and far fewer than the nation as a whole. Further, the Department is conducting fewer investigations on both an absolute and a percentage of referral basis than it did in years past.

In 1984 DHS received 9,240 referrals and opened 5,240 protective studies, a screenout rate of 43 percent. In 1991 DHS received 16,334 referrals and opened 4,034 protective studies, a screenout rate of over 75 percent. Referrals grew by nearly 77 percent from 1984 to 1991 and the screenout rate increased by more than 75 percent. A substantial increase in the screenout rate is not unexpected, given the increase in referrals; however, the decline in investigations from 1984 to 1990 suggests that too many cases which warrant investigation are being screened out.

SCREENOUT DATA[4]



Maine has the third highest population of children under 18 in New England, but ranks fifth of the six New England states in number of child protective investigations, and last in terms of the ratio of number of investigations to number of children.[5]

[4] Ibid. p. 3.

[5] "Working Paper #1 1990 Summary Data Component," National Center of Child Abuse and Neglect, U.S. Department of Health and Human Services; April, 1992.

MAINE REFERENCE GROUP[6] RATIO OF INVESTIGATIONS TO NUMBER OF CHILDREN				
State	**Pop.< 18**	**Investigations**	**# Inv.:# Children**	**% Substantiated**
Rhode Island	225,690	12,209	1:18 (5.8%)	31.3 (3,821)
Massachusetts	1,353,075	32,434	1:42 (4.3%)	55.0 (17,839)
New Hampshire	278,755	5,031	1:55 (3.4%)	15.8 (795)
Vermont	143,083	2,580	1:55 (1.9%)	48.5 (1,251)
Connecticut	749,581	11,145	1:67 (2.6%)	74.5 (8,303)
Maine	**309,002**	**4,034**	**1:77 (1.3%)**	**52.6 (2,138)**
United States	63,503,692	1,368,569	1:46 (4.3%)	35.4 (484,473)

Maine conducts one child protective investigation for every 77 children compared to Massachusetts which conducts one child protective investigation for every 42 children. The national average is one protective investigation for every 46 children. In 1990, the rate at which Maine conducted abuse/neglect investigations was two thirds of the national average. Comparing Maine ratios over time reveals a 23 percent decline in investigations between 1984, when DHS conducted 5,240 investigations, a ratio of one investigation for every 59 children, and 1991, when DHS conducted 4,034 investigations, one investigation for every 77 children.

While the Department[7] is correct in the assertion that community standards may be out of step with statutory definitions of abuse and neglect, the fact that DHS is performing fewer investigations per capita than most states and conducts fewer investigations now than it did five years ago, cannot be overlooked. Maine's community standards are probably similar to those of other states. Its ability to respond is not.

Because a referral is screened out does not mean the Department itself does not see even the potential for abuse and neglect to be present. "The Department's ability to respond to referrals of child abuse or neglect is based on factors such as the number of caseworkers, the seriousness or complexity of the cases receiving services and the availability of resources. Current staff resources are not sufficient for the Department to

[6] Ibid.

[7] Correspondence to John Rosser, January 2, 1992.

assign all of the referral for child Protective Services it receives."[8] Because many of the caseworkers who investigate also provide services to the families whose cases are opened, investigation decisions are influenced by existing caseloads.

The Department describes the 12,300 screenouts in 1991 as "...situations with evidence of serious family problems or dysfunction but did not contain serious allegations of child abuse or neglect."[9]

DHS supplied the following breakdown of 1991 screenout data:

1,658 Parent/child conflict: Children and parents in conflict over family/school/friends/behaviors with no serious allegations of abuse or neglect. Includes adolescents who are runaways or who are exhibiting acting out behaviors that *parents are unable to control.*

4,262 Non specific allegations of marginal physical/emotional care which is not considered serious enough for CPS intervention.

1,008 Conflicts over custody and/or visitation of children which may include allegations of marginal/poor care which is not considered serious enough for CPS intervention.

1,091 Families in crisis due to financial, physical, mental health, or interpersonal problems but there are no serious allegations of abuse or neglect.

3,129 Other: This category is a catch all for a variety of other kinds of cases where individual categories would be numerous and the numbers within those categories would be relatively small.

[8] "Maine Department of Human Services Bureau of Child and Family Services Child Protective Services: Annual Report 1991," p. 1.

[9] "Maine Department of Human Services Bureau of Child and Family Services Child Protective Services: Annual Report 1991," p. 1.

1,152 *Insufficient staff: The allegations would normally warrant Child Protective Services intervention but are not assigned because the office has reached the upper limits of its capacity to investigate and assess. These cases may be relatively less serious, receiving services from other social service agencies, or continued to be at lower risk of continued maltreatment. (Emphasis added)*[10]

In the first four categories of screenout above, children and families are suffering from some form of difficulty that has not been specifically linked to child abuse and neglect. In our current system there is no mechanism, including an information and referral process, for communities to respond to reports which may not be detailed or specific enough to warrant a further look by DHS caseworkers. One exception is the recently established Children's Response Program in Portland where designated police check in on families where the allegations do not appear to be as serious as in other cases. In the last category above, the allegations *do meet all Department standards but still go unseen because workers are considered to be overburdened with existing cases.*

One of the screenout categories, "adolescents who are runaways or who are exhibiting acting out behaviors that parents are unable to control" is particularly troubling in that few if any community services are available to this group except shelter care in some circumstances. DHS reports that these children do not fall under the statuatory responsibility of the Department. DHS spokespersons also pointed out that, "Unfortunately they are no one else's responsibility either." Community providers report that many runaway adolescents are beginning a pattern of homelessness, drug use and delinquency that badly need the coordinated attention of the state. Until they have committed a crime, these youth represent a terribly underserved segment of the child population in Maine.

During interviews conducted in April and May of 1992, Regions I through V each reported increases in screenout rates. Region V reported a screenout rate of 90 percent (as opposed to a norm of 75 percent from October to December of 1991). Coupled with this continued rise in screenouts is a growing use of the code I.S. (insufficient staff). I.S. cases are referrals that warrant assignment and investigation but are not assigned due to staff workloads.

[10] "Maine Department of Human Services Bureau of Child and Family Services Child Protective Services: Annual Report 1991," p. 3.

In the Machias office (Region IV), the Child Protective Services supervisor makes all screening and assignment decisions. His intake workers receive calls and transcribe information which is forwarded to him for decisionmaking. This technique allows this supervisor to control his workers' caseloads.

Region II assigns non-emergency cases on a *weekly* rather than a daily basis. The regional manager reports that this system allows the region to choose and assign the most critical cases more proactively and avoid a constant state of "crisis response" case assignment.

The Oversight Committee attributes the decline in investigations conducted to several factors: a conscious decision by Regional Managers to keep caseloads at consistent, reasonable levels despite the increased demand; the need to prioritize and therefore take only the more difficult cases which are more time consuming; the elimination of paralegals and reduction in case aides which means that the caseworkers themselves have to assume tasks which they were able to delegate to others in the past; the reduction in work week, the shutdown days and furlough day requirements which make the absolute time available to do the job far less than it once was; the growing difficulty in operating without up-to-date tools such as computers and fax machines.

Calls that do not meet established standards for abuse and neglect could be removed from the screenout statistics if they were handled in another way, such as referred to local county-based coordinating bodies for other forms of family assistance. It is clearly important to record and report these 12,300 calls, because non-specific allegations now may escalate to specific allegations later. However, treating these calls with the same weight in screenout statistics as the legitimate allegations of abuse and neglect that the Department was unable to investigate encourages the public perception of DHS failure. In fact, the screenout rate of legitimate allegations of abuse and neglect in 1991 was 28.6 percent, not 75.4 percent.

Intake Study

Once the Department decides to investigate, its Child Protective Services workers conduct an Intake Study, the purpose of which is to determine:

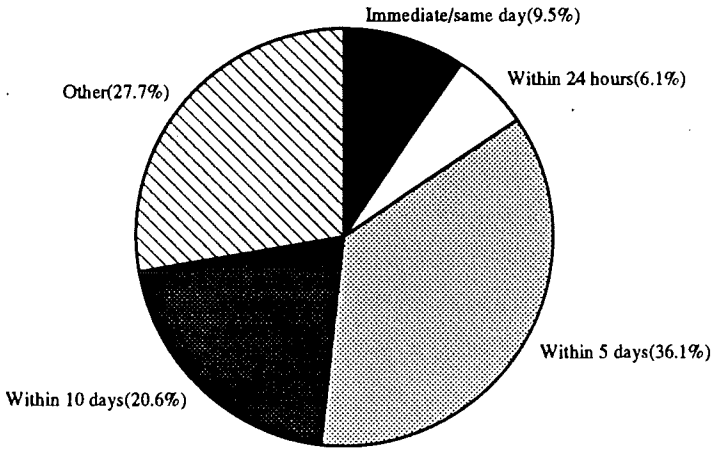
- Whether a referral/report is substantiated/not substantiated.
- The extent of harm/level of risk for each child in the home.
- The immediate steps/resources necessary to assure the safety of the children.

The guidelines used by workers to determine how quickly to conduct the Intake Study are:

- Immediate risk of serious harm: Immediately/same day;
- Risk of serious harm: Within 24 hours;
- Risk of harm: Within 5 days;
- Potential for abuse/neglect: Within 10 days.

In 1991 the Department classified less than 10 percent of the cases as immediate risk of serious harm, requiring immediate response. An additional 6 percent received responses within 24 hours. Nearly half the cases, 48 percent, were seen within 10 days or "other."

RESPONSE TIME FOR CASES OPENED FOR ASSESSMENT[11]



[11] "Maine Department of Human Services Bureau of Child and Family Services Child Protective Services: Annual Report 1991."

"Risk assessment" guidelines have been developed for workers to use in conducting the investigations; this is a trend nationally. DHS hopes to be able to extend the use of the tool throughout the decision-making process, beginning at intake and extending through the decision to close a case. South Carolina has adopted such a system called the Model for Casework Practice. Vermont, Oregon, California and Colorado also have systems designed to use throughout the life of a case.

Workers are provided with a set of worksheets, assessment forms and inventories related to family and environmental factors, parent/caregiver factors, child factors, intervention factors and maltreatment factors. These materials help the worker to determine not only whether the abuse occurred, but also whether it is likely to recur based, in part, on an assessment of family strengths as well as deficits. While there is national debate about the use of risk assessment, because not all the criteria constitute statistically valid predictors of future abuse, there is general consensus that these tools help workers to organize their assessments and develop service plans when a case is opened. In Maine the developers of the tool want it to be widely applicable, easily useful and, equally important, not a new, burdensome paperwork requirement. They want the tool to help standardize decision-making. Currently the Child Welfare Training Institute introduces new caseworkers to the theoretical foundations of risk assessment and the practical application of the Department's tool during preservice training. The tool is being gradually introduced in the field. In Region V, for example, all caseworkers reportedly use it. There will no doubt be periods of refinement and revisions before full implementation.

An investigation results in a finding about the presence or absence of abuse and/or neglect. In 1991, of the 4054 cases open for investigation, *no finding whatever was recorded in 20 percent of the cases*[12]. In 23 percent, the case was unsubstantiated in that no maltreatment was found and, in 10.8 percent, the case was unsubstantiated with a finding of "potential for abuse and neglect." The major finding (unduplicated count) in the remainder of the cases was neglect which includes emotional abuse, lack of supervision, abandonment and the deprivation of necessities (16.5 percent); minor physical injury (15.3 percent); sexual abuse (12.8 percent); and major physical injury (1.2 percent). These figures represent 520 children who were sexually abused and 47 who were the victims of major physical injury.

[12] Ibid. Run date 4/8/92.

The most prevalent family stress factors identified by the caseworkers were family violence/assaultive behavior (identified 1022 times); alcohol and/or drug misuse by parent or caretaker (identified 843 times), parent/child conflict (identified 772 times) and mental or physical health problems of the parents (identified 765 times).

One of the trends in child welfare nationally and, to some degree in Maine, is a growing use of law enforcement to assist with investigations of child abuse, especially when there is reason to believe that the allegation constitutes criminal activity, such as sexual abuse or major physical injury. The Children's Response Programs in Portland and Lewiston established formal cooperative arrangements between the Police and the DHS regional offices. Currently, the Children's Response Programs perform a supportive role, conducting visits and assessments of allegations of abuse and neglect that are not being investigated by the Department. This program, as it is currently constituted, provides an important safety net for DHS and children and families. This joint venture allows BCFS to more fully meet its mandate of investigating all legitimate allegations of abuse and neglect. Second, and more importantly, the Children's Response Program provides a model for expanded cooperation between DHS and law enforcement which should be expanded throughout the state and should include all investigations in which there is suspected criminal activity. Including law enforcement at the beginning has many benefits in addition to providing some protection to the worker in potentially dangerous situations. It sends a message to the family that children have rights under the law which will be protected. It helps to separate the investigating side of abuse from the helping side, freeing the worker to concentrate on the family risk factors and the needs of the child. It relieves the worker of collecting physical evidence and provides assistance in preparing for court, should that be necessary. Several states provide models for joint CPS/Law Enforcement investigation of child abuse and neglect allegations. Appendix D provides two examples.

A second trend nationally, which again exists to some degree in Maine but should be expanded, is the use of hospital-based SCAN Teams to assist in the identification of abused and neglected children, and in the assessment, treatment planning and service delivery processes. SCAN Teams currently exist in 13 Maine hospitals but do not all function at the same level. BCFS reports that in many hospitals SCAN Teams are "virtually powerless" due to lack of administrative and physician support. SCAN Teams as defined are multidisciplinary; they should include a SCAN social worker, and a medical diagnostic team which can include doctors, nurses, physician assistants or other relevant professionals. They employ a team approach in the assessment, diagnosis, and manage-

ment of child abuse and neglect. Richard Krugman, M.D. lists the following advantages of a hospital-based child protection team in *The Battered Child:*

1. The incidence of repeated abuse, serious injury, and death decreases;
2. Hospitals can more consistently fulfill their obligation to report suspected cases of abuse and neglect;
3. The presence of a team increases the case finding and reporting within the hospital;
4. More appropriate treatment plans are developed for the child and the family;
5. The preparation of expert witnesses and other testimony for court improves;
6. Interagency cooperation improves;
7. Frequent team meetings become a source of continuing education for the professionals who attend regularly.[13]

Currently, the SCAN Team role in Maine is largely limited to referral of suspected cases of abuse and neglect.

The current relationship between DHS and SCAN Teams is all too often one where the SCAN Team simply makes a report with limited interractive discussion. This is often the result of inadequate communication between DHS and the SCAN Team and results in decreasing the potential effectiveness of the SCAN intervention. Because SCAN Teams are professional, multidisciplinary teams they can provide a valuable service by helping the Department to prioritize the severity of cases identified by the SCAN system, as well as by providing a supplemental diagnostic and treatment resource. *Not only is there recognition that not all identification, assessment and treatment resources lie in the Department, but also there is tangible support to workers and families in fulfilling the mandate of protecting children and supporting families. SCAN Teams constitute a community-based response.*

The Oversight Committee supports formal cooperative efforts between DHS and local Police Departments, and expanding these cooperative efforts to include joint investigation in instances where the allegation may involve criminal conduct. In addition, the Oversight Committee supports the expanded funding and utilization of SCAN Teams in Maine hospitals.

[13] Krugman, R. cited in Helfer, R., and Kempe, H., Ed. *The Battered Child, 4th Edition, Revised and Expanded,* University of Chicago Press, 1987, pp. 134-135.

Continuing Protective Services

Continuing protective services are provided when one or more children remain in the home and are in need of protective services. Cases are to be reviewed every three months. The case records should contain:

1. Succinct assessment of progress toward solving problems and accomplishing the case plan.
2. Objective (continued or changed including reasons).
3. Case plan with purposes, time frames for completion of activities and specifications of who is responsible for what.
4. Agency decision whether children are safe, including specific reasons/ factors.

Failure or disruption of continuing protective services generally involves removing the child(ren) from the home in order to guarantee his/her safety. Intensive Family Based Preservation Services (IFPS) may be brought in at this point to attempt to avert the imminent removal of the child(ren). The Child Welfare League of America stipulates that these services should be used to:

> ...provide intensive counseling, education, and supportive services to families in serious crisis, with the goal of protecting the child, strengthening and preserving the family, and preventing what would be an unnecessary out-of-home placement of children, or promoting the return home of children temporarily in out-of-home care.[14]

Currently, intensive, family-based preservation services are delivered by nine private organizations which contract with DHS, Department of Mental Health and Mental Retardation, and the Bureau of Children with Special Needs, (DMHMR). Their service catchment area extends roughly from Portland to Caribou on the North-South axis and form Rockland to Lewiston on the East-West axis. All nine programs are currently unable to meet the service needs of all the families referred to them.

[14] *Standards for Services to Strengthen and Preserve Families and Their Children,* Child Welfare League of America, Washington, D.C., p. 47.

DHS has proposed adding to the existing service network by creating a parallel network of intensive family-based preservation services delivered by DHS employees.

The nine contracted IFPS programs in Maine use a model that entails 3 to 4 hours of direct client interventions per week for a period ranging from nine to thirteen weeks. Caseworkers carry caseloads of five families and generally deliver an average of 20 hours of direct client services per week. All nine agencies utilize a team model of service delivery with a team of two counselors assigned to each case. This model differs from the Homebuilders model, outlined in Appendix E, in both length of treatment and duration of services. Despite these differences, the programs are similar in that they focus on in-home intensive service delivery and on attempting to avert foster care placements.

The existing home-based family services network represents a successful collaboration between the Departments of Human Services, Mental Health and Mental Retardation and the Bureau of Children with Special Needs. Unfortunately, the Department of Corrections no longer participates due to cutbacks in funding.

Family preservation programs exist in a number of other states. Appendix F contains information on these programs.

Preventing foster care placements has both direct and indirect benefits. Every placement averted results in a placement opportunity for a child in greater need. Equally important, the averted placement results in a unified, healthier family. Oregon is attempting to fund new IFPS by returning home children who are in foster care due to mild physical abuse and using the savings in foster care payments to fund the IFPS.

RECOMMENDATIONS

1. **DHS should fully investigate every allegation of abuse and neglect which meets current screening standards to determine if the child(ren) can remain safely in the home either with or without the provision of services.**

DHS managers have determined that they cannot further erode the services their workers provide by increasing the workers' caseload in order to accommodate the rising number of abuse reports. Consequently, they have devised a code of "insufficient staff" as the reason for not investigating some allegations and formally assign this code to the report. This practice is unacceptable to the Oversight Committee.

Our analysis of the current caseloads, both for Child Protective Services and for Childrens Services, is that while they may be above an ideal standard established by national organizations such as the Child Welfare League of America, they are in fact consistent with national averages of 24 cases per protective worker and 28 cases per children's services worker. We concur that to preserve any semblance of service provision it would be a mistake to raise the caseloads. However, various circumstances and practices within the agency already erode the ability of workers to have sufficient contact with their clients, even with the current caseloads. These include the furlough days, the lack of case aides, paralegals and clerical support, and the totally antiquated means of handling information via telephones, computers, fax machines, and dictation equipment.

Therefore, to make this recommendation possible, the following steps are required:

A. **DHS should seek, as priority one, to have Childrens Emergency Services workers and Child Protective Services workers exempted from furlough days. DHS should seek, as priority two, to have Childrens Services workers exempted. This change will allow more time for current staff to perform the functions they are being paid to perform.**

B. **DHS should reinstate the case aides and paralegals whose positions have been cut due to budgetary pressures. In addition, DHS should seek authorization for 12.5 additional case aides and 5 paralegals to meet a standard of one case aide for every two units, and one paralegal for every region.**

According to a line list of staff issued by BCFS in December 1992 there were 458 authorized line positions of which 433.5 were filled and 24.5 (5.3 percent) were vacant. There are 53 units, 14 case aide positions and 1 paralegal-assistant position. If each of these were filled, we are recommending the addition of 12.5 case aide positions and 5 paralegals.

C. **If, after one year, implementation of the recommendations above do not allow for the investigation of all legitimate allegations of abuse, DHS should seek authorization to hire 10 additional caseworkers including 8 Child Protective Services workers and 2 Childrens Services workers.**

Currently each protective services worker investigates on average 25 cases per year and carries an average caseload of 24 cases at any one time. Last year 28 percent of all bona fide reports of abuse were not investigated. If no other changes in efficiencies were made, the Department would have to add 22 protective services staff to maintain current caseloads and handle all abuse investigations. However, if the case aides and paralegals recommended above were added, and the protective caseworkers could increase investigations to 33 per year, then only 8 additional caseworkers would be required. The two new children's services workers are needed to handle the increase in open cases expected from the increase in investigations.

2. **DHS should determine after one year if the Children's Response Programs in Portland and Lewiston (in which the police check into low priority abuse/neglect allegations) should be continued and/or expanded into other communities throughout the state.**

The Children's Response Programs strengthen the early intervention network and compensate for the Department's inability to fully investigate all cases. Police officers support DHS by conducting what are essentially screening investigations of referrals that are on the border of qualifying for CPS investigation. They provide the Department with a resource to help prioritize the severity of possible cases of abuse and neglect, freeing Departmental personnel to fully concentrate on higher risk cases.

3. **DHS should establish an Information and Referral Service in cooperation with the expanded Child Abuse and Neglect Councils or other organization designated in each county to plan for coordinated services.**

This recommendation creates an integral piece of a community resource and support network. DHS, in cooperation with the Child Abuse and Neglect Councils, or other designated county body, should design and implement an information and referral network capable of directing callers to appropriate resources and service providers in their communities. The effectiveness of the information and referral service is dependent upon the implementation of recommendations relating to strengthening and supporting the chosen coordinating organizations and local service networks. (See Chapter 8.)

4. **DHS should not screen out abandoned teenagers who meet the intake criteria for abuse and neglect. These teenagers are often chronically, episodically homeless and are beginning a life pattern of episodic homelessness. Unless increased attention is paid to this group of Maine citizens, the prospect of them remaining on the welfare rolls throughout their adult lives weighs heavily as a possibility.**

This age group has suffered during the current fiscal crisis due to the perception that their needs are less acute than those of younger victims. While perception may be true vis-à-vis infants in terms of immediate life-threatening circumstances, these needs have to be planned for and accommodated nonetheless. The problems of this age group are exacerbated by the recently implemented Rights of Recipients, which allow children age 14 and older to refuse services. This is another instance where planning and coordinating resources of a strengthened local services network would benefit the Department. Coordinated mobilization of local resources may help to meet some of the needs of this age group. This age group, many of whom are runaway or throwaway children, are an excellent target for community-based intervention. These teenagers present an excellent opportunity for the Department to interact with local communities in creating local solutions.

5. **Child abuse investigations, in which there is a reason to believe a crime has been committed, should be jointly investigated by law enforcement and DHS. The role of law enforcement is to determine if an arrest is warranted, and/or to facilitate a six-hour hold in order to protect a child who is at immediate risk of serious harm. The role of the DHS caseworker is to assess the risk to the child and the needs of the family. Whenever possible, these investigations should be conducted by established teams. These teams should meet regularly, train together from both child protective and law enforcement perspectives, and develop their mutual roles to have maximum impact.**

   A. **Information sharing between law enforcement and DHS should be worked out in memoranda of agreement which aim at removing confidentiality barriers and promoting a cooperative effort.**

   B. **In urban areas, one or more specific police officers should be assigned to work in the area of child abuse. In rural areas, either the sheriffs' departments or an expansion of the State Police Detec-**

tives assigned to do investigations for the D.A.'s offices should be assigned this duty. Thus, for all areas of the state there should be specific identifiable law enforcement personnel assigned to child protection.

C. **Standard recommendations, standard reporting procedures, and standard policies should be developed between DHS and law enforcement *and followed.* An up-to-date DHS organizational chart with the proper chain of command and phone numbers should be supplied to all law enforcement agencies in the state.**

Specifically, DHS and law enforcement should conduct joint investigations of all reports of abuse that may entail a criminal offense. Agreements in every community must be established detailing how such investigations will be handled. Law enforcement officers (police in large towns and state police in rural areas) should be designated as child abuse specialists and receive training with child protective caseworkers.

The Committee recommends that the formal cooperative process which occurs between DHS and the Portland Police Department in the Children's Response Program be utilized as a model for statewide implementation of these recommendations. This is a daunting challenge for the Department and will be more problematic in rural areas than in towns with established police forces. The state of Florida provides an excellent model for both rural and urban joint investigations. The Florida Department of Law Enforcement (a state police force) has six child abuse investigators. These investigators serve as both trainers and investigators. In rural areas these investigators are available as consultants or to serve as the primary investigator at the request of the local law enforcement agency. The major benefit of joint investigation is the ability of the police to do a thorough criminal investigation at the same time the DHS caseworker is focusing on assessing the needs of the child and family. Joint investigation allows the caseworker to function in a therapeutic rather than investigatory role, allowing the caseworker immediately to begin building trust with the family. In appropriate cases, joint law enforcement/CPS investigations facilitate the best use of the resources of both CPS and law enforcement.

6. **SCAN Teams should be funded in all Maine hospitals. DHS should establish a formal liaison with each SCAN Team in order to gain the maximum benefit which the SCAN Teams represent. SCAN Teams should identify, report, assess and work with high-risk families.**

This recommendation echoes a recommendation made in a 1987 report to the legislature on the implementation of the Suspected Child Abuse and Neglect Program (SCAN) Program. Among the recommendations in the report, two stand out:

1. Long-term funding of similar programs within every hospital and ambulatory care facility in Maine.

2. Continued funding for Coordinator's salary, ongoing training and expenses.[15]

Formal liaisons and cooperation between DHS and SCAN Teams can provide a valuable pre-screening resource, and additionally provide an expanded ability to intervene with at-risk families. Where DHS and the SCAN Teams have developed positive working relationships, the benefits have been evident to both sides. SCAN Teams provide a mechanism for operationalizing the concept of community coordination and involvement in not only detecting but also treating abuse and neglect as family problems.

7. DHS should review its policy regarding the investigation of cases referred by mandatory reporters in which the reporter strongly affirms that the case should be investigated. DHS should give more weight to the professional judgment of mandatory reporters and always inform them of the disposition of their report.

