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**FINAL
REPORT**



Child Protective Services Investigations

**March
2022**

Prepared for the
Government Oversight Committee
By the
Office of Program Evaluation & Government Accountability

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OFFICE OF PROGRAM EVALUATION & GOVERNMENT ACCOUNTABILITY

Director Lucia Nixon

Staff:

Matthew Kruk, Principal Analyst
Scott Farwell, Senior Analyst
Amy Gagne, Senior Analyst
Jennifer Henderson, Senior Analyst
Kari Hojara, Analyst
Joel Lee, Analyst
Lisa Plimpton, Analyst
Sabrina Carey, Administrative Secretary

Mailing Address:

82 State House Station
Augusta, Maine 04333-0082
Phone: (207) 287-1901
Fax: (207) 287-1906
Web: <http://legislature.maine.gov/opega>
Email: sabrina.carey@legislature.maine.gov

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OPEGA is a nonpartisan independent legislative office overseen by the Government Oversight Committee (GOC) a bipartisan joint legislative committee. OPEGA conducts reviews at the direction of the GOC. Independence, sufficient resources and the authorities granted to OPEGA and the GOC by the enacting statute are critical to OPEGA's ability to fully evaluate the efficiency and effectiveness of state agencies and programs.

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Office of Program Evaluation & Government Accountability
82 State House Station • Augusta, ME • 04333-0082

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I. Introduction

In July 2021, following the deaths of four Maine children ages four years or younger in the months of May and June, the Government Oversight Committee (GOC) directed the Office of Program Evaluation and Government Accountability (OPEGA) to initiate an immediate review of Child Protective Services (CPS) administered by the Department of Health and Human Services (DHHS), Office of Child and Family Services (OCFS). This immediate review was initiated in response to heightened concerns about the safety of Maine children in their homes following the four deaths and formal requests made by Senator Diamond and Senator Curry in early July for an OPEGA review of CPS and OCFS.

The GOC approved the scope of work for the CPS review in August 2021. The Committee divided this comprehensive review project into three components with staggered reporting dates, as follows:

- Oversight of Child Protective Services, with an Information Brief in January 2022;
- Protecting Child Safety – Investigation¹, with an evaluation report in March 2022; and
- Protecting Child Safety – Reunification and Permanency, with an evaluation report in September 2022.

With this document, OPEGA delivers the evaluation report on its review on child protective services investigations.

This review was designed to examine and understand how child safety is protected and the risks to child safety from the point at which alleged child abuse or neglect is reported to DHHS through the completion of the investigation. In conducting this review, the GOC directed OPEGA to consider the following:

1. Understand how initial investigations are designed and conducted, including the legal and policy framework and priorities over time;
2. Evaluate how well the initial investigations are performed, potentially including:
 - a. Roles and responsibilities of caseworkers and supervisors,
 - b. Information sources and quality and communication channels,
 - c. Thoroughness of work performed,
 - d. Role of Structured Decision-Making (SDM) tools,
 - e. Training and supervision of caseworkers and supervisors,
3. Understand how DHHS/OCFS assures quality of investigations;
4. Understand roles and coordination between key parties, including DHHS/OCFS, Assistant Attorneys General (AAGs), and courts, in decision making regarding child safety;
5. Understand and assess how stakeholders (for example: mandated reporters, service providers and state agencies) interact, communicate, and share information; and
6. Consider perspectives of DHHS/OCFS staff and stakeholders.

¹ Child Protection Investigations were formerly known as Child Protection Assessments

This report addresses the topics above by first providing a program overview of CPS and discussing common misperceptions and philosophies relating to child welfare that can impact practice. Next, we describe the design and process of CPS investigations, the training and supervision of caseworkers and the role and structure of quality assurance efforts. We then provide results from our evaluation of quality assurance case reviews on how well OCFS is performing investigations and the perspectives of OCFS staff, mandated reporters, and other stakeholders in the child welfare system derived from surveys and interviews. We conclude with a discussion of our findings and recommendations and other areas for consideration.

To complete this evaluation, OPEGA collected and analyzed data from multiple sources through multiple methodologies. Within the time available, we gathered quantitative and qualitative data from OCFS and a diverse array of stakeholders in the child welfare system. We examined agency rules, policies and procedures, conducted a literature review, reviewed state and federal legislative history, administered 5 distinct surveys, and examined 109 case reviews conducted by the OCFS Quality Assurance (QA) program (see Appendix A for a detailed description of our methodology).