Two factors support this recommendation. The first is that if a cooperative relationship can be maintained with mandatory reporters, the mandatory reporters can perform an important pre-screening function for the Department. Testimony from a SCAN Team member to the Oversight Committee furnished an example of an existing cooperative relationship in this area.[16] This SCAN Team has established a relationship with the regional DHS office in which the SCAN coordinator, while fulfilling his/her role as mandatory reporter, is free to give his/her opinion to the intake worker about the level of risk of a specific report. Secondly, DHS needs to treat mandatory reporters as members

[15] "Report to the Legislature on the Implementation of the Suspected Child Abuse and Neglect (SCAN) Program," February 23, 1987, p. 4.

[16] Testimony to the DHS Oversight Committee, September 23, 1992.

of a network with common goals. By seeking cooperative relationships, and allowing the mandatory reporters to expand their roles, DHS will be able to accomplish more with limited resources. Conversely, treating the network of professionals as if they have no credibility or special knowledge historically has damaged community relationships and promoted the isolation of the Department.

8. **DHS should establish detailed working agreements with cooperating agencies and organizations such as District Attorneys, SCAN Teams, schools, and law enforcement agencies. The purpose of these agreements is to promote collaboration, respectful sharing of information, and/or joint decision-making. The Children's Response Program in Portland provides excellent examples of formal cooperative agreements that have led to a strong working relationship at the community level.**

Formal protocols will constitute the first step to building working relationships with mandatory reporters. These agreements will allow all parties in this network to determine reasonable standards for interaction. The protocols should list the responsibilities of all parties, including referral procedures and DHS notification procedures. An important element in expanding the role of mandatory reporters is expanding the level of DHS cooperation. DHS must assume the responsibility to keep mandatory reporters informed of the disposition of their referrals and the reasoning behind it. Many states do this routinely by mail. Protocol standards will open the door to more informal and team-oriented cooperation in the future.

9. **DHS should seek legislative amendment of 22 M.S.R.A. § 4002 to provide for a second standard of jeopardy to allow the court to order services in cases where the current jeopardy standard cannot be met but where there is clear danger to the child and family.**

A standard of risk below the prevailing 'jeopardy' standard would allow DHS to intervene with and recommend services to families prior to a crisis which meets the jeopardy threshold. Department involvement at this level would allow DHS to be a service resource to families who currently can refuse services without legal intervention. This tier would not trigger an explosion of investigations; its primary aim is to allow the Department to pursue actively earlier intervention for families in crisis, before the presenting crisis reaches the jeopardy threshold.

A revised jeopardy standard will provide the legal framework for court ordered intervention in child welfare cases which demonstrate high levels of risk but fail to meet the current standard. The efficacy of a revised standard is dependent on increased DHS support of the network of prevention and early intervention providers. The establishment of a third tier of risk fits with a stronger Departmental commitment to prevention and early intervention as strategies to combat abuse and neglect.

10. DHS should examine its compliance with the confidentiality laws to make sure that communication is occurring as fully as allowed by law.

It is apparent to the Oversight Committee that the statutory language of the confidentiality laws allows more open communication and sharing of information between DHS and cooperating agencies and providers than sometimes occurs. DHS should be commended for its concern regarding client confidentiality; however, it must guard against the potential problem of not maximizing the benefits to clients by the inappropriate withholding of information. The importance of full disclosure of information to parties involved with the family for legal or therapeutic reasons is clear: effective treatment or problem resolution cannot occur without an open exchange of information. States such as Oregon have developed a confidentiality matrix (see Appendix G) to guide staff in what they can disclose.

11. DHS should work with existing Intensive Home Based Family Preservation Services Providers to strengthen the existing service network as it proceeds with implementing such services in-house.

The Oversight Committee endorses the guiding principles of Family Preservation and urges the Department to make the strongest possible commitment to maintaining children in their own homes when their safety can be assured. The Department wants to incorporate these principles and models among in-house staff, in part to help change the orientation of staff from an investigative to a family support model. While the Oversight Committee endorses the goal, it has several concerns. First, all reasonable efforts should be taken to insure that the in-house program DHS is proposing complements and strengthens the existing network. The client mix in a new program coming on line is likely to be very similar to the client mix in existing programs. The Department and agencies must work closely to determine the grounds for assigning cases. Second, the integrity of the model, which includes tiny caseloads, must be maintained; in-house staff cannot be diverted to other functions. Third, the cost versus benefit must be calculated; is it cost efficient to use in-house staff as opposed to purchased services, including in the

calculation the added benefit of re-orienting staff to family support (i.e., this is not strictly a cost question, if other benefits can be derived). Ultimately, the potential savings that result from reduced out-of-home placements and the ability of these programs successfully to intervene to strengthen and keep families together makes expansion of these services a promising direction regardless of the delivery method.

Chapter 3

Childrens Services and Substitute Care

FINDINGS

- **The number of open protective cases declined from 7,862 in 1987 to 6,675 in 1992, a reduction of 15.1 percent. During this same period, the number of children in DHS care or custody declined from 1,834 to 1,763, a decline of 3.9 percent.**

- **Timely evaluation of medical, psychological, developmental and behavioral issues is not routinely afforded to all children entering state custody.**

- **The quality of care for children in the substitute care system is compromised by the shortage of appropriate foster homes and the lack of sufficient treatment resources.**

- **Foster parents do not routinely receive needed information about a child being placed in their home including medical, diagnostic and case planning information.**

- **Foster parents and other substitute care providers are not consistently recognized as key members of the treatment and care teams.**

- **DHS does not have fully developed standards of care for all levels of the substitute care system.**

- **DHS does not employ a consistent and objective method of handling board rate discussions for children who present special needs.**

- **Training opportunities, support and respite care for foster parents require continued development.**

Discussion

When DHS assumes care or custody of a child(ren) through a voluntary agreement or court proceeding, the case is transferred to Childrens Services. If a child requires substitute care, Childrens Services locates a placement, assesses needs of the child, develops a plan of care, and arranges visitation.

Childrens Services workers participate with children, their parents, foster parents, service providers, and the courts in developing case plans. Childrens Services is responsible for the physical and psychological maintenance of children in the substitute care system, including group care, transitional living, emergency shelters, and for children in long-term substitute care, i.e., when the placement is intended to continue until the child becomes 18 years old, unless altered or terminated in the best interests of the child.[17]

The identified goals for substitute care services are:

1. To provide safe quality care and services to children who have been removed from their homes.

2. To promote rehabilitation and reunification with children's own families for children who can safely return to their families.

3. To ensure that care and services to children in legal custody, to child victims or children at risk of abuse and neglect and to their families are provided in compliance with statutory mandates and are consistent with department policy and good casework practice.

[17] 22 M.S.R.A. § 4064A, 1.

4. To promote early establishment of permanent plans for care and custody of foster children who cannot be returned to their parents.

5. To increase the availability, accessibility, and receipt of independent living services by youth in care, ages 16 and older, in preparation for adulthood.

6. To assure optimal services for children whose permanent placement will be adoption.[18]

The Department is legally mandated to attempt to reunify the children with their natural parents. The decision to return a child(ren) home is made by caseworker and supervisor. The court needs to approve reunification plans. DHS does not need court authorization to halt reunification. The Regional Program Manager must approve the return of custody to the parents. The Oversight Committee observed problems with the Department trying to fulfill the reunification requirements without sufficient work being done with the family to make return home a safe or realistic plan for the time being.

The table below illustrates the changes in BCFS caseloads for children in various statuses from fiscal year 1987 to fiscal year 1992. The number of protective cases served during this period declined by 15.1 percent while the number of children in DHS care or custody declined less than 4 percent. In 1987 children in substitute care made up 23.3 percent of the overall caseload compared to 26.4 percent in January 1991. The Department has reduced its overall load of open protective cases (although FY 92 does demonstrate a change in this trend); however, the number of children in custody has remained relatively constant. Substitute care tends to be more costly than open protective services due to the monthly maintenance costs. Further, the Department reports that an increasing number of children require placements which are more costly than traditional family foster care due to the special needs of the children. These numbers suggest that it is more difficult to move children to a permanent placement (return home or adoption) once they are in substitute care than it is to keep them out of care in the first place.

[18] "State Child Welfare Services Plan," Bureau of Child and Family Services, Sept. 11, 1990, p. 20.

PERCENT CHANGE IN CHILDREN SERVED BY PROGRAM[19]				
Measure	**Jan 87**	**Jan 90**	**Jan 92**	**% Change 87-92**
Protective Cases Served	7,862	6,192	6,675	-15%
Children in Substitute Care	1,834	1,767	1,763	-4%[20]
Freed for Adoption	94	102	79	-16%
Adoption Finalized	81	90	85	5%
Children Returned Home	288	278	275	-5%
Children in Care > Age 18	229	227	231	1%

Comparing Maine to the other New England states in terms of children per 1,000 in substitute care, we find Maine to be third lowest out of six. According to American Public Welfare Association Data (APWA Voluntary Cooperative Information System, 1982, 1988, p. 5), Maine appears not to be overly aggressive in removing children.

SUBSTITUTE CARE POPULATION PER 1000 CHILDREN, NEW ENGLAND	
State	**Rate Per 1000**
Connecticut	4.82
New Hampshire	5.43
Maine	5.99
Massachusetts	7.09
Vermont	7.27
Rhode Island	11.17

While public attention has focussed on difficulties in Child Protective Services, the Childrens Services program faces similar problems. According to statewide interviews

[19] "Child and Family Services Objective Monitor Report," BCFS Information Systems Unit.

[20] Appendix H contains a breakdown of the living arrangements of the children in substitute care.

and testimony, children entering care do not routinely receive evaluations of their medical, psychological, developmental and behavioral needs. There is a statutory provision, currently in rulemaking, that reads:

1. Physical and psychological examination. The department shall insure that a child ordered into its custody receives an appointment for a medical examination by a licensed physician or nurse practitioner within ten working days after the department's custody of the child commences.

2. Psychological assessment. If the physician or the nurse practitioner who performs a physical examination pursuant to subsection 1 determines that a psychological assessment of the child is appropriate, the Department shall insure that an appointment is obtained for such an assessment within 30 days of the physical examination.[21]

One of the most efficient ways to fulfill the requirement is to establish diagnostic settings where various forms of assessment can take place. The Mid Maine Medical Center in Waterville has developed such a service which can and should serve as a model for other communities. In addition to providing all the evaluative services in one location, staff at such facilities become both educated and trained in the particular problems generated by physical abuse, emotional abuse, neglect and sexual abuse. Like certain disease states, these problems necessitate educated diagnoses and treatment plans which average providers with no special training are ill equipped to render.

In addition to physical and psychological examinations, there are severe problems gaining access to on-going treatment services. Waiting lists at Community Counseling Centers range from three to six months throughout the state. A wide range of treatments including sexual abuse victim/perpetrator treatment, and substance abuse treatment suffer the same waiting list problems or worse do not even exist in some areas of the state. These problems impact children both directly, when they are unable to access needed therapy and care, and indirectly when their parents are unable to meet case plan treatment obligations due to these same shortages. Foster parents themselves also need to fully understand the consequences of sexual abuse on the child's behavior and how to manage that behavior in the home.

[21] 22 M.S.R.A. § 4063A (1) and (2) (1992).

The quality of care for children in the substitute care system has been compromised by the shortage of appropriate foster homes. Since 1985-86 there has been a small but steady decline in new and renewal applications for foster homes. Over the past ten years the number of licensed foster homes has fluctuated between 826 and 1101. As of October 1992 there were 977 licensed homes. Foster homes are allowed to take up to six children under age fifteen or two children under age two. Nonetheless, with nearly 1200 children residing in foster homes, caseworkers do not have a large selection of homes especially if they are endeavoring to find a good match near the home of the birth family to facilitate visitation.

The problem has been exacerbated by the shrinking pool from which to select foster parents, the greater difficulties posed by the children entering substitute care and the reduction in recruitment efforts by the Central Office due to the cutbacks in state personnel. For example, today only 15 percent of all two-parent families have one person at home for some of the day. The Bureau of Child and Family Services has established a policy, reinforced by the Legislature, that fewer children, who are traditionally the most difficult and costly to serve, be sent out of state. Thus, while 77 were placed out of state in fiscal year 89, only 42 were so placed in fiscal year 92. The Department had to make alternative, specialized in-state plans. With all the cutbacks in state government, one of the roles that was virtually abandoned by Central Office was the recruitment of foster homes, with the remaining staff focusing instead on licensing. The Maine Foster Parent Association is now under contract to conduct this function.

Only 61 percent of children (1177 individuals) in DHS care or custody live in foster family homes today. The next largest group, 13 percent (252 individuals) reside in group homes or residential care. Others live alone or independently (4.4 percent), at home (5.1 percent), with non-relatives or whereabouts unknown (3.1 percent), in pre-adoptive homes (3 percent) and other.[22]

Foster parents have testified that they do not routinely receive needed information about a child being placed in their home including medical, diagnostic and case planning information. At a minimum, the lack of such information makes it more difficult and less likely for foster parents to understand the child's needs and the underlying reasons for the child's behavior. In severe cases, the lack of information may inhibit foster parents'

[22] Memorandum to Child and Family Services Planning Committee Members from Dana Hall, Information Systems Manager, BCFS, 10/28/92. Appendix H provides a breakdown of substitute care living arrangements as of October 1, 1992.

ability to provide proper care, to the detriment of the child's well-being. Medical crises involving these children are aggravated by the absence of a medical history. This absence drives up the cost of care due to the need to recreate the history, but, more importantly, may cause delays in treatment. Maine has proposed a Medical Passport system designed to transfer medical records for children in substitute care but has not fully implemented it.

Foster parents and other substitute care providers are not consistently recognized as key members of the treatment and care teams. According to the Maine Foster Parents Association, constraints on caseworkers' time and longstanding tradition inhibit the full integration of foster parents in the casework process. Substitute care providers spend more time with the child than any other member of the treatment team. They can have a positive therapeutic effect or a detrimental effect. As time progresses they gain valuable information about the child and, depending upon the circumstances, the birth parents, which can help to guide the course of the case. Excluding or unduly limiting the role of these providers fails to take full advantage of the resource they provide.

DHS does not have fully developed standards of care for all levels of the substitute care system. Other states such as Texas and Louisiana have defined the various levels of care such as shelter care, foster family care, therapeutic foster care, group care and residential care in terms of supervision, treatment, education, recreation, health care, vocational and independent living standards. For each level of care there is generally an increasingly higher standard. Common assessment forms are used to determine which level a child should receive. Some states tie the payment to the specific needs of the child; others have a single rate for each level. Program monitors assure that the child receives the specified services and supervision. In Texas the outcome for each child is recorded and aggregated by the particular facility so that workers can see what types of placements work best with what kinds of children and youth.

Maine has been placing children with special needs in foster homes in which higher board payments are negotiated. One state report noted that the Department had authorized more than 200 special board rates for children with significant problems but who could be placed in traditional foster homes. There rates averaged $600 per month.[23] DHS does not employ a consistent and objective method of handling board rate discussions for children who present special needs. States such as Vermont tie the monthly

[23] "Report of the Results of a Review of Selected Children in Foster Care," Bureau of Social Services, January 25, 1989, p. 3.

board payment to the training and experience of the foster parents. States such as Hawaii are using a system designed by the National Child Welfare Resource Center at the Muskie Institute, together with the Institute for Social and Economic Development, to tie the monthly foster parent board rate to the specific requirements of the foster parents based on the child's needs. The National Child Welfare Resource Center is currently designing a system using similar principles for the state of Rhode Island.

Foster and adoptive parents are groups for whom training is currently being planning and delivered through the Child Welfare Training Institute. As discussed in Chapter 4, foster and adoptive parents are being included as planners and trainers. A pre-service 20-hour competency-based training curriculum is currently being developed and will be pilot tested in March, 1993. The training will be delivered regionally and will be required for all new foster parents.

Shortages in diagnostic, treatment, and appropriate placement resources combined with the escalating needs of children and their families who wind up in DHS care or custody, combined with fewer hours caseworkers have to spend on the job due to furloughs, have resulted in a fire-fighting style of case management in some regions. A BCFS review of 79 substitute care cases in Region I, for example, showed that 32 of the 79 still needed a placement at the time of review and not one could or should be placed in traditional family foster care. Too often children in need of services are unable to gain access to these services in a timely manner. This can result in escalation of unacceptable behaviors and ultimately placement disruptions, further intensifying the child's problems. Concurrently, meaningful reunification work for these children and their natural parents is held up due to the lack of adequate diagnostic and treatment services for both children and parents. The result is a substitute care system housing an increasingly dysfunctional population who face little chance of either appropriate treatment or timely reunification with their natural families.

Recommendations

12. **All children involved with the Department should have timely evaluations of medical, psychological, developmental, educational and behavioral issues. Relevant evaluative information and medical records should be recorded and safeguarded in the Medical Passport and should be shared with foster parents for children entering substitute care.**

Rulemaking to the law requiring physical and psychological assessments, discussed above, should be completed as quickly as possible. The Medical Passport system, once adopted, will establish a simplified method for transferring medical records of children in the substitute care system. Massachusetts currently has a Medical Passport system. The Passport history is begun during the initial family assessment. The child's health history is documented (or, if unavailable, initiated through EPSDT screening). Information is added as more becomes known about the child's health care status. The information in the child's passport is readily available to the child's foster parents and caseworker. The Medical Passport is reviewed every six months as a routine part of the foster care case review.

13. **Child abuse evaluations, referenced above, should be conducted in diagnostic settings within limited timeframes to allow caseworkers to quickly learn what services the child requires. The Commissioner of Human Services should work with the Director of these services at Mid Maine Medical Center and other professionals to design such a system which would include at a minimum:**

    A. **Psychological and substance abuse evaluations for parents;**
    B. **Medical/mental health evaluations for children;**
    C. **Child development evaluations;**
    D. **Educational evaluations; and,**
    E. **Parental capacity evaluations.**

This recommendation supports a need identified by DHS representatives who testified before the Oversight Committee.[24] Currently, a limited diagnostic capacity exists at the Diagnostic Program for Child Abuse at Mid Maine Medical Center in Waterville, with additional sites at The Spurwink School in Portland, and the Aroostook County Medical Center in Presque Isle. Development of this resource on a statewide basis will fill an important gap in the substitute care system, providing timely, standardized and comprehensive evaluations of children entering state care.

[24] DHS Oversight Committee, Feb. 26, 1992.

Such a system will relieve caseworkers from the burden of searching for available individual practitioners during crisis situations. Expansion of time-limited diagnostic services should also help to limit placement disruptions, easing the emotional burdens on children and care providers and cutting down on crisis situations for caseworkers.

14. **DHS should consistently recognize foster parents and other substitute care providers as a key component and integral members of the treatment and care team for children in substitute care. DHS and the Maine Foster Parents Association (MFPA) should reach an agreement concerning the specific expectations of substitute care providers, both as individuals and as members of the treatment team. All children entering substitute care should have a case plan which includes the caseworker, therapist, and the substitute care providers in order to better meet the needs of the child. The initial case planning stage should include the substitute care providers.**

Foster families and other substitute care providers constitute a valuable but often underused resource in many states including Maine. With limited social work and even therapeutic time available to many children and families, the trend is to determine how foster families can help to bridge the gap--providing transportation to medical appointments and family visits, helping birth parents develop parenting skills, and carrying out a consistent plan of behavior modification or milieu therapy with the children in their care. States which are considering expanding the foster parent role do not necessarily expect to pay the same monthly rate. They do expect the added cost to be tied to specific responsibilities that are determined in advance.

15. **DHS, the Maine Foster Parents Association, and representatives of other substitute care providers should develop standards of care for placements at all levels of the substitute care system. This process should focus on developing detailed Quality Assurance Standards for substitute care placements. DHS should use a common assessment process to determine what level of care each child requires.**

Quality Assurance Standards for substitute care placements will help to standardize the relationship between the Department and substitute care providers. Creating standards for each level of placement in the substitute care system will help to eliminate inappropriate placements of children and also help to eliminate misunderstandings and unrealistic expectations in the relationship between the Department and substitute care providers.

16. DHS and the Child Welfare Training Institute should continue to expand training opportunities and support services for substitute care providers. DHS should continue to work with the Maine Foster Parents Association to develop a community-based substitute care provider support system which includes respite care as one component.

Substitute care providers represent one of the most cost effective investments DHS can make. These providers combine the highest level of client contact at the lowest rate of reimbursement. Continued expansion of training opportunities for substitute care providers, discussed in Chapter 4, will increase the value of this resource. Other forms of support could include a buddy system in which foster parents have specific people to call when they have a need or problem, respite care, parent groups in which foster parenting issues can be raised, a newsletter in which information can be shared and special events which bring together families with common interests and concerns. These may be purely recreational or may combine recreation with training, group discussions, leadership development or supportive activities.

17. DHS and the Maine Foster Parents Association should continue to develop an objective method for handling board rate discussions between DHS caseworkers or other Department representatives and substitute care providers.

The insensitive handling of an issue that should be a clearly defined and routine part of the substitute care placement process can immediately create additional tension surrounding the placement. It is imperative that this issue be resolved. The supplemental payment system developed by the National Child Welfare Resource Center at the Muskie Institute for the state of Hawaii may serve as a model for Maine. The system is designed to:

1. Identify the special service needs of foster children;
2. Determine the level of payment for each configuration of special services above those covered by the basic board payment;
3. Contract with foster parents for the provision of specific services;
4. Monitor the provision of special services by foster parents; and,

5. Provide for one-time costs (e.g., purchasing special equipment or adapting a home for a child with disabilities) incurred by foster children. [25]

The system utilizes a simple computer program which calculates the appropriate supplemental payment based on the child's service needs and the requirements of foster parents in meeting them. A standardized system of negotiating supplemental fees, such as the Hawaii model, would eliminate a difficult negotiation for both DHS and foster parents.

18. Caseworkers should be trained in the practical functioning of a foster home, and other substitute care facilities, in order to facilitate a more cooperative relationship between caseworkers and substitute care providers.

The Maine Foster Parents Association believes that this content should be included in caseworker pre-service training. If this content remains within in-service training, it should be made available during the new workers' first year on the job, rather than to workers with three years of experience as is currently the case.

19. DHS should emphasize the rehabilitation of children and families before beginning reunification efforts.

Implementation of this recommendation is closely related to the need to strengthen community service providers. Given current shortages of diagnostic and treatment resources, children and families involved with the Department face an extended initial period in which rehabilitation services are unavailable. Lack of rehabilitation services results in longer stays in the foster care system. The lack of services creates a Catch 22 in which families eager to do the work required in case plans to expedite reunification are forced to bide their time waiting for program or service openings. The result is delayed reunification efforts, resulting in higher emotional and fiscal costs. There is a clear investment choice in this situation. If more funds could be used to support community-based treatment services, and children and families can be reunified more expeditiously, the money should be recouped through shorter stays in the substitute care system.

[25] "Foster Care Payment Project: Final Report 1991," National Child Welfare Resource Center for Management and Administration, p. 11.

Chapter 4

Personnel and Training

Findings

- **The role and attitude of the unit supervisor is critical to the smooth functioning of the Department. Supervisors need to focus more on the clinical components of supervision.**

- **Caseworkers often do not make efficient use of their time because they perform functions such as transportation which could be handled by others and they spend countless hours in court, often for the cases to be continued.**

- **Despite declining caseloads in recent years, the furloughs and shortened workweeks have the net effect of providing caseworkers with the same or less time to work with clients than before. Because people do not work on the same days, supervision is much more difficult to provide and the overall efficiency of the operation has declined.**

- **Caseworkers and supervisors derive the most job satisfaction from working with children and families, as a source of personal accomplishment, and from receiving support of coworkers and supervisors.**

- **Caseworkers and supervisors are troubled most by the agency's image in the community, paperwork, and the work environment.**

- **Recruiting qualified staff remains a difficult challenge for DHS, particularly given the antiquated personnel system; however, the new field instruction units, which will serve as training grounds for students pursuing social work degrees, provide great promise for the future.**

- **Cross-training is starting to be used in Maine to remove barriers among disciplines and provide a common knowledge base and service strategy; more is needed.**

Discussion

Within the broad topic of personnel and training, this chapter covers supervision, workload, staffing, rewards and incentives, turnover, recruitment and hiring, and training.

Supervision

In the Bureau of Child and Family Services the ratio of caseworkers to supervisors is 6:1, consistent with national averages. Nonetheless, in some regions the time devoted to hands-on supervision is minimal at best. Sample comments from DHS field interviews concerning supervision are: "Would ask for more time for supervision and more supervisors." "[Need] time for more practice discussions in unit meetings and supervisor manager meetings. Most of these meetings have been given up due to lost time via furloughs and 39 hour week. They need to be reestablished. Workers need time for scheduled supervision." "Furloughs are deadly for caseworker/supervisor interactions. [I had] one week without access to appropriate supervisor due to shutdown and furloughs." Caseworkers and supervisors generally felt a stronger need for supervision than did regional managers. Regional managers do express reservations about the lack of available supervision, however. "[I've been] on my own for 27 years," or "In two years, [I've received] supervision twice."

The Child Welfare League of America (CWLA) lists "ability to assist social workers to assess cases objectively based upon significant risk factors"[26] among the responsibilities of supervisors. This implies a collegial, mentoring work relationship between supervisors and caseworkers. Kadushin defines three types of child welfare supervision, all necessary in a well functioning agency: administrative, educational and

[26] *Standards for Service for Abused and Neglected Children and Their Families*, 1989 Child Welfare League of America, p. 49.

clinical. Administrative supervision assures that workers comply with the administrative and policy requirements of the agency. Educational supervision teaches workers to improve their practice as part of the supervisory process. Clinical supervision provides guidance to workers on casework practice.

Comments from people interviewed in the community and from testimony provided to the Oversight Committee indicate a grave concern about the uneven quality of supervision throughout the agency, particularly in the areas of clinical supervision and overall attitudes. People perceive the supervisor, especially in the child protective units, as having a huge influence in defining the job itself and in conveying specific attitudes and beliefs which the workers subsequently adopt. Too often these attitudes are those of cynicism, skepticism and a siege mentality. Many others convey upbeat and positive attitudes. People also see the supervisor's job as being too administratively oriented.

Clinical supervision, to the extent it existed before, has been a major casualty of furloughs. Individual and unit meetings have been cut back as a result of lost work time. In fiscal year 93, regional managers and supervisors are required to take 21 furlough days, in addition to 10 shutdown days for a total of 31 uncompensated days away from work, while caseworkers take 7 furlough days, 10 shutdown days, and 17 uncompensated days. The difficulty of scheduling meetings and the possibility of supervisory and/or casework personnel being unavailable during a crisis is clear. Add to this the factor of high supervisory workloads and the problems of providing adequate supervision become exponentially more difficult. First is the inability of the supervisor to be familiar with any but the most problematic cases on their workers' caseloads. The danger is the loss of time that will inevitably occur when a case unexpectedly becomes critical. On a more day-to-day level, overburdened supervisors are unable to provide caseworkers with the clinical and practice guidance the caseworker needs. This is especially dangerous in the case of new or inexperienced caseworkers who need close supervision and guidance. Experienced caseworkers also suffer. They may be required to assume greater decision-making responsibility in order to free up the time the supervisor needs to closely oversee new and inexperienced caseworkers.

Supervisors have received only limited training in their roles. Little or none relates to the clinical component. If the particular supervisor does not possess the clinical skills he or she must compensate using techniques of peer or group supervision and/or using the clinical talents of others. In general, workers *do* feel supported by their supervisors, as reported in the section on rewards and incentives, below. From a list of 31

choices, supervisory support constituted the second highest job enhancer for both caseworkers and supervisors.

Workload

The Child Welfare League of America (CWLA) recommends a maximum of 17 cases for protective workers, assuming the rate of new cases assigned is no more than one new case for every six open cases.[27] CWLA Standards for Childrens Services workers recommend a caseload of 20-30 children.[28] CWLA also lists factors that should be considered in determining manageable caseload size for both CPS and CS caseworkers:

1. The specific assigned functions and the concomitant time requirement for each (e.g., intake investigations, court work, placements).
2. The extent of the geographic area served and the availability of transportation.
3. The availability of other services, especially foster homes...[29]

Summarizing the necessity to keep caseloads at reasonable levels, CWLA lists the potential consequences of high caseloads:

1. Raises the risks to children;
2. Results in poor social work;
3. Leads to social worker burnout; and,
4. Increases the agency's liability.[30]

[27] *CWLA Standards for Service for Abused or Neglected Children and Their Families*, 1989, CWLA Inc.

[28] *CWLA Standards for Foster Family Service*, 1989, CWLA, Inc.

[29] Ibid, p. 51.

[30] Ibid.

All regions have reported problems with the size of caseloads. "Caseloads have gone from 15-19 pre-furlough to 25-30. We are now almost exclusively reactive, not proactive" (Region I CPS Supervisor). Children's Services caseloads in Portland (Region I) are currently over 30 due to worker turnover. Childrens Services workload is exacerbated by the lack of appropriate placement options such as therapeutic foster homes (Supervisor Region II). A Region IV Child Protective Supervisor states, "I control the workload. Won't let it go over 15-18 cases." This control is achieved through tight screening policies. The supervisor maintains that he feels experienced enough to "take some risks" and screen out to maintain caseload levels.

Data produced by DHS show that the average caseload statewide has declined over the last several years for both Child Protective Services and Children's Services staff. Overall, caseloads declined from 27.4 in fiscal year 89 to 25.15 in fiscal year 90 to 24.35 in fiscal year 91[31]. The decline is consistent with the amount of time available to do the job due to furloughs, shortages of support staff, and increased intensity in the cases accepted for intervention. In fiscal year 93, DHS direct service staff are required to take 17 uncompensated days, the equivalent 3½ extra weeks off, (without compensation) per year. In all, approximately 20 full-time equivalent caseworkers and 6 full-time equivalent supervisors have been lost.

DHS management testified before the Oversight Committee that "30 percent more time is involved in today's cases."[32] The increased intensity of the cases, combined with decreasing time in which to perform the work has resulted in a situation where:

> The administration and the staff of the Bureau of Child and Family Services and the Child Welfare Program in particular have the perception that child welfare staff cannot complete all of the tasks required by agency policy and expectations, and good social work practices, given the current staff resources and

[31] Data previously released by the Department to the Human Resources Committee of the Legislature (1/24/92) show average caseloads of 19.5 per Child Protective Services worker in 1991 and 25.6 per Childrens Services worker for the same year. We report average caseloads of 24 per Child Protective Services worker for 28 per Children's Services worker.

[32] Walsh, P., Testimony to DHS Oversight Committee, January 22, 1992.

> cost reduction strategies, the number and complexity of cases, increased documentation and paperwork, the increasing number of referrals, and the pervasive feeling that the child welfare system is overwhelmed along with the staff.[33]

In addition to furloughs, the amount of time consumed by court preparation and appearances was widely mentioned by caseworkers and supervisors as detracting from the amount of work that could be achieved. "Continuations are the bane of a caseworker's existence. A whole day wasted in court only to have to go back again" (Region I). "[I] waste a lot of time *sitting in court waiting for court.* Scheduled for 10:00, get in at 11:00. Attorneys don't seem to prepare ahead" (Region V).

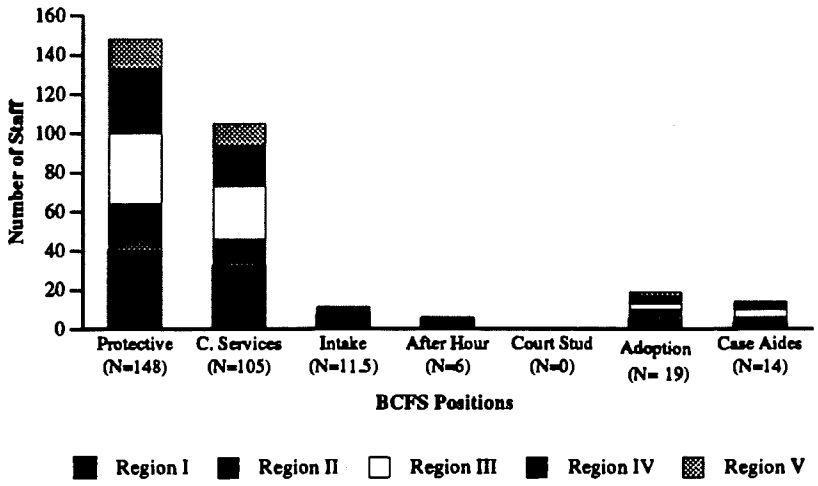
Workers also testified to the constraints placed on them by time and travel requirements. A Region IV supervisor estimated that his caseworkers spend an average of 1½ hours a day driving, and contends that the central office fails to factor this into workload expectations. Several strategies may be utilized to compensate for the constraints of time and travel. Workers can be allowed flexibility in scheduling and travel to encourage the best use of their time. Case assignments can be made that allow caseworkers to work closer to their homes. Consideration can be given to allowing caseworkers to work from their homes in situations where this would promote efficiency. Case aides, foster parents and volunteers could be used for transporting.

Staffing Needs

According to a line list of staff issued by the Department in December 1992, there were 458 authorized line positions of which 433.5 were filled and 24.5 (5.3 percent) were vacant. These included 14 case aide positions and 1 paralegal-assistant position. Positions were allocated to 53 units. Regional allocations by position are displayed below.

[33] "FY 91/93 State Child Welfare Services Plan," State of Maine Department of Human Services, Bureau of Child and Family Services.

BCFS Casework Staff



During the field office interviews, every interviewee was asked what positions should be increased if they could add 5 new employees in their region. There is nearly unanimous consensus that there is not enough support staff, including case aides, paralegals and clerical support. The comment of a caseworker in Region I, "Case aides and paralegals would help with transportation and paperwork, and allow caseworkers to do casework," is representative of the views expressed.

There was less consensus concerning the need for more caseworkers or supervisory personnel. One supervisor in Region I noted, "We don't need more caseworkers and supervisors. We need to recruit and retain foster homes." A Region IV supervisor states, "We don't need more CPS. We need more services to prevent placement." However, with only one exception (a caseworker trainee with 12 weeks' experience), no respondent asked for more than three additional caseworkers when allowed to add five employees.

The lack of consensus on staffing needs beyond the question of support staff is not surprising. Caseworkers, supervisors and regional managers all view the needs of their regions from a slightly different perspective. The agreement on the necessity of support staff indicates a serious need in this area. Casework cannot be performed effectively when caseworkers are required to perform client transportation, legal paperwork for court appearances or transcription of their own dictation. Adequate support staff, together with modern office technology discussed in Chapter 5, is a major key to allowing more casework to be performed more effectively.

Rewards and Incentives

According to a staff survey conducted for this report, DHS personnel find that their highest rewards are related to successful client outcomes. The poor public image of DHS and the difficulty of being a state worker in the current economic climate are among the greatest detractors to doing their jobs.

As the table below illustrates, of 15 statements relating to job satisfaction, caseworkers and supervisors disagree most with the statement, "Central office is supportive of regional operations." They agree most with the statement, "Working with children/ families is a source of personal accomplishment."

CASEWORKER/SUPERVISOR JOB SATISFACTION[34]

Question	CW Mean	Sup Mean	C+S Mean
Opportunities to present ideas to management are adequate	2.5	2.9	2.7
Opportunities to resolve complaints/ problems are adequate	2.4	2.9	2.65
Working with children/families is a source of personal accomplishment	3.1	3.2	3.15
Freedom to decide the best way to get your job done	3.0	3.1	3.05
Opportunities to use skills are adequate	3.0	3.1	3.05
Opportunities to develop skills are adequate	2.8	2.7	2.75
Opportunities for greater job responsibility are adequate	2.6	2.9	2.75
Reward and recognition for performance are adequate	2.2	2.3	2.25
Supervisor will go to bat for you	3.1	3.1	3.1
Supervisor sets clear expectations and direction	3.1	3.0	3.05
Decision-making authority is spread evenly in your office	2.4	3.0	2.7
Opportunities to influence agency decisions are adequate	1.8	2.5	2.15
Regional managers will go to bat for you	2.6	3.1	2.85
Central office is supportive of regional operations	**1.8**	**1.7**	**1.75**
Regional office is supportive of regional operations	2.7	3.0	2.85

[34] Responses are scaled from 1 - 4. 1 = Strongly Disagree; 2 = Disagree; 3 = Agree; and 4 = Strongly Agree.

Caseworkers and supervisors were also presented with a list of 31 potential job enhancers and detractors. They were asked to score each as great detractor, detractor, enhancer, or great enhancer. As illustrated in the table below, the greatest detractors were first, the agency image vis-à-vis the general public; second, paperwork; and third, the work environment, followed closely by caseload. The greatest enhancers were first, co-worker support; second, supervisory support; and third, feedback from supervisors on job performance.

CASEWORKER/SUPERVISOR JOB ENHANCERS AND DETRACTORS[35]

Issue	CW Mean	Sup Mean	C+S Mean
Caseload	1.9	1.6	1.75
Paperwork	1.5	1.6	1.55
Case Documentation	2.2	2.5	2.35
Liability Coverage	1.9	2.1	2.0
Personal Safety	1.9	2.1	2.0
Ability to finish work within time frames	2.1	1.5	1.8
Clarity of job expectations	2.7	2.3	2.5
Salary	2.6	2.5	2.55
Fringe Benefits	2.8	3.0	2.9
Advancement opportunities	2.2	2.4	2.3
Administrative communication and support	2.3	1.9	2.1
Interagency communication	2.3	2.3	2.3
Service availability for parents	1.8	1.7	1.75
Service availability for children	1.8	1.8	1.8
Service/resources for minority clients	1.8	1.8	1.8
Agency image vis-a-vis the general public	1.6	1.3	1.45
Agency image vis-a-vis professionals in the community	2.2	2.1	2.15
Work environment	2.3	1.1	1.7
Personal job satisfaction	2.8	3.1	2.95
Training opportunities	2.8	3.0	2.9
Co-worker support	3.4	3.5	3.45
Supervisory support	3.3	3.3	3.3
Feedback from supervisor on job performance	3.2	3.0	3.1
Clarity of policy/rules/regulations	3.2	2.1	2.65
Case screening at intake	2.6	2.5	2.55
Case investigations	2.8	2.8	2.8
Consistency of decisions to open/close a case	2.8	2.4	2.6
Consistency of decisions to remove or reunify children	2.7	2.6	2.65
Foster care review as a measure of accountability	2.8	2.7	2.65
Relationship with court/judiciary	2.6	2.4	2.5
Relationship with police	2.6	2.8	2.7

[35] Responses are scaled from 1 - 4. 1 = Great Detractor; 2 = Detractor; 3 = Enhancer; and 4 = Great Enhancer.

Responding to which aspects of the job provide the greatest reward and incentive, workers said: "The feeling that you have helped intervene to keep a child from being further hurt." "Successfully reuniting a family, and successfully arranging adoptions." "Changing the course of client lives. Knowing that successes are the result of caseworker commitment and doggedness... I will never have a job that will reward me as much as this job."

The following quotes, on the other hand, illustrate the difficulties of being perceived negatively: "The public perception of how little DHS does. Public is only aware of our failures." "The pressure created by time constraints and furloughs. There is not enough time to do the work people want to do." "Furloughs devalue from our work... We are simultaneously being asked to balance the budget and expand our mandate."

The greatest ways to enhance the job of the caseworker, according to staff feedback, is to lift the furlough requirements, add support staff, and reestablish trust between the central office and the field. All three of these conclusions were reached independently by members of the Oversight Committee as well. BCFS employees are motivated, like employees anywhere, by achieving successes in their work. There is an overwhelming sense among BCFS employees that they are being denied the tools to successfully perform their jobs.

Turnover

Increasing rates of turnover are adding to the difficulties BCFS faces. Examples of the turnover problems, expressed in field interviews, include: "100 percent turnover since January of CP staff (four positions in Houlton). Most senior person has four months' experience." "Unit has undergone transition. [We have left only] one worker with more than five years, two with five years' experience. Furloughs, 39-hour week and lack of merit have made recruitment difficult" (Region II). "Caseworker turnover is a problem. Stress and lack of support of upper management is the main cause of turnover. Takes a long time to make a good caseworker, they are losing valuable human resources" (Region II).

As of December 1992, BCFS had 524 of 562 authorized administrative and line positions filled. The 38 vacancies translate to a vacancy rate of 6.8 percent.

The effects of employee turnover are magnified during a time of organizational stress. When caseloads are high the loss of experienced workers and the need to train new workers increases the workload of the remaining experienced staff. Hiring new personnel to fill a job vacancy is only a partial step toward replacing an experienced worker. Turnover can become a self-fulfilling cycle, as the remaining workers are required to carry heavier and often more difficult caseloads during the time period required to hire and train a new worker. This leads to increased stress and the possibility of more turnover.

BCFS needs to concentrate on supporting its existing and new workers, demonstrating that the organization is aware of their stress and wants to help them cope with it. The most important step that can be taken at this point is to try to reestablish unity and solidarity within the organization.

Recruitment and Hiring

DHS has utilized campus recruitment, career days and student internships in the past. These practices have been reduced as a result of financial constraints. DHS still makes use of the caseworker trainee line as a recruiting and hiring tool.

Field interviews yielded several suggestions for improving DHS recruitment practices: "More recruitment at colleges and career offices....Student internships." "Career days at schools and colleges." "Make the personnel system more open to applicants. Current requirements are too specific. Utilize the caseworker trainee line." "Creative advertising; let people know this is an exciting place to work."

The interviews also revealed criticisms of the process: "They don't do any recruitment... Test is ridiculous, doesn't relate to the job... People hired lack experience."

One of the most exciting initiatives relates to the professional training of potential new workers. As discussed in the next section, through the Child Welfare Training Institute DHS is setting up field instruction units for individuals pursuing BSWs and MSWs. Students are selected from BSW and MSW programs for field practicums in DHS; units are staffed by experienced DHS supervisors. The field portion of the curriculum allows students to test the skills they are learning in the classroom. Field placements provide both the supervisors and the students a way to determine whether there is a good fit for future employment. Students are also paid a stipend.

BCFS managers and supervisors feel that the availability of suitable replacements is constrained by state personnel policies: "Hiring new people is constrained by the list." "Personnel doesn't provide the entire list of names. This results in endless delays in filling positions... Need additional names to move forward. Want a waiver to be exempt from using the selection list. Many people aren't qualified. Move directly to trainees list." "Also, need to look at all the candidates on the list - need a larger selection. I've had to hire people I don't want to hire." In fact, DHS is allowed to request an extended list of candidates, permitting the agency to review 12 candidates at a time rather than the normal six.

While there is unanimous agreement on the difficulties of hiring from the list, opinions regarding worker qualifications are varied: "... feels educational and experience requirements have helped staff quality." "The new hiring qualifications haven't produced better workers." "Newer workers seem to be of very uneven quality." "They need to revamp the qualifications. Some of the best people don't have French or English majors, they have something you don't find on resumes."

The difficulties of the hiring process DHS managers and supervisors complain about are exacerbated by the workload stresses currently affecting DHS. Hiring policies are determined by state civil service requirements. According to the Department of Human Resources the legal base of the hiring procedure would need to be changed in order to make alterations in the DHS hiring process.

Currently, DHS recruitment efforts are limited to standardized state personnel advertisements. This level of recruitment does little to motivate potential applicants; potential employees have little exposure to DHS prior to being interviewed for employment. Campus recruiting visits provide potential workers with a little more exposure to the agency. Even better, student internships allow potential employees a full view of the agency and provide the agency with a useful resource at little or no cost.

Training

Through a contract with the Muskie Institute at the University of Southern Maine, the Bureau of Child and Family Services has established the Child Welfare Training Institute (CWTI). After more than a year of planning and curriculum development, CWTI began delivering training in 1991. The CWTI director, located in Augusta, reports to the BCFS Bureau Director and is a member of the Bureau management team, insuring a close working relationship between the University and BCFS. In addition to the full-time director, the CWTI has three staff training specialists, two training managers and two administrative assistants. The training institute is currently being expanded to other bureaus.

The training system is designed to serve a dual function: to meet individual staff training needs and to improve agency functioning. As such, the training is specific to the objectives of the child welfare program, relates directly to the job and focuses on basic competencies required by staff to do the job. CWTI encompasses the following types of training:

1.	Preservice training	20 days of classroom training designed for new caseworkers enhanced by job shadowing using a Self-Help guide designed by the trainers
2.	In-service training	Short-term staff development and training programs (on-the-job training, workshops and other related activities) to provide specialized and more in-depth knowledge and skills needed by staff to carry out their responsibilities
3.	Supervisory training	A comprehensive approach to provide classroom training and support to supervisors which recognizes their pivotal role in fulfilling agency objectives and maintaining a high standard of quality

4. Management training — An on-going program of training for managers which recognizes their leadership role in creating and maintaining an organizational climate which supports on-going learning and is responsive to change

5. Professional development — An on-going program of continued professional development to promote the acquisition of knowledge and skills, and academic credentials. Policies and procedures developed by the Institute are consistent with the requirements for renewal of licenses established by the Board of Social Work Licensure for:
   Academic education;
   Formal organized learning experiences;
   Teaching, and participating as a trainer in pre- or in-service training;
   Professional writing or research;
   On-site or work-related training; and,
   Informal study.

6. Cross-disciplinary training for cay care providers

   Regional training for representatives of the domestic violence system, the substance abuse system and the child care system using a training the trainers model (planning underway)

7. Foster and adoptive parent training

   A statewide competency based pre-service training program will be developed. Implementation will require the use of regional trainers. In-service training to foster and adoptive parents is also under review. Currently, one annual camp program is offered for foster parents only.

8.	Field instruction units	A vehicle for training social work students in field practicums in the Department of Human Services' child welfare program. The field portion of the curriculum provides the opportunity for students to test and practice the social work skills they are learning in the classroom. Units are staffed by experienced DHS supervisors. Students are selected for the field units from the BSW (USM) and MSW (UM) programs and paid a stipend for their participation.

The majority of DHS personnel and contract providers interviewed uniformly praised the Child Welfare Training Institute. People described CWTI pre-service training as "excellent," "the best thing that's happened to the agency in years," and "workers who come out of pre-service training are good and enthusiastic." Various individuals criticized the curriculum citing, "content too general," "mixed quality of trainers," and too much "touchy-feely" content. Some expressed the need for additional training in "basic skills" such as interviewing, policy and paperwork. Two people suggested adding content on worker safety to the pre-service training; two people wanted existing case-workers to conduct the interviewing training.

Shortcomings and disappointments with training include the lack of cross-training, especially with law enforcement, although officers in Portland and an assistant district attorney in Lewiston who have been assigned to work with DHS have now completed the 20-day preservice program. Other groups cited for cross-training throughout the course of this study were Assistant Attorneys General, lawyers, mental health, and corrections workers. The need for cross-training with professionals from other fields was expressed by caseworkers, supervisors and regional managers.

Another example of cross-training which is currently being developed by CWTI makes use of the federal Child Care Development and Block Grant training initiative to make cross-disciplinary training available to day care providers. People in the fields of substance abuse, child care, family violence and child protection are working as teams to develop the curriculum; thus, not only will the training be multidisciplinary but the process of development joins people from the various disciplines and models the kind of behavior the Oversight Committee endorses. It recognizes that these providers in fact

work with the same clients in many instances but may not enjoy the knowledge, goals and perspectives of the other disciplines.

People are anxious for the foster and adoptive parent training to materialize, several citing the need for greater foster parent training. A 20-hour competency-based curriculum is being prepared and will be pilot-tested in March 1993. CWTI is striving to hire foster and adoptive parents, current or previous, with training experience to conduct it. Pre-service training, which will be delivered on a regional basis, will be required of all foster parents who want state licensure. As part of its philosophy of professionalizing foster parents, the CWTI is paying foster and adoptive parent advisors a stipend to act as consultants in attending committee meetings and designing training curricula.

In-service training for foster parents is not well attended, according to CWTI staff. They are devising new ways to assess needs and deliver the training. Staff are collaborating with the other New England states which are grappling with the same issues.

People are positive about the management and supervisory training that has been provided; there is general consensus that more is needed.

Recommendations

20. See Recommendation 1A. We reiterate here that Children's Emergency Service, Child Protective Services and Childrens Services workers should be exempted from furlough days so that the staff of those units can receive proper supervision.

The first step toward strengthening the supervisory process is to create an environment in which effective supervision can take place. Exempting these workers from furlough days will help create enough time for supervisors and caseworkers to coordinate meeting times to help reestablish effective supervisory practices.

21. BCFS should improve its capacity to provide clinical consultation and supervision to its workers.

To the extent it is not already implemented in practice, every major decision about a family should be made jointly between caseworker and supervisor. When supervisors are not professionally trained and/or experienced clinicians, the decisions must be reviewed by people who are. This is important for two reasons: no worker should be burdened with making critical decisions, like whether it is safe to return a child home from foster care even if only for overnight visits, on his or her own. Second, such judgments require both training and experience. If it is not already available in a given supervisor, it can be obtained in a structured process from another supervisor in the office, from a clinician hired by the agency to review cases periodically with staff, or by a multidisciplinary team.

22. **DHS and the Child Welfare Training Institute should expand clinical training resources for supervisors. These resources should include training within the CWTI, expanded utilization of offerings in the State University system, and use of other professional training facilities within the state.**

Increased emphasis on strengthening and improving clinical supervision will result in better clinical casework. The rewards of improved clinical casework will include better decision-making at every step in the casework process. The result will be better and more appropriate case planning, fewer inappropriate substitute care placements resulting from poor clinical decision-making, and better therapeutic interactions between caseworkers and children and their families.

23. **BCFS should explore the development of a formal system of mentoring among the casework staff. This system would create pairs or triads of caseworkers constituted according to experience, with experienced caseworkers paired with less experienced ones.**

The mentoring relationship is not intended to replace the role of the supervisor but to provide an extra layer of support for the caseworkers. The mentor relationship will be an especially important resource for new caseworkers. New and inexperienced caseworkers are at an additional disadvantage when unit supervisors are unavailable. The mentoring system will provide these new workers with access to the experience and judgment of more experienced caseworkers and will also provide the new workers with a formal peer support system which should boost morale.

24. BCFS should conduct a time study of caseworker functions to determine where and how workers currently spend their time and what functions could be performed by case aides, clerical staff and/or volunteers.

BCFS management needs a better handle on the way workers actually spend their time in order to make adjustments in tasks and staff allocations. The depletion of clerical staff, of paralegals, and even of central office staff has a clear impact on the work that must be performed by caseworkers. Organizations do not operate without administrative functions and, when they attempt to do so, they find that their line staff are performing these functions. Thus, each retrenchment of staff of any type is likely to have an impact on the Bureau's basic ability to serve clients.

A time study of caseworker functions would provide a realistic estimate of the number of cases of each type which the average caseworker could reasonably be expected to handle. The current time recording system in use within the Bureau will not suffice for this purpose because it was created to allocate funds, not to capture all of the activities required to carry a case including traveling to see clients, waiting for court appearances and even filling out the time recording sheets.

25. See recommendation 1B. DHS should reinstate the case aides and paralegals whose positions have been cut due to budgetary pressures. In addition, DHS should seek authorization for 12.5 additional case aides and 5 paralegals to meet a standard of one case aide for every two units, and one paralegal for every region.

26. The Governor, the Commissioner, and the BCFS central office staff can demonstrate their support for the line workers and supervisors by publicly acknowledging the difficulties the organization faces as a result of stresses created by turnover, furloughs and shutdowns, and the reduced workweek. Public acknowledgment of these stresses would be a large step in restoring the confidence of the regional offices.

Managers should also continue to address the question of agency image by implementing other recommendations in this report which help to remove the isolation of the agency and foster working agreements with other groups.

27. DHS should develop a recruitment plan which may incorporate some or all of the following:

A. Re-implement or expand campus recruitment and student internships as an active recruiting tool if the field instruction units do not provide sufficient new recruits.

B. Develop recruiting techniques for older workers.

C. Expand the use of the caseworker trainee line. This will allow the agency to bring on potential caseworkers and allow the agency a full year to evaluate the future potential of the workers, as opposed to the six-month probationary period of an employee hired as a caseworker.

D. Continue developing and testing the Field Instruction Units through the CWTI.

28. DHS should utilize the current personnel system as effectively as possible since attempting to change it will require a tremendous amount of time and resources and is unlikely to be successful.

29. DHS should continue to develop all aspects of the Child Welfare Training Institute as planned. CWTI provides pre-service and in-service training to Bureau of Child and Family Services (BCFS) personnel, supervisory and management training, and is currently expanding training in the areas of professional development, foster and adoptive parent training, field instruction and training to day care providers. CWTI should also expand training opportunities for other substitute care providers, and continue to expand cross-training opportunities. In addition to expanding training opportunities within the Institute, CWTI should explore collaborative arrangements with other educational and training institutions (such as the Maine Criminal Justice Academy) within the state.

CWTI should continue and actively pursue its plans to include foster and adoptive parents in its training. It should continue to explore technologies which will make training accessible around the state. CWTI should continue to make training available to people in provider agencies and eventually broaden its scope of offerings to providers as it has initiated in day care. It should continue to facilitate and emphasize "cross-training," especially with law enforcement.

30. **The Department should take steps to formalize a procedure for adding cross-training to the CWTI as already initiated on a limited basis. In particular, DHS should continue to assure that the law enforcement officers and state police who will be assigned in each region to work with BCFS are identified and required to participate in the 20-day pre-service training program.**

Chapter 5

Management, Accountability and Legal Issues

FINDINGS

- **Lines of authority between regional and central offices remain unclear to caseworkers and supervisors. The need to rebuild trust and initiate open communication remains strong.**

- **The concept of Total Quality Management, while good in the abstract, will require strong commitment and follow-up at all levels of the organization to make it work.**

- **Agency policy manuals have not been comprehensively updated in nearly a decade.**

- **Caseworkers' ability to record and retrieve information about clients is severely hampered by the lack of automated case management and recordkeeping systems.**

- **The Bureau of Child and Family Services is sorely lacking many forms of modern office technology.**

- **Internal monitoring and accountability systems relating to the effectiveness of services and the outcomes achieved for clients are weak to nonexistent.**

- **External accountability mechanisms, such as the Ombudsman position, provided a valuable, impartial capacity within state government to investigate complaints from clients, citizens in general, and others interested in the agency's functioning.**

- **The Department's ability to examine why a child has died or suffered serious injury in Maine using a multidisciplinary committee has been compromised by the lack of staff support for this critical function.**

- **Aspects of the Child and Family Services and Child Protection Act need re-examination.**

- **Methods other than court procedures are needed to resolve disputes in child protection cases.**

- **DHS and the Attorney General's office need to clarify areas of decisionmaking.**

DISCUSSION

Lines of Authority

This study was initiated during a time of particular turmoil for the Bureau of Child and Family Services caused by: the case crises noted in Chapter 1, a change in leadership both at the bureau director and the commissioner level, and particularly low morale due to the State's financial crises and the resulting shuffle in staff positions. Thus, this section must of necessity deal with historical problems rather than the unfolding attempts to resolve them by the new leadership such as improving communication with regional offices, instituting additional family-based services programs, developing a Total Quality Management approach, and continuing to expand the training system.

The Bureau of Child and Family Services is divided into one central office, five regional offices and seven subregional offices. The Child Welfare League of America says that, while lines of authority should be clearly defined, there should be sufficient flexibility for effective intra-agency communication among all levels of administrative responsibility.

It is unusual to find a system in which tensions do not exist between the regional or operating arm of an organization and the management or policy setting arm. This bureau is no exception. Feelings in the regions tend to range from benign neglect to bafflement to open hostility toward central office. Caseworkers and supervisors have more questions about the appropriate role of central office staff than do regional managers who have a better sense of where their authority ends. Through the interviews and staff surveys we learned that BCFS caseworkers and supervisors feel that lines of authority are unclear above the regional level.

Caseworkers and supervisors perceive clearly delineated lines of authority with strong supervision, leadership and support at the regional level, but they perceive little support or direction from central office. As reported in the previous chapter, in the survey of workers staff made a strong statement about the lack of support from central office. In the interviews, one caseworker stated, "I don't know who is in central office, don't know what they do...they're only 45 minutes away but actually very far away." Similarly, supervisors noted the lack of direction and leadership from central office. One supervisor noted, "There really isn't a central office, they've been decimated. There isn't anyone in central office that oversees cases; there is no support from central office. Central office people became administrators, not supervisors or sources of substantive information."

Part of the dichotomy in the views of caseworkers and supervisors compared to the regional managers may be the result of differing perspectives on what the relationship with the central office *should* be. Regional managers have fewer expectations of central office as a casework resource. They are generally used to being the final line of authority on casework decisions and rarely feel the need for consultation in this area. Supervisors and caseworkers express frustration precisely because central office does not perform this function. The lack of understanding springs in part from a lack of contact as well as shifts in authority and roles since the former bureau director left.

During the course of this study the new bureau director experimented with different organizational configurations. One configuration put one person in charge of regional operations and one person in charge of policy development and implementation. Another put both functions under one person. Licensing and purchased and support services stand outside any authority relationship with the regions except through the bureau director. Whatever structure is finally adopted, the critical factor is for central office to maintain meaningful, consistent and collegial relationships with the regional offices. Overt and

consistent mechanisms must exist for the policy, licensing and contractual services units to receive feedback from the regions about their needs. From a Total Quality Management perspective the regions are the clients of the central office and should be treated as such. Without this feedback policy may be developed with less than total awareness of field realities. Licensing functions may be reduced or altered (as they have been in recent years with the central office de-emphasis on foster parent recruiting) without sufficient knowledge of its impact on the field, and contracts for new services may fail to meet the new needs perceived by caseworkers on a daily basis. The structure also necessitates strong leadership from the bureau director, not in terms of mandating but in terms of listening and inspiring.

Central office personnel who perform work that directly affects the service staff should visit (or continue to visit) regional offices on a regular basis. This would encourage closer relationships between regional and central office personnel and help to establish more firmly the concept of the central office being a vital part of the team. A corollary benefit of these visits would be to bring central office people closer to the day to day casework world. Restoration of trust between the central office and the regions remains critical to the effective functioning of the agency.

The Governor has announced plans and taken steps to implement the concept of Total Quality Management (TQM) in state government. The Department of Defense defines Total Quality Management as "a philosophy and set of guiding principles that represent the foundation of a continuously improving organization... It integrates fundamental management techniques, existing improvement efforts, and technical tools under a disciplined approach focused on continuous improvement."[36] Total Quality Management is based in the management theories of Edward W. Deming. Sensenbrenner identifies the most elemental level of Deming's system as the creation of a "culture of quality."[37] Sensenbrenner emphasizes, "Most important, it must define quality first as a continuous improvement in pleasing customers, and second, as reducing the variation in whatever service or product it offers.[38] Appendix I contains a more detailed description of Total Quality Management.

---

[36] Adapted from DoD, Office of the Secretary, 32 CFR Part 281, July 19, 1989.

[37] "Quality Comes to City Hall," Sensenbrenner, J.F., Harvard Business Review, March-April 1991, p. 65.

[38] Ibid, p. 65.

The system is still in its infancy in BCFS. The concepts have been taught to people at the state office level through a training session sponsored by the Child Welfare Training Institute. The extent to which it will ultimately be implemented in the field is currently unknown. While the ideas sound good in principle, it is difficult at this point to know how they will be incorporated or used. We expect, however, that the approach will involve strong regional input into improving the organization and will give local people a say in how this should be achieved. Regional office ideas and even autonomy should be encouraged when they result not from the lack of action or leadership on the part of central office but as part of a planned effort to improve operations as well as morale.

Automation and Technology

Included in this section is the way information is recorded and transferred. Means include telephone, computers, FAX machines, photocopying, dictation. The current computer system includes a mainframe system which encompasses the central registry and foster care tracking system as well as a separate system for payment to vendors. In Region I there are approximately 200 child welfare staff (80 of these are caseworkers) and five computers. The Portland office has recently acquired a FAX machine, and the Biddeford office now has a FAX modem. Neither the Portland nor the Biddeford office telephone systems has voice mail capacity. Workers may have their calls screened or may receive them directly.

Maine is planning to install the FAMIS computer system. This system will largely serve the income maintenance system. It will not provide for the specific needs of BCFS.

The basic technological resources are lacking in the Bureau of Child and Family Services. BCFS is far behind other bureaus in the same agency such as the Bureau of Medical Services which operates the Medicaid program. The resource that would provide the greatest boost to worker productivity is an automated case management and record system. In such a system workers would no longer manually complete forms which are then entered into the computer by clerks. Instead the forms would be programmed in data base form on computers which are networked throughout the region and across the state. Only once would a worker ever have to enter basic identifying information about the cases. Records would be pulled up on the computer and updated when new services are added or deleted or there is a change in case status.

Through programming, information on the computer could be aggregated to produce reports for workers on their own caseloads, for supervisors, and for program managers. The case record would form the basis for all reports. Any information that is not needed by the caseworker would not be needed by the supervisor or manager.

Commercial vendors (e.g., Bull, Lockheed Information Systems and Andersen Consulting) have developed packaged case management systems for personal computers (PCs) and mainframe applications. At present the National Child Welfare Resource Center at the Muskie Institute is developing a case management system for the state of Rhode Island on a pilot basis in one office. The approach has been to analyze the forms used as well as the casework process and to program "computer screens" using data base software. Once the pilot is completed the screens can be modified and, if successful, expanded to other offices. This approach minimizes cost and makes implementation far easier.

Other resources that are needed are a fax machine for every office and updated telephone equipment with voice mail capability for every office.

Policy Manual

Worker actions are guided by federal and state law and agency policy. The policy manual currently in use is nearly a decade old although pieces of policy are added periodically. According to interviews in the field the policies on reunification and termination of parental rights are not clear to some workers. Others have noted that there is "not enough flesh on the bones" of CPS policy.

While practice has changed in the last ten years and new social problems have arisen such as the birth of drug-addicted babies, formal policy has not always kept pace. The Bureau contracted for the development of a new "practice" manual to address these problems, in part. However, it was never issued. The Bureau is currently undertaking a comprehensive update of its Policy Manual.

Internal Accountability and Quality Assurance

This section addresses internal accountability, i.e., the Bureau's capacity and current practices of monitoring its own performance by site visits and record reviews as well as routine information collection and analysis.

Monitoring regional offices: Central office staff have made periodic visits to the regional offices. However, there are no routine protocols or processes for monitoring compliance with agency policy or reviewing case records during these visits. In depth reviews occur when a case has "blown up." The major exception is the system of administrative case reviews which applies to children who have been in foster care for more than six months. Staff with no other functions are specifically assigned to review these cases as their full-time jobs. This system was set up in the early 1980's in response to federal requirements under Public Law 96-272 and recommendations from the Governor's Task Force on Foster Care. Administrative case reviews do not cover open Child Protective Services cases. While there have been efforts in the past to extend the reviews to this group, they have never materialized. As such, there is no routine mechanism to assess cases which have been in that part of the system to determine what progress is being made, what services are required or even whether state involvement should continue.

Information collection and analysis: At present BCFS routinely collects data on the following:

CPS Intake Statistics:

1. Cases opened for assessment;
2. Cases screened out; total volume;
3. Percentage screened out.

Cases Opened for Study:

1. Statewide;
2. By region;
3. Statewide substantiation rate;

Child and Family Services Monitor Report:

1. Number of protective studies opened;
2. Number of protective cases served;
3. Number of children removed from home voluntarily;
4. Number of children removed from home through court action;
5. Number of special studies completed;
6. Number of children in care/custody;
7. Number of children freed for adoption;
8. Number of children adoption finalized;
9. Number of children in custody returned home;
10. Number of children retained in care beyond age 18.

The above information is available statewide and for the five regions by fiscal year.

Child Protective Services Caseload Distribution:

Number by region by objective for the following objectives:

1. Study/Investigation;
2. Correctable abuse/neglect;
3. Secure protection order;
4. At risk;
5. Supervision;
6. Post adoption difficulties;
7. Special studies;
8. Secure medical treatment;
9. Prepare/place;
10. Problem pregnancies.

At the bottom of each report observations are made such as the percent increase or decrease in cases since the last quarter statewide and by region.

BCFS issues an Annual Report covering child protective services. In addition to some of the information above, the Report presents case assessment priorities (the num-

ber and percent assigned for immediate investigation, within 24 hours, within 5 days and within 10 days); the living arrangements of children whose cases were opened; case findings (e.g., sexual abuse, major physical abuse, minor physical abuse, neglect or unsubstantiated); age and sex of victim; family stress factors necessitating intervention (e.g., alcohol/drug abuse of parent; mental/physical health problem of child); and cases assessed/investigated/substantiated by each office.

BCFS has a very weak system of program monitoring compared to many other states reviewed by the Oversight Committee. As discussed above, one effort to address this problem is the initiation of a Total Quality Management system throughout state government in Maine. What aspects of agency performance, if any, will be addressed is not clear. Some places, for example a county in Ohio, have used quality management concepts in local units to establish performance goals for the unit (e.g., return 50 percent of the children home within two months with no recurrence of abuse for six months) and to examine the best operating procedures to implement these goals.

While it is fairly typical for states not to have routine methods and protocols for reviewing regional operations, especially in state-administered systems (as opposed to county systems), many are attempting to establish such systems. They may entail pulling a sample of cases to examine compliance with state law and policy and reviewing the quality of case planning and decision-making. They may entail meeting with clients or distributing client satisfaction questionnaires on a periodic basis. Even more prevalent around the country is the move to establish "performance indicators," "outcome measures" or "benchmarks." Appendix J describes several states' quality assurance and performance measure systems as a basis of comparison.

In addition to these efforts, some agencies have attempted to elicit community response to their services by providing "report cards" to schools and other mandatory reporters.

What Maine's current data collection and reporting system is lacking is any concept of performance from the perspective of quality assurance. What it does provide is essentially numbers of cases opened by various categories established by the agency to describe its services: e.g., protective studies conducted, protective cases served. It also provides a limited amount of case status information: assessment overdue, case open under objective longer than accepted time limits. It does not establish goals, such as the number or percent that should be returned home during each timeframe. (The concept

referenced above of cases open under objective longer than accepted time limits does suggest the presence of a standard.)

A quick review of examples from other states demonstrates the kind of information that is being used by management to assess agency strengths and make adjustments. South Carolina's system of "critical success factors" consists of an overall outcome followed by a series of critical success variables. An example of an outcome for child protective services is:

"Children who are reported to DSS are not abused, neglected or exploited after the report is accepted for investigation, substantiated and subsequently closed for services." Examples of critical success variables for this outcome are:

1. Initial contact occurs within 24 hours.
2. Assessments are completed within 90 days.
3. When risk factors are identified during the investigation a case plan is developed to address them.
4. Case plans are reviewed as needed but at least every six months.

Sample measures used in Florida to assess the outcomes of the state agency's involvement are:

1. Percent of children removed from home during service provision.
2. Percent receiving abuse or neglect reports during service provision.
3. Percent showing a decrease of 40 percent or more on the Child Abuse Potential Inventory.
4. Percent with gradual weight gain based on age and weight at intake.
5. Percent within normal range of Denver Prescreening Developmental Questionnaire.

We have categorized Colorado's indicators as descriptive, effort, performance and outcomes. Examples of indicators to describe the population served are:

1. Percent change in ethnicity of clients served.
2. Percent change in age of clients served.

Examples of indicators developed to measure agency effort are:

1. Percent of child welfare case open, year x and year y.
2. Number and percent of referrals which are investigated quarterly.

Examples of indicators developed to measure performance are:

1. Recidivism: number of new incidents of abuse for cases that are open.
2. Number and percent of children returned to foster care after being returned home.
3. "Drift" analysis: percent of children in foster care with return home goal by time in out-of-home placement, number of placements and average level of restrictiveness.

Examples of indicators developed to measure outcomes are:

1. Percent of children adopted by length of time before finalization.
2. Number of child abuse victims who become perpetrators.

As noted in the appendix, some other states have also developed measures for private providers. These states are holding private providers to the same level of accountability as they hold themselves. This tends to be the exception rather than the rule at present.

External Accountability

In addition to internal accountability and quality assurance mechanisms, well-managed public agencies should have the capacity to respond to individual complaints and concerns of the people it serves and should be subject to the oversight of concerned citizens, service providers and consumers. One mechanism to perform such oversight is the Child Welfare Services Ombudsman Office. After two years, this office was shut down due to the lack of public funds. A second mechanism is the creation of a Department of Human Services Oversight Committee which is the author of this report.

The loss of the ombudsman function removes the capacity of an external, impartial individual to respond quickly to complaints in a less formal capacity than the formal grievance procedure. People testifying before the Oversight Committee found this to be a serious loss of specifically citizen/client accountability on the part of the Department of Human Services.

The strength of the Oversight Committee is that it consists of a cross section of Maine citizens representing education, mental health, law enforcement, service providers, medical providers, legal agencies (public and private), foster families, and others. Unlike the Ombudsman, the Oversight Committee has no legislative or fiscal authority over the Department but merely has an interest in advocating for the most efficient and effective services for abused and neglected children and their parents. Its focus is on one of the most vulnerable and at-risk client groups of the Department. The weakness of the Committee is that it is time-limited. After developing the recommendations contained herein, it lacks the capacity to follow up on the Department's response. It does not have a continuing forum in which to advocate for more resources for change, not just within the DHS but within other Departments which have the capacity to enhance services to this group.

Child Death Review

A third and critical form of external oversight relates to the agency's capacity for self-analysis when a tragedy occurs. The death of a child resulting from abuse or neglect represents the consummate failure of the state's capacity to protect children and assure their safety. Many states, including Maine, have established multidisciplinary committees to review the cases of children who have suffered death or very serious injury to determine why the child was not identified (e.g., were there physical signs that medical personnel failed to associate with abuse) and, if identified, what glitches or anomalies in the system prevented it from acting to save the child. Often these investigations are complex and time-consuming. They require the assistance of staff to work with the committee of volunteers. While a staff person is assigned to such a committee in Maine, the responsibility is currently considered an "add-on;" no other tasks were removed when this was added. Consequently the staff member cannot devote the time necessary to perform the job in the way that it should.

Statutory Changes and Legal/Court Issues

The Department is routinely involved with the court system. Many more cases require contested hearings and often cases are judicially reviewed as often as every six months.

Departmental involvement in the court system has risen markedly. DHS court involvement has increased from 5 to 8 percent of caseload in 1986 to 25 percent of caseload in 1991.[39] The increase in involvement in the court system has been accompanied by an increase in demands on the human services system. DHS casework is required to provide "expert" support; this has led to increases in the need for professional evaluations of child or family circumstances, and worker time spent in court, further straining Departmental resources.

The increase in court involvement and the increasing complexity of cases in the court system has affected caseworker efficiency and contributed to the current overload in the judicial system. Time and resources would be saved in both systems if serious efforts were made to develop alternative methods to resolve a portion of these cases. The length of time required to pursue child welfare cases in the court system can seriously detract from and delay the service and treatment provision to children and families.

Increased court involvement strains DHS resources in several areas. Treatment resources are stretched in order to provide court ordered evaluations of children and/or families. Caseworker court time seriously impacts the caseworker's ability to perform work associated with other cases, contributing to the need to manage by crisis. Finally, extensive court involvement often runs counter to the goals of treatment and reunification.

The current fiscal climate presents a number of problems surrounding the issue of reunification. The legal requirement that workers pursue reunification is made more difficult during an economic downturn as a result of a number of stress factors, including unemployment and an increasing demand for services. Without sufficient services available to improve the family situation, reunification becomes a sham.

---

[39] DHS Testimony, February 26, 1992.

All support systems must be expanded to deal with the increase in caseloads. Time, especially judicial time, is essential. The availability of diagnostic services and reunification services is critical. In the ideal world, a child protective case would be tried at the earliest possible time, with jeopardy clearly identified and appropriate services implemented. Assuming that services are available, the parents would either be able to achieve reunification or the court would determine that reunification is not possible and that other permanent plans should be made for the child.

The availability of appropriate (preferably multidisciplinary) diagnostic evaluations, with clear expectations for parents, would alleviate much wasted time between court hearings and would allow the courts to make informed decisions in a timely manner.

The Oversight Committee recognizes the strains that DHS court involvement places on both the Department and the court system. The following recommendations are made with the intention of easing the stresses the systems place upon one another.

RECOMMENDATIONS

31. The Bureau Director should actively coordinate the work of each bureau function such as purchase of services, licensing, regional operations and policy-making to assure that consistent messages are sent to the regions and that regional needs are heard and reflected in the decisions of central office.

32. BCFS should actively pursue its plans to implement Total Quality Management.

To make TQM work, support must exist at all levels of the organization. Efforts should be made to use the process as one means to improve relationships between central and regional offices.

If the TQM model does not include regularly scheduled meetings, at least quarterly and preferably bi-monthly, with central office staff in each regional office, they should also be incorporated. The purposes of the meetings should be to share information from the top down and the bottom up, to foster understanding of the roles of each unit,

and to solve problems that are not being addressed through the TQM process. In short, the supervisor of regional operations needs to be a very visible presence in the regions.

33. **BCFS should develop an automated case record system, giving each worker the capacity to enter and retrieve client data directly. BCFS should consider using one office as a pilot site both to reduce start-up costs and to minimize disruption to the agency.**

The system will allow data to be aggregated for unit, regional and statewide reporting. It will allow cases to be pulled up on a screen and reviewed at the central office and in offices where it is not currently active. It will greatly reduce time spent on paperwork. It should be designed to fulfill all the reporting requirements of the federal NCANDS and AFCARS data systems, the former relating to child protection and the latter to foster care and adoption. It would be sufficient for the Department to have one computer for every two to three workers at the pilot site. Building on its experience in Rhode Island, the National Child Welfare Resource Center at the Muskie Institute could assist Maine with the pilot.

34. **BCFS should assure that one FAX machine per office exists. It should assure that sufficient phone lines are available to serve the public adequately and that voice mail is installed where it does not already exist.**

35. **BCFS should review, update and codify the policy manuals governing all aspects of child protection and childrens services.**

36. **BCFS should develop a system of accountability which provides the Commissioner and bureau director ongoing feedback about agency performance and which includes:**

    A. **Defining performance measures for the agency.**
    B. **Defining performance measures for private providers of direct services.**
    C. **Conducting periodic reviews of regional operations which include checks of compliance with agency policy through reviews of case records.**
    D. **Generating reports quarterly and writing them up annually to report on progress in attaining agency goals.**

This recommendation should be performed in two stages. The first should be to determine what kinds of performance measures can be reported upon using information that is already collected on the various mainframe systems. This may entail using existing data elements in new ways. The National Child Welfare Resource Center at the Muskie Institute has published "Model Child Welfare Management Indicators"[40] which includes numerous indicators and formulae for generating them which can be used as a guideline.

The second stage will be conducted in conjunction with the recommendations on case automation and Total Quality Management. As Maine moves to an automated case record system it will be adding and subtracting information from its current forms for placement on the PC system. In conjunction with the Total Quality Management process, this activity will provide an opportunity to revisit the performance indicators and determine which are truly critical to monitoring the agency's performance.

The periodic review of regional operations should include a peer review process. People from other regions (at all levels) as well as central office personnel should take part in the reviews. This will institute a sense of collegiality and will help promote uniformity in practice.

37. DHS should request funding to enable the implementation of Administrative Review of Child Protective Services cases.

The Department has attempted to institute this process repeatedly in the past. In each instance circumstances have required the personnel scheduled to conduct the reviews to be assigned to other duties. The need for review of Child Protective Services cases was cited repeatedly during interviews with BCFS staff. Such reviews will provide an important safeguard, assuring that casework practice is consistent with agency and professional standards. They will also provide an opportunity to document whether and how progress is being made, the availability of treatment services and the outcome of the cases. Analysis of this information on an aggregate basis will help the agency to plan services and target resources more directly to the needs of the clients.

[40] Zeller, D.E.; *Model Child Welfare Management Indicators*, National Child Welfare Resource Center for Management and Administration, University of Southern Maine, Portland, Maine, 1991.

38. The Child Welfare Services Ombudsman position and Office should be funded and reinstated.

This office served as a very valuable resource in permitting access to the State system for parents, foster parents, providers and interested citizens leading to enhanced communications and problem resolution. On June 17, 1992 former Commissioner Ives reported to the Oversight Committee that the Governor will request funding to reestablish the Ombudsman position.

39. The Legislature (or Commissioner) should establish a permanent Oversight Committee whose primary purposes are to establish annual goals, provide an ongoing system of feedback to the Commissioner and Director of the Bureau of Child and Family Services, and review recent trends in national and regional systems. The Oversight Committee should provide an annual report to the Director of the Bureau of Child and Family Services, the Commissioner of Human Services, the Legislature, and the Governor. The duties of this committee complement the duties of the Child Welfare Advisory Committee. The Department should consider consolidating these functions under a single committee.

The proposed committee will serve an important role in supplying public input to DHS in addition to its oversight functions.

40. The Commissioner should request funding dedicated to providing staff support to the Child Death Review Committee.

This committee provides a valuable resource as a result of its ability objectively to examine the circumstances surrounding deaths that are attributed to abuse and or neglect. The Child Death Review Committee provides a valuable, independent resource that can examine these instances from a systemic perspective and needs adequate staff support to fulfill its function.

41. DHS should advocate for the establishment of a task force to examine the Child and Family Services and Child Protection Act. The Task Force should be established jointly by the Executive Department and the Legislature. Its goal should be to amend the Child and Family Services and Child Protection Act to expedite the Department's mission to support and strengthen families. Aspects of the law to be examined should include:

A. Amendment of 22 M.S.R.A. § 4031, 4051 to allow the District Judge to change venue in order to facilitate Child Protective Hearings.

B. Amendment of 22 M.S.R.A. § 4002 to provide for a second standard of jeopardy to allow the court to order services in cases where the higher standard of proof cannot be met but there is still some danger to children and families.

C. The issue of rehabilitation and reunification keeping in mind federal mandates and shrinking resources.

D. The issue of children in need of supervision.

This task force should include key persons handling child protection cases including attorneys, judges, caseworkers, guardians ad litem, foster parents, attorneys representing parents, attorneys representing children, physicians, psychologists, representatives of the Department of Education and DHS, as well as legislators. The Task Force should review the Child and Family Services and Child Protection Act to ensure the safety of children and an effective and efficient procedure for handling these cases through the judicial system.

42. Legislation must be initiated to insure that the Department is allowed "standing" as a surrogate parent in the PET process.

Currently, the Department is allowed to participate in the PET process only in an observational role; social workers are not permitted to have direct input in the process. Granting standing to the Department will allow the Department to contribute its knowledge of the child being evaluated. This will help to broaden the information base utilized to determine the appropriate treatment intervention for the child.

43. DHS and the Courts should examine ways to streamline procedures and establish alternative methods of resolving cases. One suggestion would be to use the current administrative case review process to resolve uncontested cases administratively.

This method would utilize an existing system to resolve cases in which all involved parties are in agreement. The level of court involvement required in these cases would be reduced to a level of rubber stamp approval. This process will help to reduce caseworker and Department court time and will help the court system by opening docket space for other uses.

44. DHS and the Attorney General's office should continue to clarify decision-making in order to work effectively as a team. The process should include:

A. Assuring that communication continues on a regular and ongoing basis;

B. Assuring that consultation is occurring prior to decision-making. This would require advance notice of decisions and communication to the Assistant Attorney General as to the Department's position well in advance of the scheduled proceeding;

C. Insure that the system to resolve conflicts is utilized to ensure that conflicts are not left unresolved.

Given the importance and increasing frequency of DHS involvement in the courts, it is imperative that this relationship, as well as relationships with District Attorneys' offices, be cooperative and oriented toward mutual goals. Lack of preparation and inadequate information can occur on both sides of this relationship, in each instance to the detriment of the client. The time court cases consume for both caseworkers and attorneys make it imperative that this time be used as constructively as possible. The Department, the Attorney General's office, and involved District Attorneys must all make an effort to assure cooperation in order to gain the best client outcome.

Chapter 6

Interagency Relationships

Findings

- **Four agencies with differing legal bases cannot serve children in a comprehensive fashion**

- **Efforts at interagency coordination at the state level, while positive, have not achieved the objective of creating a comprehensive social services system in which agencies *embrace* the needs of clients rather than *deflect* them to other agencies.**

- **Mental health services, particularly residential care, are being denied to children who sorely need them under the current system which links entitlement to mental health services with a local public school's ability to educate the child.**

- **External studies and reports such as these need to be codified into a single multi-year plan and strategy which is sanctioned by both the legislative and administrative branches of government.**

Discussion

Children's services are delivered by the Departments of Human Services, Education, Mental Health and Mental Retardation, and Corrections.

In the 1970's the Interdepartmental Council was established as a formal mechanism for commissioners and their designees from the four agencies to meet to resolve issues which cross two or more agencies. Until recent years, accompanied by financial

retrenchment, the IDC had professional staff support. The IDC generally relies on a consensus process that in effect gives veto power to any single participating agency, according to the Special Commission on Governmental Restructuring.

In 1990 Governor McKernan issued an executive order establishing a Governor's Task Force to Improve Services for Maine's Children, Youth and Families.[41] The Task Force identified the following models for restructuring: creating a new department; consolidating programs within an existing department; restructuring the existing departments; establishing an office for children; forming a strong local/regional structure; developing a parastatal/quasi-agency[42]; and enhancing the present system of interagency coordination. The Task Force also defined in some detail six models for state and local operation which incorporate the Interdepartmental Council as the coordinating mechanism at the state level and expand the concept, in some models, to the local level (such models are already operational in other states such as Ohio and Hawaii). The Office of Child Welfare Services Ombudsman is designated as the mediator for conflict resolution in each of the models which delineates such a function.[43]

According to the Special Commission on Governmental Restructuring, "Despite good faith efforts on the part of department heads, no interdepartmental coordinating mechanism exists that has the authority, staff, and budget to provide leadership for extensive coordination and collaboration." The IDC structure itself has become highly bureaucratized with committees and subcommittees. Many layers have to be transgressed before decisions can be made. As a case in point, the Central Placement Review Committee, a subcommittee of the Children's Policy Committee of the IDC has been working for several years on an interdepartmental case review system for children who are in the custody of the Department of Human Services but who are also being served by at least one other agency. These are the "multi-agency, multi-problem kids," generally adolescents, who are often the most difficult for the state to serve. Many are about to leave a correctional facility or mental health institution and require comprehensive community-based services. The Committee reviewed ten cases on a pilot basis with the aid of a

[41] "Governor's Task Force to Improve Services for Maine's Children, Youth, and Families," May 6, 1991.

[42] Defined as entities that look and function like public agencies; may contain parts of the public and private sectors; not fully independent like Maine State Housing Authority.

[43] State of Maine Governor's Task Force to Improve Services for Maine's Children, Youth and Families, A Preliminary Report to Governor John R. McKernan, Jr., May 22, 1991.

psychologist and found the following barriers to developing a comprehensive service plan for these children:

1. *Barriers to assessing needs:* Information is divided among multiple agencies and service providers; information in any one agency may be incomplete; access to information is limited by varying confidentiality requirements.

2. *Barriers to providing funding for an appropriate case plan:* Categorical funding cannot purchase certain services; many children or their families do not fit eligibility criteria; services are driven by available funding rather than human need; there are limits to the dollar amounts available to the participating state agencies when the cost is high.

3. *Barriers to providing appropriate resources:* The type of service needed often was not available in the community.

4. *Barriers to providing appropriate programming:* Existing providers often could not address the particular needs of the children.

5. *Barriers to responding to emergencies:* The agencies cannot respond to crises in a coordinated manner.[44]

These various studies and efforts consistently point to the problems endemic in a system where four agencies serve children who are often clients of more than one agency.

One of the most intransigent interagency problems brought before the Oversight Committee related to the inability of children with severe emotional and mental health problems to gain access to mental health services, particularly residential, through special education if they did not also display an educational problem which could not be addressed by the local school system. Even if a child was in the custody of the state and the local school system was not responsible for paying for the residential treatment, access was denied because local schools did not want to set precedents which they could not live

[44] "Final Report: A Plan to Establish an Interdepartmental Central Case Review System," Submitted by the Central Placement Review Committee to the Maine Interdepartmental Council, June, 1992.

with later. That is, what would happen if other children who were not state wards demanded similar treatment or the child for whom residential care was authorized then left state custody.

The interagency problems laid out in this report are not new. However, they have not been addressed in a comprehensive and systematic fashion at the highest legislative and administrative levels of government. A Blaine House Conference on Children and Their Families would serve as a mechanism for reviewing a comprehensive, multi-year plan to address these issues.

RECOMMENDATIONS

45. The legislature should establish a Department of Children and Families and a Department of Health and Developmental Services.

This recommendation is consistent with that made by the Special Commission on Governmental Restructuring[45] and by The President's and Speaker's Blue Ribbon Commission on Children and Families.[46] Within each department, services should be organized along consumer lines to break down categorical barriers and facilitate consumer access to services.

46. In the absence of such restructuring, the Governor should exert his leadership over the four commissioners who provide services to children to require a single, unified approach to the following:

A. Children who require residential care but who do not have educational needs that cannot be met by the local school district.

B. Children being served by more than one agency.

[45] "Special Commission on Governmental Restructuring: Final Report," December 15, 1991.

[46] "President's and Speaker's Blue Ribbon Commission on Children and Families," August, 1991.

For those children in state custody who are served by more than one agency, and who constitute the most problematic, high profile children in the system, a case review system such as that recommended by the Central Placement Review Committee should be adopted. The features of this system are spelled out in *Final Report: A Plan to Establish an Interdepartmental Central Case Review System* submitted by the Central Placement Review Committee to the Maine Interdepartmental Council, June 1992. Recommendations cover mission and philosophy, goals, organizational structure, review structure and processes, nature of review, financial arrangements, monitoring plans and progress, evaluation and reports.

C. Adolescents who are not in DHS care or custody but who move throughout the residential care system (emergency shelter care; community-based group care or group homes; and transitional living facilities).

47. The Governor and the Legislature should require that the Commissioners of Human Services, Education, and Mental Health and Mental Retardation give priority attention to the establishment of "mutual agreements and specific regulations" which would ensure the elimination of loopholes and inconsistencies in current state statutes and regulations involving children and youth which in fact allow for abdication of responsibility for needed services. Incentives must be provided and creative planning must occur to develop and implement "real" interagency cooperative agreements among all agencies serving children and youth.

The four agencies should cooperate in establishing a case management system which would follow adolescents through any out-of-home placements with the intention of returning them home at the earliest possible time or, if they are too old and this is an impossibility, preparing them for independent living.

48. DHS should negotiate with the Department of Education, the Department of Mental Health and Mental Retardation and other appropriate state officials concerning the responsibility for identifying and coordinating mental health services for children in need through the school system. Reimbursement for these services should come directly from DHS and the Bureau of Children with Special Needs.

49. DHS, in concert with the Department of Education, the Department of Corrections, and the Department of Mental Health and Mental Retardation should advocate for legislative action creating an entitlement to mental health services. State extension of this entitlement should be accompanied by state commitment to pay for it.

A. The four agencies should explore whether or not the Americans with Disabilities Act can serve as a method for providing mental health services to children who do not currently demonstrate an educational need. Additionally, the four agencies should explore P.L. 93-112 § 504 as another potential funding source for these services.

B. The interagency agreement should incorporate a broader definition of mental health needs based on the behavior of the child exhibited outside the classroom, in the community, and at home, in addition to the child's classroom performance.

Education is the common arena where all children interact and are observed. It is the place that a cohesive group of professionals come in contact with youngsters on a daily basis. It is the natural environment for potential interventions to be designed and implemented. Coordination in this area will boost the commitment of local communities to identifying mental health needs through the PET and/or Child Study Teams or Student Assistance Teams. The extension of an entitlement to mental health services will help to overcome the over-emphasis on the educational component of special needs children that currently dominates the PET process.

50. DHS should engage in more consistent dialogue between CPS staff and local school and police personnel, especially with respect to "cracking the system" to obtain services for children who are perceived to be at risk and in need of services.

The Educational system needs to be incorporated as an essential part of a multi-disciplinary approach to the prevention, early intervention, and protection of children from abuse and neglect. DHS must recognize the natural fit between the schools and the Department in creating an environment dedicated to children and families. The beginnings and the potential of this alliance are exemplified by programs such as the Jack

Elementary School Family Center in Portland, and the evolving parent mentoring program in Franklin County which will involve school guidance staffs in the screening of potential parent mentors.

51. DHS and the Department of Education should encourage the establishment of widely available community-based parenting courses throughout the state.

52. Over the last decade at least nine Maine studies have addressed improving services to children. The Commissioner of Human Services, who is also the Chair of the Interdepartmental Council, should take the lead in prioritizing the recommendations in this and other recent reports. This should be a joint effort of the Administration and the Legislature which should result in a multi-year plan to address the needs of children and their families.

The conclusion of this effort should be a Blaine House Conference on Children and Their Families convened by the Governor and the Legislature. Participants should engage in dialogue about the Plan while selected members of the public, the Administration, and the Legislature should finalize a multi-year strategy.

Too often the efforts of various commissions, committees, and study groups are lost in spite of the fact that valuable content is reflected in the conclusions of these groups.

The Oversight Committee may be the group designated to assist with such an effort.

Chapter 7

Finance Issues

Findings

- **DHS has made good strides in recovering federal funds in some areas although more can and should be done.**
- **Three federal sources--Title IV-E, Title XIX and Title IV-A--all hold promise for new federal cost recovery.**
- **In some instances additional seed money would be required to capture new federal funds, representing a cost effective way to expand services.**
- **DHS does not necessarily use newly recaptured federal funds to enhance and develop child welfare and family support services.**

Discussion

The importance of finance issues becomes paramount during periods of extreme financial stress. The need to restrict or even reduce expenditures can often be driven by political considerations that fail to examine the full significance of proposed expenditure reductions. Among the issues to be considered during the budgeting process are issues of costs and benefits (i.e., will there be a significant long term cost as a result of a program reduction or cut today), the real dollar cost of proposed spending reductions, (i.e., if state funding that had previously triggered a federal match is cut, what actual revenue loss occurs), and the global effect of reductions (i.e., will a cut in one area [e.g., preventive programs] result in a rise in costs or service demands in another area [e.g., CPS intervention] that will neutralize the savings).

These issues become increasingly important in light of rising abuse and neglect referrals and service demands, documented above. The need to cut government spending during economic downturns is accompanied by increasing demands for human services stemming from the same economic conditions. Clearly, this scenario illustrates the need for expanded, not reduced, services during this period.

"A Medicaid Plan for Children and Families of Maine" points out that some of the services and programs most susceptible to budgetary crises are those eligible for federal reimbursements.[47] This applies especially to preventive programs where executive budget designers are unlikely to examine the long term effects of cuts at a level of detail needed to project the net monetary effects of the cuts.

The Department must present its budget request in a manner that clearly details the costs and benefits of each program. This level of detail should include:

- The services that will be lost when a program is cut or reduced;
- The matching funds that will be lost when a program is cut or reduced;
- The systemwide impact of the cut or reduction:

  What other services will be lost?
  What new demands on the system will result?
  What increased spending in other areas will result?

"The State of Maine is a leader nationally in maximizing its federal reimbursements through the Medicaid program..."[48] The DHS role is central to this maximization; zealous care must be taken to continue to aggressively pursue federal funding through both refinancing and the additional triggering of new federal funds through the provision of state match dollars.

The Oversight Committee supports the DHS initiative to reorient the focus of the child welfare system toward prevention, early intervention, and family preservation provided needed treatment services are in no way compromised. Needs continue to exist at all levels of the continuum. The Pew Charitable Trust-sponsored Children's Initiative states:

---

[47] "A Medicaid Plan for Children and Families of Maine"; January 15, 1992, p. 5.

[48] Ibid, p. 3.

> Fundamental to the design is a belief that current federal, state, and local resources can be much more effectively utilized to improve children's outcomes if they are refocused on prevention and early intervention and pooled in ways that are less categorical, more flexible in meeting comprehensive needs, and less cumbersome in administration.[49]

The Children's Initiative identifies the "complex and highly categorical nature of funding streams"[50] as a major barrier to the design of holistic, needs based interventions for children and families. While some states purposely use categorical funding to narrow client eligibility others have attempted to decategorize funding streams. In 1987 Iowa, for example, created pilot decategorization projects in two counties. The experiment included blending funding from the mental health, juvenile justice and child welfare systems. The decategorization allowed the two counties to reallocate funding. They have expanded home-based and community services and have shown positive results in holding down or reducing expenditure growth for out-of-home care.[51] The localities report that decategorization of funding has allowed them to rethink the values and directions underlying their service systems, and initiate a continuum of care based on principles of supporting families in their homes and communities.[52]

General Fund Appropriations

The table below, supplied by the Legislative Office of Fiscal and Program Review, provides general fund appropriations for child welfare services for the past four years. The net increase in final appropriations over that timeframe is 8.5 percent.

---

[49] "The Childrens' Initiative: Making Systems Work," A Design Document for the Pew Charitable Trusts, November 1991, p. 65.

[50] Ibid, p. 77.

[51] Farrow, F., "Services to Families: The View From the States," The Journal of Contemporary Human Services, 1991, p. 273.

[52] Ibid, p. 273.

General Fund Appropriations for Child Welfare Services				
	1989-90	**1990-91**	**1991-92**	**1992-93**
Initial Appropriation	$6,490,122	$6,518,665	$8,106,497	$8,162,703
Final Appropriation	$7,696,122	$7,979,915	$8,356,018	$8,350,817
Increase (decrease)	$1,206,000	$1,461,250	$249,521	$188,114

Division of Purchased and Support Services

Services purchased to support families constitute an important part of the child welfare service continuum. During fiscal year 1992, $27.6 million was allocated to purchased social services. Of this, 51.7 percent came from federal funds and 48.3 percent from state funds. However, not all these services are for child welfare clients exclusively. They encompass all divisions of the Department of Human Services. The accompanying table shows how the funds were allocated by service area.

SUMMARY OF DHS SERVICE AREA ALLOCATIONS[53]

Service Area	Federal Funds	State Funds	Total Funds
AIDS	$266,013	$212,525	$478,538
Day Care - Providers	$3,802,487	$1,755,142	$5,557,629
- Resource Centers & Voucher Allocations	$1,012,411	$1,234,216	$2,246,627
- State Employees	-	$30,000	$30,000
- Training (O.C.C.)	$115,825	$34,425	$150,250
Family Crisis	$193,647	$1,117,375	$1,311,022
Family Planning[54]	$680,003	$181,907	$861,910
Homemaker	$2,200,815	$193,862	$2,394,677
Nutrition[55]	$435,455	-	$435,455
Rape Crisis	$85,466	$298,694	$384,160
Substance Abuse	$3,750,170	$4,440,165	$8,190,335
Support Services	$331,360	$3,399,792	$3,731,152
Teen Health	-	$348,400	$348,000
Transportation	$1,215,746	$69,611	$1,285,357
Victim-Witness Advocate	$182,715	$34,945	$217,660
Totals	$14,272,113	$13,351,059	$27,623,172

The Division of Purchased and Support Services provided the Oversight Committee with a breakdown of purchased services delivered to clients of the Bureau of Child and Family Services.[56] The breakdown covers the period from fiscal year 1986 to fiscal year 1991. By focusing on 1986, 1989, and 1991, changes in the BCFS purchased services budget can be tracked.

[53] "Purchased Social Services Annual Report FY 92," June 11, 1992.

[54] Family Planning funds are administered by the Bureau of Health.

[55] Nutrition funds are administered by the Bureau of Elder and Adult Services.

[56] Provided by Division of Purchased Services, January 7, 1992.

PURCHASED SERVICES DELIVERED TO BCFS CLIENTS

Service Area	FY 1986	FY 1989	FY 1991	% CH 86-91
Day Care	$502,320	$554,788	$553,107	10.1%
Family Crisis	$99,536	$168,750	$187,521	88.4%
Homemaker	$319,610	$285,710	$344,203	7.7%
Substance Abuse	$527,505	$673,330	$802,054	52.0%
Support Services	$1,222,716	$3,521,052	$3,669,288	200.1%
Transportation	$361,376	$413,202	$505,080	39.8%
Victim-Witness Advocate	$46,500	$194,865	$201,005	332.3%
Totals	$3,079,563	$4,963,294	$6,262,250	103.3%

The largest increases in spending, on a percentage basis, have occurred in the funding for victim-witness advocate programs (332.3%), and Support Services (200.1%). The next table provides an expanded view of the Support Services line in the Service Area Allocations table for fiscal year 92. Purchased services for child welfare clients have grown at a faster rate than inflation (assuming 3 percent annually) for this period. While funding dedicated to support services has increased over time, the stresses on children and families have also increased as a result of the economic downturn. The need for increased services and support for children and families during times of economic stress was cited earlier in this chapter, and should be emphasized again here.

SUMMARY OF SUPPORT SERVICES ALLOCATION, FY 1992
(EXPANDS SUPPORT SERVICES LINE IN THE PREVIOUS TABLE)

Category	Federal Funds	State Funds	Total Funds
Blind Services	-	$54,613	$54,613
CAN Councils	$3,500	$276,244	$279,744
Contingency Accts	$39,000	$192,540	$231,540
Homebased Services	-	$219,590	$219,590
Mental Health	-	$892,612	$892,612
Mental Retardation	$84,935	$6,800	$91,735
Residential[57]	-	$1,263,943	$1,263,943
SCAN Teams	-	$135,940	$135,940
Special Needs	$203,925	$357,510	$561,435
Totals	$331,360	$3,399,792	$3,731,152

The provision of Purchased and Support Services is an important portion of the continuum of services and support offered to BCFS clients. For instance, without transportation services many clients would be unable to access other support services required to fulfill case plan requirements. The importance of maintaining these purchased services cannot be overemphasized; the cumulative loss to clients through reductions in this area would be far greater than the initial cost savings imply. In many instances these services are the key factor in providing sufficient support to families to prevent family stresses from escalating to a level of crisis.

Preventive Services

Maine currently spends approximately $279,000 on the statewide network of Child Abuse and Neglect Councils. These expenditures are currently not matched

[57] Residential includes thirteen different areas. The majority of these residential funds are used to purchase bed space in group homes and shelters.

($3,500 of this expenditure, 1.3 percent, is federal funds: $2,500 is Title IV-E Independent Living funds, and the remaining $1,000 originates from Federal Child Abuse and Neglect Prevention Activities funds). It may be possible to match these expenditures under the Title IV-E program, generating approximately $108,000 in new federal funds.

Family Preservation Services

Currently, Intensive Family Preservation Services (IFPS) are delivered by nine private nonprofit agencies under contract with the Department of Human Services and the Department of Mental Health and Mental Retardation, Bureau of Children with Special Needs. DHS hopes to expand the existing network of family preservation services by transferring workers and resources within the Department to enable in-house delivery of IFPS.

States can use family preservation services as an assessment and treatment program reimbursable under EPSDT for eligible children. The rehabilitation services program option allows states to define family preservation services in the state Medicaid plan as remedial services necessary to reduce physical or mental disability. When recommended by a physician or other licensed practitioner, family preservation service is reimbursable to restore the recipient to optimum functional level. The Medicaid case management option allows states to claim that portion of family preservation services related to some aspects of handling cases for certain populations.[58]

Medicaid and Mental Health Services for Children

The Department has taken many important steps in recent years to recover funding under various Medicaid provisions for services to children. To continue to be successful, particularly in the mental health area, the following overall principles should be followed:

[58] "Family Preservation Services: State Legislative Initiatives"; National Conference of State Legislatures, 1991, pp. 19, 31-32.

1. The process must include representatives from the Governor's office, the legislature, and the four state agencies serving children.

2. Child Welfare staff and Medicaid staff must continue to strengthen their cooperative relationship.

3. Child Welfare administrators and Mental Health administrators must work together to combine the strengths of both systems. They must help Medicaid staff understand the social work/mental health treatment model.

4. The state's Medicaid office will need additional staff to help administer the changes as a result of refinancing. The need to provide adequate staffing levels cannot be overemphasized; the benefits of accessing additional Medicaid funding for mental health services for children will easily pay for necessary staffing enhancements.

Three sources of federal funds, Titles IV-E, XIX and IV-A hold promise for expanded federal cost recovery. However, some areas of expansion require new seed money. Each area is explained in the recommendations below.

A major purpose for recovering federal funds is to strengthen and enhance services to children and families, not to offset deficits in other areas. The Oversight Committee strongly believes that the Department should aggressively pursue legislation to assure this end.

RECOMMENDATIONS

53. DHS should seek federal funds to strengthen the Child Abuse and Neglect Councils (or other designated county-level coordinating organizations) by aggressively seeking to match state expenditures supporting these organizations. The support funds should include the requirement that the designated organizations be able to provide documentation to support the federal claims.

Two possible strategies for this refinancing are:

1. *Training:* Much of the work these organizations currently do is "training" for community people in areas of child abuse and neglect. If this activity were included as a formal part of the Title IV-E Plan it could be matched as a training expense under a cost allocation formula:
If the current cost of this activity is $100,000 statewide, the allocation formula would be:

   a. 67 percent of the DHS caseload (in CPS) is IV-E eligible or "candidates" for IV-E eligibility.
   b. 67 percent of the cost of "in-service" training may be claimed.
   c. 67 percent * $100,000 * 75 percent = $50,250 in new federal funds.

2. *IV-E Administration:* This would require viewing the designated organization's activities as administrative activity under the IV-E Program (planning assistance in preparation and implementation of the IV-E and IV-B Plans).

   Assuming the cost of this activity to be $175,000, this cost could be allocated and claimed:

   a. $175,000 claimed against the Title IV-E eligibility percentage ($175,000 * 67 percent = $117,250).
   b. $117,250 * 50 percent (administrative services matching rate) = $58,625.

54. DHS should seek to strengthen non-categorical finance for family support.

Options for strengthening these financial supports include:

A. Developing a Medicaid "Rehab" option for Child Protective Services clients, similar to that for the substitute care group, and opening Medicaid reimbursement to MSW level clinicians.

The Bureau of Medical Services (BMS) currently covers Home-Based Mental Health Services as a Rehab option for children who are at risk of being removed from their homes. BMS is changing that policy so that the child does not need a diagnosis of mental illness to access services.

BMS has draft rules ready to go to rulemaking to implement coverage of LCSW services, required by statute in the last legislative session. This is a Medicaid maximization effort which will free up BCFS funds. In the absence of this effort BCFS would be required to fully fund crisis counseling services for children at risk of removal from their homes.

Maine provides Medicaid coverage for Case Management Services for children and young adults who are in the care or custody of another agency in another state and are placed in Maine, and the families of children who are receiving post-adoption services.

BMS reports that the addition of coverage for MSW's as independent practitioners is contingent upon a source of state seed money. Equally important is an estimate of the cost impact of this service. The estimate, and the source of seed money, must be provided by the Bureau of Child and Family Services in order to implement this option.

B. Expanding use of the "Katie Beckett" funding to allow non-Medicaid eligible families whose child(ren) are in danger of out-of-home placement access to Medicaid-supported in-home treatment.

Katie Beckett is an optional eligibility category which is covered in Maine. However, it is limited by regulation to children who would otherwise be institutionalized in a medical institution which includes only hospitals, nursing facilities, in-patient psychiatric hospitals, and Intermediate Care Facilities for the Mentally Retarded.

The Bureau of Medical Services is currently seeking clarification from the federal Health Care Finance Administration regarding acceptable definition of Katie Beckett-eligible children. This clarification includes determining eligibility for children for at-home or community-based treatment after discharge from an institution. BMS expects the clarifying decision in January of 1993.

C. Expanding Medicaid Targeted Case Management to include community agencies which serve Department clients.

This expansion is contingent on a source of state seed money. The State can claim only as much as it has funds to match.

55. DHS should pursue full implementation of the Medicaid Ribicoff amendments.

This option allows Medicaid coverage for children up to age 21 who do not fall within the mandated categories of recipients whom a state must cover. The state is free to create categories of children eligible for Medicaid services under the Ribicoff option.[59] A state may choose to cover financially eligible individuals under age 21 who would be eligible for AFDC except that they do not meet the definition of dependent children. A program may cover all of these children or it may cover any number of the following classifications:

1. Individuals for whom public agencies are assuming full or partial responsibility in foster homes or private institutions;
2. Individuals placed in foster homes or private institutions by private nonprofit agencies (assumes that # 1 is in place);
3. Individuals in adoptions subsidized in full or in part by a public agency;
4. Individuals in intermediate care facilities, which must include intermediate care facilities for the mentally retarded if opted;
5. Individuals receiving active treatment in psychiatric facilities or programs;
6. Individuals in other reasonable classifications by the state.[60]

Essentially, the Ribicoff option allows the state to declare individuals under age 21 who fall within the parameters "families of one" who then become eligible for Medicaid coverage.

---

[59] DeWoody, M., *Medicaid and Supplemental Security Income: Options and Strategies for Child Welfare Agenices*, 1991 Child Welfare League of America, Washington, D.C., p. 13.

[60] Small, M.A.; "Obstacles and Advocacy in Children's Mental Health Services: Managing the Medicaid Maze," Behavioral Science and the Law, Vol. 9, p. 181.

The major barrier to implementation of this program element has been the difficulty of defining eligibility in a manner acceptable to the federal regional office which must approve expenditures. The issue has revolved around the question of "care and control" of the child the state is seeking to serve. The latest interpretation will allow families to assign care and control (as opposed to custody) to the facility making the child independent enough to qualify as a family of one. The Bureau of Medical Services, in conjunction with the Bureau of Income Maintenance, believes that this is an acceptable solution allowing implementation of this service option. However, AFDC recipients who voluntarily sign off on care and control will lose benefits relating to that child.

56. The Department should explore the design and development of a Medicaid "Rehab" option for therapeutic child care.

This option would parallel the existing P.L. 99-457 system administered by the Child Development Services Program. The advantage to this parallel option would be to allow children who do not fit the educational definitions of disability or special need to access services. This option can be implemented upon provision of a source of state seed money.

57. DHS should explore matching Family Crisis Services expenditures ($1,311,022 in fiscal year 92, 85 percent state funded) through the Title IV-A Emergency Services Program. This program has been recommended for elimination in order to reduce state expenditures. DHS must advocate for the restoration of this program.

Eligibility for the Title IV-A Emergency Assistance Program is limited to one eligibility period, not to exceed 30 days, once every twelve-month period. Therefore, if a family received assistance through Family Crisis, they would be ineligible for more assistance for twelve months, per federal regulation. Allowable claims under this option would be reimbursable at a 50 percent match rate.

The Bureau of Income Maintenance reports that, subject to the restrictions referenced above, the Department could request approval for the funding of Family Crisis Services.

58. DHS should pursue legislation to codify a requirement that federal funds generated by child and family programs remain available to these programs.

The intent of this legislation, if approved, would be to use newly recovered dollars to support child welfare and family support services rather than to offset shortfalls or expand services in other areas.

Chapter 8

A Comprehensive System

Findings

- **A comprehensive system of family support services must include prevention, early intervention and treatment services.**
- **To develop a community-based system of care, one organization in each county should be responsible for planning.**
- **Several community structures exist but they are not adequately supported or sufficiently coordinated.**

Discussion

While the primary focus of this report has been the child protective services system as it functions within the broader array of services to children, the Legislature was also concerned with the question of how local communities and agencies could become more involved in planning and resource allocation development and how the State's role in planning, resource development and technical assistance could be increased to support local communities. This chapter addresses those questions, particularly as they relate to developing a more comprehensive system of prevention and early intervention services.

Interventions can take place at any of three points: before the abuse or neglect has occurred (primary prevention); before it has occurred to a serious degree but after warning signs have appeared (secondary intervention); and after it has occurred to keep it

from recurring (tertiary intervention).[60] Any comprehensive system must include all three types of interventions.

Prevention

The Maine Children's Trust Fund (MCTF), established by the Legislature in 1985, was designed to receive funds from an income tax check-off to be used to fund primary prevention programs. Among its initial goals were:

- To promote primary prevention on a statewide basis;
- To support local and geographically diverse efforts focused on primary prevention;
- To market the fund with the goal of becoming financially independent.

The Maine Children's Trust Fund has had a stormy history, featuring attempts to redirect its efforts, the dissolution of the original Board of Directors, the appointment and subsequent dissolution of an Advisory Board of Directors, transfer of the authority to distribute MCTF revenues to Community Services, then subsequently to the Department of Human Services. One result of this instability is the failure until late 1992 to distribute the MCTF funds which had accumulated since 1990 for primary prevention programs.

Since the administration of the Maine Children's Trust Fund was transferred to DHS, the Division of Purchased and Support Services has been working with the Maine Child Abuse and Neglect Councils to develop a strategy for distribution of Trust Fund revenues and for generating further income. The Oversight Committee supports this effort and would urge a continuation of this process with the goal of re-establishing the Maine Children's Trust Fund as an independent organization. Although well intentioned, the original designers were not realistic in their assessment of the potential income that would be generated through the income tax check-off. A new structure should be well planned with a realistic understanding of the Fund's potential.

[60] Gray and DiLeonardi, 1982; cited in "Model Child Abuse Prevention Program," Initial Grant Proposal, July 21, 1989, p. 10.

Primary prevention programs are aimed at the general population, require minimal family intrusion and can be provided at the lowest per person cost. Examples of primary prevention activities include prenatal health care, parent education and support, and public awareness programs about positive parenting and family support.

Child Abuse and Neglect Councils, which provide primary prevention and sometimes secondary intervention services, currently exist in all sixteen counties. They are mandated by state legislation and receive support from the state in the amount of $279 thousand statewide. The directors have a statewide organization whose leadership meets on a consistent basis.

Formal and informal alliances spearheaded by local Child Abuse and Neglect Councils and other organizations have resulted in the following achievements:

- Legislation establishing a Maine Children's Trust Fund in 1985, which by 1988 was receiving $.82 per capita, third highest among the sixteen states with income tax check-offs.

- Development of an adolescent peer support network, with 96 programs functioning statewide as of 1989.

- Establishment of an Adolescent Pregnancy Coalition. One council in each region plans counseling and prevention programs.

- Establishment of the Maine Prevention Network, committed to the promotion of healthy people and communities through advocacy, education and information sharing.

- Formulation of the Maine ASPIRATIONS Foundation. Endowed by a $600,000 grant from L.L.Bean, the Foundation's goal is to prevent high school drop-outs and raise the aspirations of Maine students through school-business partnerships.

- Establishment of the Primary Prevention Committee, charged by the Legislature to develop a prevention plan for youth.

- Involvement of business and industry. The Cumberland County Child Abuse and Neglect Council has enlisted financial and programmatic support in prevention activities from S.D. Warren Paper Company, UNUM, and Casco Northern Bank among others.

- Aggressive media campaigns. The four major television networks have run extensive prevention campaigns such as "Family Matters" and "For Kids Sake."[61]

These organizations have identified the following weaknesses in the preventive system:

- Interventions have not been comprehensive.

- They have not always been client focused, but rather have served the convenience of service providers.

- They have not employed social marketing concepts which elicit feedback from the intended consumers and bring interventions directly into community institutions (supermarkets, shopping centers, doctors offices).

- They have not gone far enough in engaging large and small businesses.[62]

In response to these identified weaknesses, Franklin and Cumberland counties have been active in developing preventive programs under the auspices of Project Maine Families (PMF), a five-year federally-funded demonstration project.[63] PMF has been instrumental in conducting needs assessments and helping to implement a number of preventive programs in the two counties selected as pilot sites by Project Maine Families. Examples of these programs developed by the two initiatives are listed in Appendix K.

---

[61] Ibid, p. 2.

[62] Ibid, p. 3.

[63] Project Maine Families, pp. 1-6.

One of the most prominent models of primary prevention programs nationally is the home health visitor model. Two distinct models of home health visitation programs exist. The first, the primary prevention model, attempts to provide education and support to all parents at the time they give birth, either by targeting all births in a given hospital or a given geographic area. One or a few contacts with parents are used to impart information, acquaint the parent with community resources, and make referrals if indicated. In the second model, the early intervention model, certain parents are identified and targeted for service because they are believed to be at higher risk for abuse. Typically, home visits are offered on a more intensive basis for a longer period of time. Research evidence indicates that the more intensive approach with high risk parents is the more effective model.[64]

Donnelly identifies nine program elements considered essential to a successful home health visitation program:

- Start at the time of birth or earlier;
- Universal provision of some service to all new parents;
- Screen for high risk (by highly qualified workers);
- Offer follow-up home visitor services on a voluntary basis, especially to high risk parents;
- Offer services in the home, where one has complete access to the parents and the child;
- Offer intensive services: at least once a week for the first six months;
- Offer services for a long period of time: at least six months, up to five years;
- Tailor services to a family's specific needs;
- Focus on friendship, trust, social support.[65]

Currently, home health visitation programs exist in most areas of the state. Depending on location and circumstance, services are delivered by the Department of Public Health Nursing (DPHN) or through contracted agencies. The Division of Public Health Nursing acts on referrals from local hospitals. Hospitals refer according to different standards, ranging from universal referrals to identified high risk referrals. DPHN reports that the intensity of services varies according to the needs of the family, ranging from a

[64] Ibid, p. 5.

[65] Donnelly, op. cit, p. 8.

single contact (sometimes no more than a telephone call), to frequent home visits extending until the child reaches pre-school or school age. Maine meets to some degree all of the identified characteristics of a home health visitors program with the exception of universal provision of services to all new parents.

The weakness of the current system is uneven service availability, and uneven referral relationships with participating hospitals. For example, in Cumberland County the City of Portland's Public Health Nurses provide extensive home health visitation. However, according to the Division of Public Health Nursing, outlying areas of Cumberland County are covered by relatively few nurses in relation to the area's population.

DPHN and contractors also conduct well baby clinics and early detection work. A DPHN spokesperson characterized the system as an effective system that needs to be strengthened.

Funding for existing prevention programs comes from a wide variety of sources of which DHS is only one factor. In one sense this fosters disorder in the preventive system. However, multiple funding sources creates an opportunity to build connections between public and private agencies. The work of Project Maine Families is an example of the potential for service linkages on the local level. Creating small localized programs will allow Project Maine Families to design, implement, and modify new services. These initiatives can then be replicated on a regional or statewide level once they have proven their effectiveness.

The current Child Abuse and Neglect Council system is uneven in terms of the strengths and roles of the individual councils. The Cumberland and Franklin County Child Abuse and Neglect Councils provide a working example of the potential the individual councils represent in terms of helping to plan, coordinate and provide preventive services on the local level. Research by Project Maine Families indicates that the most important need is for "relatively small investments in existing organizations and structures, not new and expensive programs."[66] The need for interdepartmental coordination is equally as important as expanded investment in preventive services. Interdepartmental

[66] "Draft Report," Community Response Subcommittee, Sept. 30, 1992.

coordination is essential to help target investments efficiently. Perhaps the greatest systemic weakness is the lack of utilization of these coordinating resources.

Early Intervention

Early intervention services are used with families in high risk groups. Services may be delivered after warning signs but before a full-blown crisis has occurred. Support groups which encourage parent participation for parents under stress, and projects which aim to prevent alcohol and drug related child abuse are examples.[67] Early intervention services require a greater degree of intervention into family life and are more costly per person than preventive services.[68]

Three systems in Maine have the potential to deliver early intervention programming on a statewide basis, especially for young children: Early and Periodic Screening, Diagnosis, and Treatment programs, referred to in Maine as the Preventive Health Program (PHP); hospital-based Suspected Child Abuse and Neglect (SCAN) Teams; and Project Head Start.

The Preventive Health Program (PHP) is administered by the Bureau of Medical Services. It is a comprehensive child health program of prevention and treatment services that seeks to:

- Find eligible children and inform them of the benefits of prevention and the health services and assistance available;
- Help children and their families to use health resources effectively and efficiently;
- Assess the child's health needs through initial and periodic examinations and evaluations; and,

[67] Project Maine Families, op. cit., p. 11.

[68] "A Medicaid Plan for Children and Families of Maine: Final Report," Institute for Human Services Management, Inc., Cares, Inc., January 24, 1992; p. 11.

- Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.[69]

Hospital-based Suspected Child Abuse and Neglect Teams (SCAN) Teams, also discussed in Chapter 2, are currently in place in 13 Maine hospitals. The SCAN Teams identify possible instances of abuse and neglect and employ a multidisciplinary team approach in the assessment, diagnosis, and management of child abuse and neglect. They provide a critical but underfunded link between the medical, social service and public case work service communities.

Project Head Start is a federally funded pre-school program for low income children and families. Head Start provides a family focused support system, which includes pre-school child care and, in some circumstances, health services such as immunizations and preventive health care.

Two major changes affecting Project Head Start are contained in a bill passed by Congress in October 1992. The Head Start Improvement Act (HR 5630) authorizes local Head Start Grantees to purchase the facilities housing their programs. This change will allow programs to establish a more stable physical plant base, enabling them to plan more effectively for the future. The legislation also allows Head Start Programs to expand health programs to the younger siblings of enrollees, enabling the program to make a larger contribution to effective health care for low income children. The final change in the legislation is a mandate which requires local programs to offer or to refer parents to literacy training and parent education classes.[70]

Teachers and physicians are mandatory reporters: the existence of PHP, SCAN, and Project Head Start programs serve as a resources to strengthen and validate the quality of their reports. These programs can help to refine the roles of these two sources of mandatory reports, cutting down on inappropriate referrals.

The strength of the current system is the ability of these resources to provide early identification of possible instances of abuse and neglect, and to support the Department's

[69] "A Medicaid Plan for Children and Families of Maine: Final Report," Institute for Human Services Management, Inc., Cares, Inc., January 24, 1992; p. 11.

[70] "Congress Improves Head Start," CDF Reports, Vol. 13, No. 12, October, 1992, pp. 1, 8.

role in early intervention. Each of these systems can play an important role in expanding BCFS's ability to accurately screen referrals, and intervene in critical situations.

There are two major weaknesses in the current system. The first is the lack of universality of either PHP, Head Start, or SCAN Teams in Maine. The second weakness is the failure to utilize the existing elements of these systems to their maximum potential. Currently, these elements of the early intervention system are used primarily as identifiers and referral sources. While pieces of each system may actually function in a more active manner, DHS does not appear to encourage this. Writing on the role of mandatory reporters, Zeltman and Antler observe that:

> Unfortunately, this legal mandate to report has never been accompanied by clear guidance on what constitutes abuse or reasonable suspicion of abuse, nor have reporters been accorded any special status by overloaded CPS agencies. As a result, professionals who are supposed to be a key element in the fight to protect children have become increasingly alienated from the child protective system.[71]

Properly utilized, this network can perform a much larger supporting role in helping DHS to fulfill its mission. The fact that DHS is generally unable to meet its statutory mandate of investigating all appropriate allegations of abuse and neglect (Chapter 2), speaks to the need to more fully utilize this network. The weakness of this system is similar to that of the preventive system: a lack of a unified vision for its functioning. The early intervention system represents another opportunity to reap large benefits from an existing system, and to increase these benefits with limited investment.

An example of the potential for expanded utilization of this system is the role a SCAN program can play in hospital-identified instances of abuse or neglect. Children abused by "out-of-home" perpetrators are often screened out and referred for services to the criminal justice system. The focus of services for that system is not the victim. A system needs to be in place to insure that all child victims and families are able to obtain access to necessary services and receive treatment. A hospital-based SCAN program can

[71] "Mandated Reporters and CPS: A Study in Frustration"; Zeltman, G.L., Antler, S.; Public Welfare, Vol. 48, No. 1, Winter 1990, p. 30

provide a referral point to ensure medical and social work services are offered to these children and families.

RECOMMENDATIONS

59. DHS should provide adequate base level funding for Child Abuse and Neglect Councils or other appropriate organizations in each of the 16 counties. Funding should be sufficient to enable each organization to hire a full time executive director. In each county, the chosen organization should be defined as the vehicle for drawing together appropriate community representation to enhance cooperative, community-based attempts to address the issues of prevention, volunteerism, early intervention, combining of community resources, and the design of strategies to address such needs. In addition, the chosen body should design and implement the Information and Referral Service discussed in Recommendation 3, Chapter 2. DHS should have discretion in choosing the appropriate organization in each county to fulfill this role. This funding should be accompanied by specific outcome measures and evaluation criteria to allow the Department to closely monitor the performance of the chosen organizations.

60. The sixteen coordinating organizations, with financial support from DHS, and technical assistance from Project Maine Families, should focus on creating and enhancing their organizational capabilities to enable them to fulfill their roles. These enhancements must include developing the capacity to measure outcome and evaluation criteria required by the Department of Human Services.

From a systemic perspective, the sensible first step is to inventory existing strengths, weaknesses, and needs for services at the county level and to identify strategies to strengthen the system. Strengthening these organizations allows the Department, first, to gain a resource for families who may not qualify for service by child protective standards but who still need family support and, second, a coordinating mechanism for information and referral services with a limited investment. In implementing this recommendation, DHS should specify the needs assessment, planning, and coordination functions it expects the coordinating organizations to perform in each county. Specifically,

the sixteen organizations should inventory existing programs and establish priorities for targeted investments to create a comprehensive, statewide prevention and early intervention system that meets both state and local needs. In addition they should establish protocols and procedures with the Department of Human Services for an information and referral service.

61. DHS should initiate any necessary legislative changes required to allow the Child Abuse and Neglect Councils or other appropriate organizations to fulfill these roles.

62. The fundamental goals of the Maine Children's Trust Fund (MCTF) should be reinstated, establishing the Trust's independence from any state agency. The role of the MCTF should be clearly defined, focusing on resource development. Strategies should include promotion of the tax check-off through an aggressive marketing campaign, and the exploration of opportunities to match these revenues through various private and public sector funders. The primary goal of the MCTF should be to build a substantial fund to create a self-perpetuating funding source for prevention focused activities.

It is the view of the Oversight Committee that the Maine Children's Trust Fund can be an important funding source for primary prevention activities. Vigorous promotion of the Maine Children's Trust Fund tax form check-off will yield dedicated revenue for prevention programs. In 1988, The Maine Children's Trust Fund yielded $.82 per capita, the third highest rate of the sixteen states with tax check-off programs. Aggressive promotion of the MCTF will assure a constant source of seed money for prevention-related research and services. Properly administered and managed, MCTF funds can be used by grantees to trigger matching funding from other public and private sector funders. The MCTF represents a potentially substantial contribution toward the goal of establishing a comprehensive network of prevention services.

63. DHS should pursue statutory actions to reinstate the Board of Directors of the Maine Children's Trust Fund, with the intention of recreating the original intent and structure of the MCTF.

The proposed legislation should include language establishing the disbursement mechanism for the funds in the trust, including the method of disbursal and the require-

ments of the disbursal process such as administrative allowances and the requirement that the awarded funds be directed to services, not administration.

64. DHS should take steps to insure universal prenatal care and to coordinate this program with the strengthening of existing home health visitation programs. DHS should establish a long term goal of strengthening this system to include full implementation of the Healthy Start Model of home visitation, beginning at the prenatal stage.

Given the implementation of Recommendation 59, the newly empowered coordinating organizations and the existing home health visitor programs can work together to help currently underserved regions develop stronger programs.

The existing Home Health Visitor network provides a well organized base for comprehensive home health visitor services. The current system already includes the interorganizational relationships and cooperation necessary to effectively deliver a strengthened program.

The Department should embrace universal prenatal care as the beginning of a continuum of preventive support for children and families. Starting the continuum of preventive support at the prenatal stage allows identification of high risk families and the targeting of more intensive and focused intervention to precede the birth of the child. Including the goal of universal prenatal care with a strengthened home health visitor program will create a preventive program that can support and strengthen high risk families from pregnancy through the child's fifth birthday.

Anne Cohn Donnelly reports "that the earlier the prenatal intervention the more positive the parenting later."[72] The U.S. Advisory Board on Child Abuse and Neglect declared that while there are dozens of important things to do, a logical place to start is with new parents, helping them get off to a good start before abuse patterns begin.[73]

---

[72] Larson, C.; and Daro, D.; as cited by Donnelly, A.C., "An Approach to Preventing Child Abuse: The Home Visitor Model," p. 7.

[73] *Creating Caring Communities: Blueprint for an Effective Federal Policy on Child Abuse and Negelct,* Washington, D.C., U.S. Department of Health and Human Services, cited in Donnelly, p.2.

Full implementation of the Healthy Start Model will require substantial investment and commitment by DHS. In Hawaii, Healthy Start makes extensive use of trained paraprofessionals, as opposed to the Maine programs which utilize professionals to deliver services. The strengthening of existing programs through the addition of supervised paraprofessionals may allow existing programs to be expanded at a lower cost. The use of trained "mentor parents," as envisioned in the Project Maine Families-sponsored New Parent/Home Visitor initiative in Franklin County, may provide an inexpensive avenue to expanding home health visitation services. DHS support to strengthen the existing home health visitation programs represents a much smaller initial investment that will provide the foundation for full implementation of the Healthy Start Model.

65. Recognizing the pressures and need to deal with "crisis" cases, especially when financial and human resource needs are limited, the Department can demonstrate its commitment to the value of preventive programs by designating a fixed proportion of available funds for preventive programs and activities.

Strengthening this network will require a deeper financial commitment to preventive services. The commitment to the preschool and home health visitor programs demonstrates a commitment to a portion of the preventive network that will produce results in the short term. The Department needs to forcefully advocate for resources for preventive interventions. One way to demonstrate this commitment is to establish fixed standards for preventive spending.

The long-term returns of these programs make an immediate investment fiscally sound. While state investment is initially necessary, the opportunity to refinance programs through Medicaid or other Social Security programs may recapture a substantial portion of the initial investment. Additionally the avoided costs of Child Welfare interventions in both the protective and children's services areas will substantially reduce the impact of the initial investment.

The "Federal Child Abuse and Neglect Challenge Grant" [74] requires that 3 percent of state funds for purchased social services be restricted to funding of child abuse and neglect prevention activities. This law may provide an avenue for the implementation of this recommendation.

---

[74] PL 1991, Ch. 528, Sec. 44, effective 7/8/91.

Strengthening and maximizing the utilization of the existing early intervention network can help the Department to meets its goal of developing a comprehensive system of family support. The existing early intervention system, like the preventive system, furnishes a strong foundation to build upon. While investment will be required to expand the existing network, there are a number of opportunities to explore which require little or no fiscal investment.

Increasing the cooperation and interaction among the different pieces of the existing network will help to develop positive working relationships and help to maximize the use of currently available resources. In addition to building relationships, more active cooperation will lead to better understanding of the potential contributions of each element of the system.

SCAN Teams should be funded in all Maine hospitals. DHS should establish a formal liaison with each SCAN Team in order to gain the maximum benefit the SCAN Teams represent. SCAN Teams should identify, report, assess and work with high-risk families.

66. DHS should explore options for providing pediatric consultants to DHS through the American Academy of Pediatrics Maine.

Pediatric consultants, trained in recognizing symptoms of abuse and neglect, would be a valuable supplement to SCAN Teams, providing expert examinations to help prove or disprove suspected abuse/neglect. A network of available consultants may help to overcome the identified problem of pediatrician reluctance to get involved with abuse and neglect cases due to time commitments and dislike of hostile courtroom confrontations.

Pediatric consultants can provide another important link in the relationship between DHS and SCAN Teams. The pediatric consultant can contribute to and refine the pre-screening function of the SCAN Teams. Secondly, the pediatric consultant will lend the strength of a trained evaluator to DHS/SCAN allegations of abuse and neglect.

67. Project Head Start should be encouraged to take full advantage of legislation allowing local grantees to purchase program facilities. This will provide a level of stability which will enhance the Department's ability to expand the health and education components of the Head Start Program.

The Federal legislation (HR 5630) enabling Head Start Programs to purchase the buildings housing their programs and allowing and/or mandating the expansion of services represents an enormous opportunity. Head Start is one of the most visible and successful early intervention programs and, as such, represents an excellent opportunity to strengthen and expand available services. Equally important, Head Start offers a highly visible opportunity to strengthen community linkages.

The Head Start Program provides a highly visible opportunity to highlight the Department's commitment to early intervention programs. Strengthening and expanding Head Start programs should include developing and publicly promoting cooperation between the Head Start Program and the Bureau of Child and Family Services. The cooperation of BCFS and Head Start is an opportunity to highlight one of the most positively oriented interactions between BCFS and the community.

68. The pre-school and school age Preventive Health Program should be supported in all public schools and all publicly supported pre-school programs. Formal links between PHP and BCFS should exist in all regions.

This recommendation focuses on strengthening an existing system. Strengthening and expanding this system will require the investment of resources. Equally important as fiscal investment is working to maximize the potential contributions of this system. Full acceptance and utilization of this program will help DHS meet its mission of supporting children and families. Before committing new funding to expand the network, steps should be taken to improve the current use of the system. These include establishing formal relationships between BCFS and PHP delivery personnel.

The Departments of Mental Health and Mental Retardation, and Education both currently participate in this system, which is administered by DHS. The existence of formal linkages will allow more productive utilization of the system. Established contacts and protocols among the different actors in the system will result in mutual understanding and goal recognition, resulting in better access to and coordination of services.

69. Funding for early intervention activities should be available for non-Department of Corrections, non-DHS children who are in a high-risk environment and in need of group care or other services.

This recommendation focuses on the troubling phenomenon of children and families "falling through the cracks" of the services network. The specific focus of this recommendation is on teenagers who are currently screened out by BCFS. Too often, these teenagers' only access to services is through the mechanism of their parents voluntarily relinquishing custody of the child to DHS in order to allow the children to gain access to services. Full implementation of the Medicaid Ribicoff provisions may provide substantial relief from this problem, allowing access to services without the need of the child's parents relinquishing custody.

70. DHS should invest in community resources to support at-risk families whose level of risk does not require Child Protective Service involvement. DHS should join in collaborative planning efforts with community service providers and the CAN Councils or other coordinating organizations to facilitate the strengthening of this service network.

DHS needs to strengthen the network of support resources for at-risk families who do not meet the standard of risk required to trigger Department intervention. In many instances community-based family support resources are inadequate to serve current DHS clients. Currently screened out allegations of abuse and neglect often receive no supportive services. The possibility of the initial crisis escalating to a point requiring DHS intervention in the absence of any supportive intervention is strong. This problem is additional evidence of the need to further strengthen the existing prevention/early intervention network. Failing to provide support at this level of need may lead to an escalation of the crisis to a point requiring DHS intervention.

APPROVED | CHAPT

Appendix A | APR 09 '92 | 72

BY GOVERNOR | RESOLV

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-TWO

H.P. 1633 - L.D. 2297

Resolve, to Ensure Protection and Family Support for Maine's Children

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the State's child protective services system is only able to respond to 25% of the referred cases and does not have adequate resources to offer to those children that do come into the State's custody; and

Whereas, it is essential for the State to make maximum use of federal resources available to support children in need of protection; and

Whereas, it is critical to the health and safety of our children to conduct a comprehensive review of the State's child protective services system and to recommend necessary changes; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Comprehensive review. Resolved: That the Department of Human Services shall conduct a comprehensive review of protective and family support services for children. In conducting the review, the department shall:

1. Identify state, local, public and private resources available for provision of services to children who are abused or neglected;

2. Identify areas of need in order to make recommendations to enhance the State's child protective services system;

3. Determine the extent to which state and federal dollars might be increased for those services currently provided or for added services;

4. Review the protective case system of the Department of Human Services to determine the extent to which protective services might be further developed through additional community services activities;

5. Determine how local communities and agencies might become more involved in planning and resource allocation and development and how the State's role in planning, resource development and technical assistance can be increased to support local communities;

6. Determine what, if any, statutory, regulatory or policy changes are necessary to allow or support an increased role for local communities and contracted service agencies in the provision of protective services;

7. Determine what, if any, statutory changes are necessary to allow or support maximization of federal funding sources for local expenditures, as well as technical, regulatory or procedural changes in the Department of Human Services that may be necessary to maximize the use of federal resources in support of local programs and services; and

8. Determine whether adequate mechanisms exist to enable families, providers, state employees and citizens to request further action when they believe that the State's child protective services system is not responding appropriately to abuse or neglect; and be it further

Sec. 2. Establishment of oversight committee; consultation. Resolved: That the Department of Human Services, in conducting this comprehensive review, shall establish and consult with an oversight committee consisting of appropriate state agencies, local provider agencies involved with children in need of protection and other appropriate representatives, including, but not limited to:

1. Chiefs of Police;

2. Maine State Nurses Association;

3. Pediatricians;

4. Superintendents of school administrative units;

5. Maine Municipal Association;

6. Child abuse and neglect councils;

7. Mental health centers;

8. Parents;

9. Principals and special education directors;

10. Human services providers involved with children in need of protection;

11. Low-income organizations; and

12. Other groups and individuals the department finds appropriate; and be it further

Sec. 3. Coordination with Medicaid Plan for Children and Families. Resolved: That the Department of Human Services shall coordinate the development of this comprehensive review with the implementation of the Medicaid Plan for Children and Families developed pursuant to Resolve 1989, chapter 103. In so doing, the Department of Human Services shall:

1. Determine the implications of the Medicaid Plan for Children and Families for increasing support of other state, local, public and private agencies in the provision of protective services;

2. Identify local dollars that may be available for match by any appropriate federal source; and

3. Identify any state, local or private resources to assist in the maximization of available federal resources; and be it further

Sec. 4. Staffing; funding. Resolved: That the Department of Human Services shall provide support staff and funds for

contracted consultant services within its existing resources to conduct the comprehensive review; and be it further

Sec. 5. Report. Resolved: That the oversight committee established in section 2 shall submit an interim report to the Joint Standing Committee on Human Resources and the Joint Standing Committee on Appropriations and Financial Affairs by September 1, 1992. The oversight committee shall submit a final report to the Joint Standing Committee on Human Resources and the Joint Standing Committee on Appropriations and Financial Affairs by November 15, 1992.

The Department of Human Services shall review the final report of the oversight committee and develop a comprehensive plan. The department shall submit its plan to the joint standing committees of the Legislature having jurisdiction over human resources matters and appropriations and financial affairs by March 1, 1993. The plan must outline the department's response to the findings of the oversight committee and must include any necessary implementing legislation. The department shall implement recommendations prior to submitting its plan if possible, and shall defer only those changes that require legislative approval; and be it further

Sec. 6. Access to information. Resolved: That, notwithstanding the Maine Revised Statutes, Title 22, section 4008, subsection 1, the department may disclose relevant records that contain personally identifying information and are created in connection with the department's child protective activities or activities related to a child while in the care or custody of the department to members of the oversight committee established in section 2. Members of the oversight committee are subject to the provisions of Title 22, section 4008, subsection 4.

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

Appendix B

Sources of Testimony Received by The DHS Oversight Committee

January 22, 1992:	DHS Commissioner Rollin Ives, BCFS Director Peter Walsh.
February 26, 1992:	Sandi Hodge, Richard Rogers, Karen Westburg, BCFS.
March 4, 1992:	Helaine Hornby, USM; Peter Walsh, BCFS; Jamie Morrill, DHS.
March 18, 1992:	Deanna Staples, AAG; Merris Bickford, AAG; Nancy Carlson, AAG; F. David Plummer, Maine Vocal, Inc.
April 8, 1992:	Steven Roberts, Portland Police Department.
April 15, 1992:	Karen Morrison, Bruce Willson, Cliff Goodwin, Sylvia Glidden, and Laura Jewell, MFPA; Jamie Morrill, DHS.
May 6, 1992:	Mary Gay Kennedy, Nina McKee, CASA Volunteers; Barbara Kates, B. Hoxie, J. Melanson, MFPA; Rollin Ives, Commissioner, DHS; Kevin Gordon, Guardian ad Litem.
May 20, 1992:	Jim Breslin, Advocate, DMHMR; Dean Crocker, Consultant, CARES, Inc.
June 3, 1992:	Jim Souza, Director, CHCS; Linda Knight, Beverly Schumacher, Barbara Seeley, Jackie Ward, staff CHCS; Leslie Nicoll, Bruce Clary , USM Muskie Institute.
June 17, 1992:	Rollin Ives, Commissioner, DHS.
July 8, 1992:	Presentation from Law Enforcement Sub-Committee, (Paul Vestal, Steve Roberts.)
July 22, 1992:	Sub-Committee Presentations: Community Response Sub-Committee (Tony Scucci), Foster Parents Sub-Committee (Cliff Goodwin).
August 5, 1992:	Sub-Committee Presentations: Education Sub-Committee (Bette Manchester, Bill Davis); Legal Sub-Committee (Anita St. Onge, Bob Moore).

August 19, 1992:	Jane Sheehan, Acting Commissioner, Jamie Morrill Assistant Deputy Commissioner, DHS; Sabra Burdick, Consultant.
Sept. 9, 1992:	Al Monier, Group Home Association; Charlotte Scot and Betsy Houston, Foster Parents of Special Needs Child.
Sept. 23, 1992:	David Stockford, DOE; Shelley Legaire, Pat Phillips, Pen Bay Medical Center, Eastern Maine Medical Center SCAN Teams.

August 1990

Recommendations: First Report Of The U.S. Advisory Board on Child Abuse and Neglect

RECOMMENDATIONS

A. RECOGNIZING THE NATIONAL EMERGENCY

RECOMMENDATION #1:

The Board urges each citizen to recognize that a serious emergency related to the maltreatment of children exists within American society and to join with all other citizens in resolving that its continued existence is intolerable.

RECOMMENDATION #2:

The Board urges each citizen to demand that his or her elected officials at all levels publicly acknowledge that the American child protection emergency exists, and, having so acknowledged this emergency, take whatever steps are necessary—including the identification of new revenue sources—to rehabilitate the nation's child protection system.

RECOMMENDATION #3:

The Board urges the U.S. Congress, State legislatures, and local legislative bodies to view the prevention of child abuse and neglect as a matter of national security and, as such, to increase their support for basic necessities, such as housing, child care, education, and prenatal care for low income families including the working poor, the absence of which has been linked to child abuse and neglect.

B. PROVIDING LEADERSHIP

RECOMMENDATION #4:

The Board urges the President to become the visible and effective leader of a renewed Federal effort to prevent the maltreatment of American children and to help the nation better serve those children who have been abused and neglected.

RECOMMENDATION #5:

The Board urges each Governor to become the visible and effective leader of a renewed State effort to prevent the maltreatment of children and to assure that child victims of abuse and neglect receive appropriate services.

RECOMMENDATION #6:

The Board urges each Mayor and County Executive to become personally involved in improving the delivery of services related to the prevention and treatment of child abuse and neglect.

RECOMMENDATION #7:

The Board urges legislative bodies at all levels to join with the President, Governors, and County Executives and Mayors in a renewed national commitment to child protection by providing the funds necessary to prevent and treat child abuse and neglect.

RECOMMENDATION #8:

The Board urges national scientific societies and professional associations to undertake major initiatives to stimulate the development of knowledge about child abuse and neglect and the improvement of the child protection system and to diffuse such knowledge to their members, policymakers, and the general public.

C. COORDINATING EFFORTS

RECOMMENDATION #9:

The Secretary of Health and Human Services, in conjunction with his counterparts within the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), and the Governors of the several States should identify and eliminate barriers which stand in the way of providing coordinated community services related to the protection of children.

RECOMMENDATION #10:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), and the Director of the Office of National Drug Control Policy in the White House should take steps to assure that all relevant aspects of the national effort to control substance abuse are coordinated with efforts to prevent and treat child abuse and neglect. These steps should begin immediately and should be made apparent to the public. All steps taken at the national level should be coordinated with relevant State and local "front-line" programs.

RECOMMENDATION #11:

The Secretary of Health and Human Services and the Attorney General (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect) should undertake joint efforts to address the issue of fatal child abuse and neglect caused by family members and other caretakers. These efforts should include the identification and vigorous dissemination to State and local governments of models for: (a) prevention of serious and fatal child abuse and neglect; (b) multidisciplinary child death case review; and (c) identification and response to child abuse and neglect fatalities by the social services, public health, and criminal justice systems.

D. GENERATING KNOWLEDGE

RECOMMENDATION #12:

The Secretary of Health and Human Services and the Attorney General (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect) should take whatever steps are necessary to establish a Federal data collection system that provides a comprehensive national picture of child maltreatment and the response to it by the several governments of the United States. This new system should insure: accurate, annual, uninterrupted, consistent, and timely data collection; mandatory participation from the States; and a focus on actual incidence, reported incidence, and the operation and effectiveness of all aspects of the child protection system. This new system should be designed and implemented either by the Bureau of the Census or the Centers for Disease Control, working in collaboration with leading experts on child maltreatment.

RECOMMENDATION #13:

The Secretary of Health and Human Services should launch a major coordinated initiative involving all relevant components of the Department of Health and Human Services to promote the systematic conduct of research related to child abuse and neglect.

RECOMMENDATION #14:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), should launch a major initiative to use multidisciplinary knowledge about what works as the cornerstone of Federal efforts to rehabilitate the quality of the child protection system. This initiative should include the translation of what is already known about interventions that produce positive results. It should also include the evaluation of possible systemic improvements the value of which has not yet been established.

RECOMMENDATION #15:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), in concert with the nation's private foundations that have an interest in children, should launch a major initiative to increase both the number and the professional qualifications of individuals conducting knowledge-building activities on child abuse and neglect. The initiative should include the active encouragement of noted researchers from other fields in the social, behavioral, and health sciences to do work in this area.

E. DIFFUSING KNOWLEDGE

RECOMMENDATION #16:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), should take whatever steps are necessary to assure that practitioners, policymakers, and the general public (especially parents) have ready and continuous access to comprehensive, consistent state-of-the-art information on child abuse and neglect. Such steps should include establishing a permanent governmental unit from which this information is available.

RECOMMENDATION #17:

Leaders of the media should join in a campaign to promote public understanding of the child protection emergency and the most effective ways of addressing it, including coverage of the complexity and seriousness of the emergency and the alternatives for dealing with it.

F. INCREASING HUMAN RESOURCES

RECOMMENDATION #18:

The Secretary of Health and Human Services, the U.S. Congress, their counterparts in State governments, and the Governors of the several States, in concert with professional associations and organizations, should take concrete steps to establish the position of public agency "child protective services caseworker" as a professional specialty with commensurate minimum entry-level educational requirements, salary, status, supervision, administrative support, and continuing education requirements.

RECOMMENDATION #19:

The Secretary of Health and Human Services, the U.S. Congress, and their counterparts in State governments should take the necessary steps to establish minimum educational requirements for the position of public agency CPS caseworker in agencies which receive Federal financial support. Such requirements should provide for the substitution of appropriate experience for education.

RECOMMENDATION #20:

The Secretary of Health and Human Services, the U.S. Congress, and their counterparts in State governments should take the necessary steps to assure that all public agency CPS caseworkers systematically receive adequate pre-service and in-service continuing training for the proper performance of their duties. Such training should be offered at different levels in keeping with the differing needs and responsibilities of CPS caseworkers, and should reflect emerging issues in the field.

RECOMMENDATION #21:

The Secretary of Health and Human Services, the U.S. Congress, and their counterparts at the State and County levels, in concert with private sector support should take the necessary steps to establish acceptable caseload standards so as to reduce the caseload sizes of public agency CPS caseworkers in agencies which receive Federal financial support. A part of this initiative should be the recruitment and maintenance of a sufficient number of qualified staff so that services can be provided at the acceptable caseload level.

RECOMMENDATION #22:

State and local social services officials should launch an aggressive campaign to recruit new CPS caseworkers representative of the racial, ethnic, and cultural composition of the child maltreatment caseload population.

RECOMMENDATION #23:

The Secretary of Health and Human Services and the Secretary of Education (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect) should take concrete steps to assure a steady increase in the total number of the nation's professionals who possess the necessary competence and skill to participate effectively in the protection of children. Such steps should include: the development, introduction and expansion of curricula and clinical programs concerned with child abuse and neglect in all the nation's institutions of higher learning; the replication and institutionalization of models for the interdisciplinary training of graduate students preparing for work in child protection; and the establishment of a new program of Presidential or Secretarial Child Maltreatment Fellowships for graduate students willing to commit themselves to entering the field.

G. PROVIDING AND IMPROVING PROGRAMS

RECOMMENDATION #24:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), and the Governors of the several States should ensure that comprehensive, multidisciplinary child abuse and neglect treatment programs are available to all who need them.

RECOMMENDATION #25:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), and the Governors of the several States should ensure that efforts to prevent the maltreatment of children are substantially increased. Such efforts, at a minimum, should involve a significant expansion in the availability of home visitation and follow-up services for all families of newborns.

RECOMMENDATION #26:

The U.S. Congress and State and local legislative bodies should ensure that, in any expansion of programs concerned with child abuse and neglect, resources devoted to prevention and resources devoted to treatment do not come at the expense of each other.

RECOMMENDATION #27:

The headquarters or regional units of private sector organizations–voluntary, religious, civic, philanthropic, and entrepreneurial–should take the necessary steps to increase significantly the involvement of their local affiliates and outlets, members, or employees in efforts to support and strengthen families as well as to prevent and treat child abuse and neglect. At a minimum the efforts for which increased involvement is encouraged should include: participation in neighborhood home visitation networks; participation in formal volunteer programs; the introduction of workplace measures aimed at reducing familial stress; participation in programs aimed at increasing greater accountability within the child protection system; and the promotion of greater awareness of the child protection emergency, as well as advocacy for more enlightened public policies in response to it. Government at all levels should facilitate the development of public/private partnerships aimed at enhancing the role of the private sector in the prevention and treatment of child abuse and neglect.

RECOMMENDATION #28:

The Attorney General, the U.S. Congress, the State legislatures, the Chief Justice of each State's highest court, and the leaders of the organized bar should assure that all State and local courts handling the large numbers of civil and criminal child abuse and neglect cases coming before the court system promptly and fairly resolve these cases. Prompt and fair resolution will require sufficient resources including: (a) adequate numbers of well-trained judges, lawyers, and court support staff, as well as manageable caseloads that take into account the complex and demanding nature of child abuse and neglect litigation; (b) specialized judicial procedures that are sensitive to the needs of children and families; (c) improved court-based diagnostic and evaluation services; and (d) greater educational opportunities for all professional personnel involved in such proceedings. Courts hearing child maltreatment cases must also be given the funding and status befitting these most important of judicial tribunals. These officials should also take steps to assure that every child has independent advocacy and legal representation, and every CPS caseworker is effectively represented by counsel throughout the judicial process.

RECOMMENDATION #29:

The Secretary of Education and his counterparts in State and local educational agencies, in concert with the leaders of all relevant national educational organizations and their State and local affiliates, should launch a major initiative to establish and strengthen the role of every public and private school in the nation in the prevention, identification, and treatment of child abuse and neglect.

H. PLANNING FOR THE FUTURE

RECOMMENDATION #30:

The U.S. Congress should direct an appropriate research agency to determine the cost of developing and implementing a comprehensive national program for the prevention and treatment of child abuse and neglect, as well as the projected cost of not developing and implementing such a program.

RECOMMENDATION #31:

The Secretary of Health and Human Services, in conjunction with his counterparts in the Federal Government (working through the U.S. Inter-Agency Task Force on Child Abuse and Neglect), in concert with the National Governors Association, the U.S. Conference of Mayors, and the National Association of Counties, should develop a model planning process aimed at generating plans for the coordinated, comprehensive, community-based prevention, identification, and treatment of abuse and neglect, and take appropriate steps to assure that the model process is implemented throughout the nation.

Appendix D

Joint Police/CPS Investigative Initiatives

Florida

Child Protective Employees of the Florida Department of Health and Rehabilitative Services are trained to conduct child abuse and neglect investigations that meet both legal and social work needs. Police involvement in child abuse investigations is determined by local agreements in Florida. In addition, the Florida Department of Law Enforcement has a team of six child abuse investigators who serve as both an investigative and a training resource.

While the success of joint child abuse/law enforcement investigation varies from region to region within the state, the presence of the six state police level investigators help to make law enforcement officials who concentrate on child abuse and neglect issues a statewide resource, available for both training and investigative purposes.

Des Moines, Iowa

The Youth Section of the Des Moines Police Department began by co-investigating criminal child sexual abuse with child protective workers. The Youth Section has recently expanded its co-investigatory role into child abuse cases involving physical trauma. The Youth Section has been in existence for two years, and works from a specifically developed protocol defining the responsibilities of police and child protective workers. The members of the Youth Section and the child protective investigators who work with them have developed a multi-disciplinary team approach through cross-training and the building of close working relationships.

Guidelines

Sources in both Florida and Iowa stressed that the success of joint investigation initiatives is dependent on the ability of the people involved to put aside turf and personal

issues in order to allow the team building process to evolve. Formal protocols for situations involving joint investigation and responsibilities during the investigations are necessary to establish a guideline for building cooperation. Wilson and Pence make four recommendations for the development of successful joint investigative initiatives:

1. ***Establish formal teams:*** Much conflict is overcome simply through familiarity and trust. Long-term teams can be established on community levels through mutual agreement of the team members or through statutory changes.

2. ***Establish investigative protocols:*** Investigative protocols clearly lay out the roles of both police and CPS workers. This can be done even when no standing team agreement exists. Protocols limit conflict by clarifying expectations.

3. ***Provide adequate personnel to both agencies:*** The sources of conflict are amplified when a disparity exists in the personnel resources available to the two agencies... Disparity in resources may also affect the individuals' commitment to the team concept, resulting in conflict.

4. ***Joint training:*** Joint training is a key once a team is established. It gives all parties an opportunity to hear the same message and learn skills together, and provides an opportunity to acquaint disciplines with each others philosophical perspectives and unique difficulties....[1]

Joint initiatives between DHS and local law enforcement agencies exist in Portland, Lewiston and Bangor. These three programs provide a base to build fully cooperative joint investigation initiatives between DHS and law enforcement.

---

[1] Wilson and Pence, "Professional Exchange: Facilitating Communication Among Professionals"; Advisor Vol. 1, August 1988, pp. 2, 6.

Appendix E

The Homebuilders Model

The Homebuilders Model of IFPS details ten necessary program elements:

1. ***Services in the clients' homes:*** The Homebuilders model assumes that in the home the worker can best understand the context, the pattern and the nature of the problems and can most effectively suggest problem-solving techniques, along with altered behavior patterns.

2. ***Immediate response:*** Cases are accepted on a first-come, first-served basis. Homebuilders defines immediate response as within 24 hours of accepting the referral.

3. ***Intensive:*** As long a session as needed; frequently up to 20 hours a week. The length of sessions is allowed to vary according to the need of the client.

4. ***Highly flexible scheduling:*** Family preservation workers are on call 24 hours a day. Clients are given the caseworker's phone number, the supervisor's phone number, and the office phone number; the client has a 24 hour safety net for the duration of the treatment.

5. ***Accept almost all cases:*** Homebuilders utilizes a cognitive behavioral approach which emphasizes helping families learn to manage the emotions and feelings that have triggered crises. The trust that evolves from the cognitive methodology means that family preservation workers rarely reject referrals if they have a slot.

6. ***Clients set their own goals:*** Homebuilders limits families to four ongoing goals to keep the family situation manageable.

7. ***Small caseloads, 2 - 3 families at a time:*** Small caseloads afford therapists the time to spend on intensive client therapy. A year's worth of conventional therapy may be delivered during a 4 - 6 week IFPS treatment course.

8. ***Short-term, time limited, with referral to other ongoing helping services as needed:*** Homebuilders delivers the IFPS in a 4 - 6 week timeframe with 4- 4 1/2 weeks now being the standard. The focus is to deliver a year's worth of counseling and to make a substantive change in the family. The end of the intervention is usually followed by continuing, less intensive help services.

9. ***Focus on the Family:*** Family preservation works on the premise that change in any one member of the family affects everyone else. This allows family preservation workers to concentrate on the family members most motivated to change.

10. ***Blend of hard and soft services and availability of "flex dollars":*** Homebuilders workers are required to do what is necessary to help the family. Michigan offers carpentry classes to allow therapists to acquire home improvement skills. "Flex dollars" allow money to be spent on whatever the family needs most at that moment and can get no other way.[1]

---

[1] Barthel, J., *For Children's Sake: The Promise of Family Preservation*, Annie E. Casey Foundation, Edna McConnel Clark Foundation, The Foundation for Child Development, and the Skillman Foundation; 1992.

Appendix F

Family Preservation Initiatives

States with Large Family Preservation Initiatives[1]					
States	**Date**	**Families**	**Budget FY**	**Availability**	**Target[2] Population**
Alabama	1990	338	$1,500,000	20/67	CW
Colorado	1988	350	$764,000	16/63	CW, MH,JJ
Connecticut	1988	500	$2,597,000	Statewide	CW,MH,JJ
Iowa	1988	1,400	$3,500,000	Statewide	CW, JJ
Kentucky	1989	300	$2,000,000	47/120	CW, MH, JJ
Michigan	1988	3,600	$14,000,000	Statewide	CW, JJ
Minnesota	1990	400	$1,200,000	18/87	CW, MH, JJ
Missouri	1987	411	$2,450,000	40/115	CW, MH
New Jersey	1987	465	$2,300,000	10/21	CW, MH, JJ
New Mexico	1990	279	$1,100,000	10/32	CW
New York	1989	n/a	$6,700,000	18/63	CW, MH, JJ
N. Carolina	1984	n/a	$2,200,000	25/100	CW, MH, JJ
Tennessee	1989	900	$2,277,000	35/95	CW, MH, JJ
Washington	1974	573	$4,300,000	11/39	CW, MH, JJ, DD

Several of these states have conducted studies to attempt to determine the effectiveness of Intensive Family Based Preservation Programs. The following table depicts the results of some of these studies in terms of deferred costs, and, when available, deferred placements.

---

[1] Barthel, J., *For Children's Sake: The Promise of Family Preservation*, Annie E. Casey Foundation, Edna McConnel Clark Foundation, The Foundation for Child Development, and the Skillman Foundation; 1992.

[2] CW = Child Welfare, MH = Mental Health, JJ = Juvenile Justice, DD = Developmentally Disabled.

Family Preservation Costs/Benefits[3]				
State/City	**Cost IFBPS**	**Cost Foster Care**	**Savings**	**Averted Placements**
Connecticut	$9,855	$14,235	$4,380 (30.8%)	NA
Iowa	$2,577	$8,890	$6,313 (28.9%)	85%
Kentucky	$2,500	$8,900	$6,400 (28.1%)	NA
Michigan	$4,500	$12,000	$7,500 (36.0%)	NA
New Mexico	NA	NA	NA	85%
New York City	$8,000	$20,000	$12,000 (40.0%)	NA

Federal Funding Sources for Family Preservation Services

The National Conference of State Legislatures identifies seven possible federal funding sources for Family Preservation Services:

Source:	Title IV-B of the Social Security Act
Purpose:	Subsidizes states' child welfare services costs
Eligibility:	No federal eligibility requirements
Availability of Funds:	Capped appropriation
Federal Match:	75 Percent
Funding Level:	$300.6 million in FY 91
States using this Source for FPS:	Minnesota and North Carolina

Source:	Title IV-E of the Social Security Act
Purpose:	Subsidizes states' foster care costs
Eligibility:	AFDC eligible children
Availability of Funds:	Open-ended entitlement
Federal Match:	Maintenance - state Medicaid match rate, Administrative 50 Percent; training 75 Percent

Funding Level:	$1.78 billion in FY 91
States using this Source for FPS:	Alabama, Arkansas, Connecticut, Illinois, Kentucky, Michigan, Missouri,New York, Tennessee, and Virginia
Source:	National Child Abuse and Neglect state grants
Purpose:	Prevention and treatment of abuse and neglect
Eligibility:	States must have abuse and neglect procedures, such as reporting and investigation, and confidentiality provisions that meet federal standards
Availability of Funds:	Capped appropriation
Federal Match:	No state match required
Funding Level:	$16.5 million in FY 91
States using this Source for FPS:	Alabama and Connecticut
Source:	Title XX of the Social Security Act
Purpose:	Block grant to fund social services program
Eligibility:	No federal eligibility criteria
Availability of Funds:	Capped appropriation
Federal Match:	No state match required
Funding Level:	$2.8 billion in FY 91
States using this Source for FPS:	Louisiana, North Carolina and South Carolina
Comments:	Title XX is an unlikely source for expanding state crisis intervention services since appropriations have declined, after adjusting for inflation, and because of multiple demands for these funds.
Source:	Alcohol Drug Abuse and Mental Health Grant
Purpose:	Funding for community mental health services and drug abuse and alcoholism programs (79 percent is earmarked for substance abuse programs, 21 percent for mental health)
Eligibility:	Substance abusing and mentally ill individuals
Availability of Funds:	Capped appropriation
Federal Match:	No state match required

Funding Level:	$1.2 billion in FY 91
States using this Source for FPS:	Oklahoma, Tennessee, and Louisiana
Comments:	Although this program provides the largest federal funding resource for mental health programs, only 10 percent of the monies is directed specifically for children's services
Source:	AFDC Emergency Assistance (EA)
Purpose:	Emergency needs of low income families and children, AFDC children under 21 and their families. At state option families need not meet AFDC requirements. Services are authorized for only one continuous 30-day period in any 12 months.
Eligibility:	
Availability of Funds:	Open-ended entitlement
Federal Match:	50 percent
Funding Level:	$205 million in FY 91
States using this Source for FPS:	Unknown
Comments:	This optional state program was available in 29 states and three jurisdictions in FY 90. Despite its apparent suitability as a funding source for family preservation, it has remained untapped. An additional benefit to EA funding is its ability to provide cash, allowing Family Preservation programs to assist clients with needed repairs, or other immediately necessities.
Source:	Medicaid, Title XIX of the Social Security Act
Purpose:	Health care for the poor
Eligibility:	Recipients of AFDC are automatically eligible. In addition, states must cover pregnant women and children up to age six at 133 percent of the federal poverty level.

Availability of Funds:	Open-ended entitlement
Federal Match:	30-80 percent depending on the state's low income population and option used. Starting July 1, 1991 states are required to cover children born after September 30, 1983 until they are age 19 who are in families with incomes below 100 percent of the federal poverty line.
Funding Level:	$36.9 billion in FY 91
States using this Source for FPS:	Arizona, Kentucky, New York, Oklahoma, South Carolina, Virginia and Wisconsin
Comments:	Medicaid funding for family preservation services are accessed generally through EPSDT, case management, or rehabilitation services options.

State of Oregon
CHILDREN'S SERVICES DIVISION
Department of Human Resources

Appendix G

■ CONFIDENTIALITY MATRIX ■
Court Involvement

Case Status:

Matter pending before Juvenile Court. Motion filed or petition filed; matter scheduled for court action, or wardship established, custody to CSD. OPEN and CLOSED cases are subject to the same guidelines.

Information Requested

Person/Group Requesting Information	Protective Service Investigation Results	General Case Info	Client Specific Case Information	Psychological/ Psychiatric Report	Other Treatment/ Counseling Report	Report on Alcohol/ Drug Treatment	Location of Parent/Child	Adoption Information	Juvenile Court Records	Information on CSD Policy and Procedure	Foster Home Certification Records	Day Care Certification Records
Guardian	1	1	1	9	9	9	1	4	9	8	7	7
Custodial Parent	1	1	1	9	9	9	1	4	9	8	7	7
Non-Custodial Parent	1	1	1	9	9	9	1	4	9	8	7	7
Court	1	1	1	9	9	9	1	4	NA	8	7	7
Juvenile Dept.	1	1	1	9	9	9	1	4	NA	8	7	7
Persons with Intervenor Status	2	2	2	2	2	2	2	4	2	8	7	7
CASA	1	1	1	1	1	1	1	4	1	8	7	7
CRB	1	1	1	1	1	1	1	4	1	8	7	7
Child's Attorney	1	1	1	9	9	9	1	4	1	8	7	7
Cust. Parents Attorney	1	1	1	9	9	9	1	4	1	8	7	7
Non-Cust Parent Attorney	1	1	1	9	9	9	1	4	1	8	7	7
Step Parent	1	1	1	9	9	9	1	4	9	8	7	7
CSD Attorney	1	1	1	9	9	9	1	4	1	8	7	7
Law Enforcement Agency	11	11	11	9	9	9	5/11	4	9	8	7	7
Grandparent	3/5	3/5	3/5	3	3	3	3	4	3	8	7	7
Other Relative	3/5	3/5	3/5	3	3	3	3	4	3	8	7	7
Public	3/6	3/6	3/6	3	3	3	10	4	2/3/10	8	7	7
Media	3/6	3/6	3/6	3	3	3	10	4	2/3/10	8	7	7
School	5	5	5	9	9	9	1	4	9	8	7	7
Advocacy Group	3/6	3/6	3/6	3	3	3	3	4	2/3/10	8	7	7
Mental Health	5	5	5	9	9	9	1	4	5	8	7	7
Physician	1	1	1	9	9	9	1	4	1	8	7	7
Foster Parent	5	5	5	5/9	5/9	5/9	1	4	5	8	7	7
Res/Day Treatment	5	5	5	5/9	5/9	5/9	1	4	5	8	7	7
Other DHR Agency	6/1	6/1	6/1	5/9	5/9	5/9	1	4	5	8	7	7
District Attorney *	1	1	1	9	9	9	1	4	9	8	7	7
Child Protection Team	1	1	1	9	9	9	1	4	1	8	7	7
Other Medical Staff	5	5	5	9	9	9	1	4	5	8	7	7
Emancipated Minor: Child Over 18 **	1	1	1	9	9	9	N/A	4	9	8	7	7
Indian Tribe/Social Services	1	1	1	9	9	9	1	4	1	8	7	7

* Dependency matters only
** Case record information about minor children may be shared with them at the discretion of their guardian.

Conditions of Disclosure

In cases in which there is an active court matter (juvenile, criminal, civil) the attorneys for the parties may have the right of discovery (to ask the court for access to certain portions of the file) or to subpoena the entire file. We will respond to the direction of the court in regard to disclosure of materials in these situations. If your files are subpoenaed, immediately notify your Branch Manager. **Note**: Your case notes may be considered a part of the legal record.

In criminal or delinquency cases, law enforcement and the district attorney have right of access to case information related to the current, specific criminal incident, only.

◆ Under most circumstances, anyone who is entitled to access to CSD records (see below) may look at, copy, and use file information with the **exception of the following**:

A. Name of the complainant (or any other identifying information) in a child abuse case. [1]
B. Materials done by a third party which are protected from further release without that party's permission (e.g. psychological evaluations, school records). When a client signs a consent for release of information, all client-specific information may be disclosed to the person/agency designated on that document. Information about other persons must be deleted.
C. Information in a closed adoption file or expunged court record.

Law enforcement, attorneys for the child and for CSD, the District Attorney, the Juvenile Court and Juvenile Department, CRB's (Citizen Review Boards), CASA's (Court Appointed Special Advocates) and child protection teams are typically **NOT** subject to the above exceptions (A and B).

1. All case record information [2] (also see footnote number 1) may be disclosed, except information in A, B, and C above. Disclosure of information about the location of a parent or child should be based on need-to-know and predicated on assurance of the privacy and safety the parties whose location is requested. (See 11 below for additional information on disclosure of location of a child.) If a child has been placed in CSD custody by the juvenile court, CSD may share with the parent over the objection of the child.

2. No case record information may be disclosed, unless ordered by the court.

3. No case record information may be disclosed without signed release of information.

4. No case record material in a sealed adoption record may be disclosed, except by court order.

---

[1] Reports, records, and findings of child abuse investigations will not be disclosed until the investigation is complete.

[2] The extent of the disclosure to be provided to a step-parent should be based on that person's level of involvement/relationship with the child(ren) in the case, in addition to the legal limitations involved in all disclosures. Since CSD records are usually multi-person records, the person entitled to access may have access ONLY to information about himself or herself.

5. May have only case record information necessary to assure safety of the child or to administer child welfare services.

6. If a client grievance is involved, findings of the citizen review board may be disclosed if the client has directly or indirectly disclosed the information to the public. The decision to disclose this rests with the Administrator, Deputy Administrator, or their designee.

7. All certification record information may be disclosed, except reference letters/ information, criminal records, and materials done by a third party which are protected from further release without that party's permission (e.g. psychological evaluations).

8. All CSD policy and procedure information is public record; it may be shared with anyone upon request.

9. The contents of psychological, psychiatric, medical and other treatment reports may be **discussed** with persons who have a need to know for purposes of child protection and case planning. Copies of reports may not be released without the permission of the writer.

   Copies of reports may be given **ONLY** to the following parties upon request. These reports must be stamped "Confidential-Not to be Redisclosed":

   A. Attorney for the child or for CSD.
   B. Law enforcement involved in an investigation.
   C. The juvenile court.
   D. The district attorney.
   E. The child protection team.

   Note: Reports about alcohol/drug treatment are confidential and usually marked "not for redisclosure".

10. A public announcement may be made when:
   A. A child escapes from MacLaren, Hillcrest, or one of the corrections camps.
   B. A child in CSD's custody if abducted or missing and believed abducted.
   C. CSD determines that public recognition is in the child's best interest either to secure essential services or to recognize a special achievement.
   D. When there has been the serious injury or death of a child, the name and photograph may be disclosed.

11. Law enforcement may have these materials for purposes of conducting an investigation ONLY.

Note: *State and federal laws prohibit the release or disclosure of information in files maintained by the Children's Services Division files unless:*

1. *the client, or other person to whom the record pertains, consents in writing to the disclosure;*
2. *disclosure is necessary to the administration of child welfare services* ***and*** *is in the best interests of the affected child;*
3. *the court, having reviewed the file* ***in camera*** *and having determined what portions of the file are relevant to the proceeding, orders disclosure of that relevant information.*

Appendix H

Substitute Care Living Arrangements

Distribution of Children in Substitute Care (October 1, 1992)[1]		
Living Arrangements	**Number of Children**	**Percent of Total**
Alone/Independent Living	86	4.4%
One Parent Family	68	3.5%
Two Parent Family	31	1.6%
With Relatives	67	3.5%
With non-relatives	23	1.2%
Whereabouts Unknown	37	1.9%
School	15	0.8%
Adult Boarding Home	2	0.1%
Foster Home	1,177	60.8%
Relative Adoptive Home	0	0%
Foster Adoptive Home	19	1.0%
Other Adoptive Home	36	1.9%
Residential/Group Home	252	13.0%
Emergency Shelter	26	1.3%
Nursing Homes	0	0%
Hospital/Other Med. Fac.	28	1.4%
Correctional Institution	61	3.1%
Inst. for Mentally Ill	4	0.2%
Inst. for Phys. Handi.	3	0.2%
Inst. for Ment. Retarded	2	0.1%
Military Service	0	0%
Total	1,937	100%

[1] "Department of Human Services Bureau of Child and Family Services FY 91/93 State Child Welfare Services Plan," September 11, 1990, Department of Human Services, Augusta, Maine.

Appendix I

Total Quality Management

The Department of Defense defines Total Quality Management as:

> A philosophy and set of guiding principles that represent the foundation of a continuously improving organization. It is the application of quantitative methods and human resources to improve the material and services supplied to an organization, all the processes within an organization, and the degree to which the needs of the customer are met, now, and in the future. It integrates fundamental management techniques, existing improvement efforts, and technical tools under a disciplined approach focused on continuous improvement.[1]

Deming identifies Fourteen Points and Seven Deadly Diseases that govern his management model. While Deming's work concentrated on industrial management, the applicability of his work to public sector endeavors is clear. The Fourteen Points, Seven Deadly Diseases and four obstacles are summarized below:

The Fourteen Points

1. Create constancy of purpose for improvement of product and service;
2. Adopt the new philosophy;
3. Cease dependence on mass inspection;
4. End the practice of awarding business on the basis of price alone;
5. Improve constantly and forever the system of production and service;
6. Institute training;
7. Institute leadership;
8. Drive out fear;
9. Break down barriers between staff areas;
10. Eliminate slogans, exhortations, and targets for the work force;
11. Eliminate numerical quotas;
12. Remove barriers to pride of workmanship;
13. Institute a vigorous program of education and retraining;
14. Take action to accomplish the transformation.

---

[1] Adapted from DoD, Office of the Secretary 32 CFR Part 281, July 19, 1989.

The Seven Deadly Sins

1. Lack of constancy of purpose;
2. Emphasis on short-term profits;
3. Evaluation by performance, merit rating, or annual review of performance;
4. Mobility of management;
5. Running a company on visible figures alone;
6. Excessive medical costs for employee health care, which increase the final costs of goods and services;
7. Excessive costs of warranty, fueled by lawyers who work on the basis of contingency fees.

The Obstacles

1. "Hope for instant pudding," the idea that "improvement of quality and productivity is accomplished suddenly by the affirmation of faith,"
2. "The supposition that solving problems, automation, gadgets, and new machinery will transform industry,"
3. "Search for examples," which companies undertake to find a ready-made recipe they can follow when they must instead map their own route to quality;
4. "Our problems are different," the pretext managers raise to avoid dealing with quality issues;[2]

---

[2] Walton, Mary,; *Deming Management at Work.*

Appendix J

Quality Assurance Systems

Following is a brief overview of several states' efforts to develop performance measures and management indicators. These descriptions demonstrate the variations in terminology and levels of sophistication of the states' efforts.

South Carolina

South Carolina is currently developing a series of Outcome Measures to replace its Standards and Indicators which were formulated in the mid 1980's and revised in 1989 and 1990 for each of the agency's discrete social service areas such as child protective services, foster care services and adoption services. Also included are supportive and therapeutic services such as transportation, homemaker, specialized residential treatment services and family management counseling.

Its system of "critical success factors" consists of an overall outcome followed by a series of critical success variables. An example of an outcome for child protective services is:

> Children who are reported to DSS are not abused, neglected or exploited after the report is accepted for investigation, substantiated and subsequently closed for services.

Examples of critical success variables for this outcome are:

1) Initial contact occurs within 24 hours.
2) Assessments are completed within 90 days.
3) When risk factors are identified during the investigation a case plan is developed to address them.
4) Case plans are reviewed as needed but at least every six months.

South Carolina's original system of Standards and Indicators has more conceptual clarity than the new system of outcomes and success factors. Under the old system a sample standard for child protective services is:

Removal of a child from his/her birth parents shall only occur when absolutely necessary.

Accompanying indicators are:

1) At least 95 percent of all emergency removals are upheld by family court.
2) Prior to the removal of a child from home, support services are offered to the family except when the child is in imminent danger.
3) A placement conference is held prior to any non-emergency removal, to assure that removal is the best plan.

A sample standard for adoption services is:

Children who have been freed for adoption shall be promptly placed.

Sample indicators are:

1) All non-special needs infants freed for adoption are placed in an adoptive home within one month of relinquishment.
2) At least 50 percent of the freed children for whom adoption is the plan are placed in adoptive homes within 18 months.

In these examples, the indicators are more closely linked to the standard it supports. Another feature of the South Carolina system is that in many instances the standards define a target number or percent to be achieved. In other states the indicator may tell what to measure but not what quantity would constitute an acceptable standard.

Indicators may be one of three types:

1. enhancement (e.g., the staff-supervisory ratio does not exceed 7 workers to each supervisor);
2. required (e.g., child protective workers providing treatment services are certified within six months of employment) and;
3. diagnostic and research (e.g., when a child is removed from home a court hearing is held within 10 days.)

In this example the difference between required and diagnostic is not entirely clear.

South Carolina is one of only a handful of states reviewed in which the standards apply to all local social service agencies, public or private, including those under contract. Examples of standards developed specifically for contractual agencies in the area of special needs adoption area:

1. The contractor shall comply with all standards and indicators required of the State Health and Human Services Finance Commission (the public agency).

2. The contractor shall give a copy of the child's social summary to the adoptive family and the appropriate Department of Social Services area adoption office at the time of placement.

COLORADO

Colorado, a county-administered state with 66 counties, is developing a set of "performance indicators" for its child welfare services program. The indicators are designed to be extracted from the state's computer tracking system entitled CWEST in which data are entered at the county level. The performance indicators are intended to be reviewed monthly by Field Administrators who are the state agency's representatives and monitors at the local level. Part of the reason for the review is merely to assure that the counties are supplying information routinely to the computer system. Thus, if over 5 percent of the caseload information is coded as "unknown" or "missing" the Field Administrator is supposed to determine why. The second purpose is to monitor changes in the indicator itself, both for quality assurance and planning purposes. The third reason is to monitor agency performance. Each regional administrator monitors approximately 6 counties, depending upon their size.

Colorado has identified indicators for the following program areas:

1. child protection in-home services;
2. central registry and time response;
3. foster care general;
4. foster care with return home goal;
5. foster children awaiting adoption;
6. foster children with independent living goal;
7. foster children with permanent foster care goal;
8. foster children with long term institutionalized care goal.

We have categorized Colorado's indicators as descriptive, effort, performance and outcomes. Examples of indicators to describe the population served are:

1. Percent change in ethnicity of clients served.
2. Percent change in age of clients served.

Examples of indicators developed to measure agency effort are:

1. Percent of child welfare case open, year x and year y.
2. Number and percent of referrals which are investigated quarterly.

Examples of indicators developed to measure performance are:

1. Recidivism: number of reincidents of abuse for cases that are open.
2. Number and percent of children returned to foster care after being returned home.
3. "Drift" analysis: percent of children in foster care with return home goal by time in out-of-home placement, number of placements and average level of restrictiveness.

Examples of indicators developed to measure outcomes are:

1. Percent of children adopted by length of time before finalization.
2. Number of child abuse victims who become perpetrators.

Colorado is beginning to develop indicators for contracted services in its residential treatment program. Examples are:

1. Percent of successful discharges (reunified with family).
2. Percent of unsuccessful discharges (runaways).
3. Recidivism rate by provider (children who return to out-of-home care after discharge).

KANSAS

Kansas has been required by the legislature to develop a system of performance measures which will be instituted statewide. In its SRS Family Agenda for Children and Youth, issued in 1991, Kansas outlined a series of indicators and expected outcomes which accompanied each of its proposed initiatives. In addition to a series of standard measures of performance, these indicators can help the state to assess achievement of specialized goals and initiatives. Expected outcomes have been defined for the following clusters:

1. Helping families to safely care for their children.
2. Improving out-of-home care for children when placement is necessary.
3. Working with juvenile offenders while protecting public safety.
4. Involving communities and other systems in the care and protection of Kansas children.
5. Strengthening the Department's capacity to better serve children and families.

Examples of expected outcomes for family-based assessment are:

1. Families and children will receive services appropriate to their needs;
2. Fewer children will be placed out of their homes;
3. Fewer children and families will go unserved due to incomplete information and contact.

It is easy to imagine how Kansas could take these general outcomes and develop quantifiable indicators which can be used for both process and outcome evaluation purposes.

NORTH DAKOTA

For the past four years, North Dakota has been engaged in a major child welfare reform initiative entitled, "Families First" supported in part by the Annie E. Casey Foundation. As part of the initiative the Department of Human Services has worked with the University of North Dakota to develop a "Child Welfare Chartbook" containing "child welfare indicators." In their current form, most of the indicators are descriptive statistics about the system such as "number of abuse and neglect reports 1980-1990"

displayed as vertical bar graphs, "number of reports by type of abuse" displayed as pie charts, and "probable cause by age of victim" displayed as horizontal bar charts. Some of these indicators could be converted to outcome measures by analyzing them in new ways. For instance, the agency could compare the number of completed adoptions to the number of children available for adoption in a given year.

UTAH

In 1992 the Utah Department of Human Services published a book of "Critical Success Variable Indicators" as a "test" document for internal review. It consists of figures and estimates derived from many sources but contains interesting features and analyses. For example, for foster care services it contains a "drift analysis" similar to Colorado's. However, Utah has developed "best practice targets." For example, the target for median months in custody before achieving a return home goal is "under 12;" the target for average number of placements is "under 2;" the target for new children in care with prior episodes is "under 20 percent;" and the target for average placement restrictiveness (where own home = 1, relative home = 2, foster home = 4, group home = 7, etc.) is "4." In its section on Family Preservation, the best practice target for percent of cases that remained open more than 60 days is "under 20 percent;" its target for children remaining home at closure is "over 80 percent; and its target for children in state custody at closure is "less than 10 percent."

Data are presented and displayed graphically by region. Then a brief narrative analysis is presented. For example, "As in the last quarter, Central's ratio of child abuse victims to new foster care openings remains significantly greater than the other four regions." These descriptive statements are followed by "action needed" statements.

Areas covered are child in custody case flow; case reviews conducted and needed; permanency goal analysis by permanency goal; availability of foster homes; home-based child welfare case flow; family preservation; in-home protective counseling; in-home protective supervision; youth services; child protective investigations; and social service caseloads.

FLORIDA

Children, Youth and Family Services within the Department of Health and Rehabilitative Services publishes an annual "Outcome Evaluation Report" for the legislature, following a 1986 mandate to develop outcome evaluation measures. This far-reaching 200-page document represents one of the most elaborate systems of outcome measures in the country. For each of 39 separate program groupings in five general areas, the report examines two major outcomes: successful program completion and recidivism. All outcomes are tracked over time and, wherever possible, information is provided at the state, district, program and facility level. A sample program under "prevention and diversion services" is home-visitor for high-risk newborns. Sample outcome measures are:

1. Percent of children removed from home during service provision.
2. Percent receiving abuse or neglect reports during service provision.
3. Percent showing a decrease of 40 percent or more on the Child Abuse Potential Inventory.
4. Percent with gradual weight gain based on age and weight at intake.
5. Percent within normal range of Denver Prescreening Developmental Questionnaire.

What is most significant about the Florida model, compared to all the others reviewed, is the effort at collecting indicators of client improvements such as the measures referenced in the last three examples above. The agency relies on individual contract providers, in these instances, to supply the requisite information on client gains. The system requires agreement up front on the types of measures that will be used and diligence on the part of contractors to collect and submit the data, some of which are missing in the report. These client measures, in addition to the system measures, have been identified and instituted over the five years of program development. Many areas have yet to incorporate client outcomes. However, for each program area there are recommendations and a table showing progress in fulfilling last year's recommendations. For example, under "family enrichment," one recommendation is to "select a standardized test of parental function such as the Child Abuse Potential Inventory and report pre and post test scores."

OTHER

Many other states have been contacted and information received, where available. Kentucky is currently attempting to formulate a performance measure system. This activity would logically be coordinated with its development of a comprehensive new management information system called TWIST. Connecticut is developing performance measures as part of its federal consent decree. Oklahoma is in the first year of a federally-ordered procedure to develop performance measures, outcome measures, and establish a statewide management information system.

Appendix K

Project Maine Families

Project Maine Families (PMF) is a federally supported five year demonstration project. Its purpose is to plan and organize prevention services in Cumberland and Franklin counties (working through the Child Abuse and Neglect Councils) and to disseminate its process to other Maine counties. Project Maine Families will offer technical assistance and support to any council that chooses to replicate the PMF planning process.

Project Maine Families asserts that the following elements constitute a "model prevention program":

- It will be comprehensive, employing multiple strategies encompassing primary, secondary, and tertiary activities.

- It will be coordinated, building on existing activities and designed to avoid duplication and overlapping effort.

- It will be community-wide, involving varied sectors including health professionals, education professionals, social service professionals, business professionals, and consumers of service.

- It will build upon current knowledge, using research findings to determine examples of effective programming, for example self help groups.

- It will be innovative, testing principles developed in other fields such as health promotion and marketing, and emphasizing an emerging, but underutilized setting for prevention activities, the workplace.[1]

---

[1] "Model Child Abuse Prevention Program," Initial Grant Proposal, July 21, 1989.

Cumberland County Initiative:

Jack Elementary School Family Center (Portland): The project includes a site for informal parent meetings, a clothing exchange program, and several parent support groups, covering coping with children's behavior, cross cultural issues and other issues such as stress reduction, and informal support.

Deering High School Family Day Care (Portland): The intent of this program is to encourage teen mothers to attend and complete high school; the program is currently serving three mothers, the maximum program capacity at this time.

Teen Mothers Drop-in Laundry Program (Portland): The program has been in existence since January of 1992. The program began with seven teen mothers, currently it serves 30 to 40 during an average session. This program has been an extremely successful medium for stress relief for teen mothers and has evolved into an excellent opportunity to disseminate information on healthy parenting. This program has generated enormous interest and has received many requests for information on replication.

Franklin County Initiative:

Parent Co-ops: There are currently nine active co-ops in Franklin County. The co-ops serve a variety of functions including general support, a group to support parents of children with seizure disorders, a support group for single parents, and a support group for parents of chronically ill children.

Family Resource Centers: Two sites, a regional health center and the New Life Children's Center in Dryden (20 miles north of Farmington), have committed to provide space and services to these programs.

New Parents/Home Visitor Program: Implementation of the program is scheduled for January of 1993. The program will be administered by PMF and will use professionally trained "mentor" parents to provide home visitation during the first year after birth.

Mentoring Program: PMF will provide a Mentor's Training Program in the fall of 1992 to help concerned people develop the skills and knowledge to positively intervene with at risk youth.

Project Maine Families has described the project as:

> ...exciting because it works, it gets people in the community involved in prevention who possessed the passion but did not know what to do, and it takes relatively few monetary resources, tapping first on existing strengths of individual communities.[2]

[2] Ibid, pp. 3, 4.