II. Key Takeaways

Throughout this report, we present our understanding and evaluation of child protective services investigations, with a focus on protecting child safety. Below we highlight our key takeaways from this review, along with our recommendations to OCFS and other considerations for the agency and the GOC.

Common Misconceptions about Child Welfare

- There are a number of common misconceptions that limit individual and collective understanding of the realities of child welfare, which may lead to unreasonable expectations and missed opportunities for improvement. These misconceptions include the role and authority of OCFS and other key parties; the availability of timely, accurate, and complete information; and the causes and preventability of adverse outcomes. (See page 11.)

Child Welfare Philosophy and the “Pendulum Swing”

- There is a continuum of child welfare philosophies that emphasize child safety and family preservation to varying degrees. Child welfare practice at any given time may vary in response to the prevailing philosophy. Federal and state laws and policies have reflected both family-oriented and child safety principles, and have not substantially changed in several decades. In recent years, demands on the child welfare system have changed periodically as a result of elevated concerns caused by events like high-profile child deaths or unusually high numbers of children in state custody. Regardless of the prevailing child welfare philosophy at any one time, the initial investigation provides the basis for critical child safety decisions. (See page 14.)

Investigation Process Design

- Child abuse and neglect investigations are designed by OCFS to be comprehensive, employing structured tools to guide workers and supervisors to make decisions about child safety at several points throughout the course of the investigation. It is the goal of investigations that all threats to child safety be addressed, planned for, and/or resolved within a 35-day timeframe. The process, however, is lacking in guidance for sufficiency of investigation thoroughness and how to triage multiple cases and priorities. (See page 18.)

Training and Supervision of Caseworkers

- There is wide agreement that the training offered to new caseworkers has been insufficient to prepare them for investigations work. Over the past two years, OCFS has collaborated with the Cutler Institute of the Muskie School of Public Service to restructure the training, and a new course of training took effect in January 2022. (See page 28.)
- Supervisors have significant involvement in the training of new caseworkers, and they support a relatively inexperienced staff of caseworkers in the midst of relatively high turnover. (See page 33.)
- Supervisors are key to the investigations process. Supervisors assign investigations to caseworkers and monitor the whereabouts of caseworkers for safety purposes. They are involved in critical safety decisions at various points, and they provide support, mentoring, and oversight of investigations caseworkers throughout the investigations process. (See page 33.)

Quality Assurance Case Reviews

- OCFS's Quality Assurance Program performs ongoing case reviews. The reviews are conducted based on the federal Child and Family Services Review (CSFR) protocol. OCFS uses case reviews both during the federal CSFR period and on an ongoing basis as a tool for understanding and monitoring the quality of investigations of reported and alleged child abuse or neglect. The standards and expectations of the case review system are very high, and meeting them requires exceptionally thorough and comprehensive work to evaluate risks. (See page 34.)
- The QA case review results indicate a lack of overall thoroughness and completeness in investigations. However, we observed that caseworkers do generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns, and the most critical and relevant individuals, with respect to the reported allegations. We attribute the lack of thorough and complete investigations to issues related to workload. (See page 36.)
- While infrequent, we observed several practice issues in the conduct of investigations that do not appear to be a function of workload challenges, but rather departures from expected practice. (See page 40.)

Perspectives on Elements Impacting Investigations

- OCFS staff reported that their workloads are unreasonable and that they do not have adequate time to understand risks to the child or the needs of the family. (See page 41.)
- Caseworkers reported that families are usually willing to engage with CPS during investigations, though they are sometimes unwilling to participate in services offered. (See page 45.)
- The sharing of medical and treatment information with OCFS appears to be a barrier to completing thorough and timely investigations. (See page 46.)

Family Perspectives and Service Needs

- Parents and children may experience a variety of reactions during a CPS investigation, including fear and confusion. Organizations that advocate for parents indicate that support for parents to assist in understanding and navigating a CPS investigation would be beneficial. (See page 49.)
- Access, availability, and engagement in services for families were concerns that emerged through interviews with OCFS management and other stakeholders, as well as in our surveys of caseworkers and supervisors, and in the results of the federal oversight of OCFS. (See page 51.)

Recommendations

OPEGA makes three recommendations for OCFS management's consideration. OPEGA recommends that OCFS:

- Take steps to address the workload issue to ensure that caseworkers and supervisors have the time necessary to conduct thorough investigations and more effectively assess the safety risks to children and the needs of families; (See page 52.)
- Evaluate the nature and extent of after-hours work requirements and expectations currently placed on caseworkers, and the risks to caseworker effectiveness and burnout; design and implement policy and program changes to address identified issues and risks; and consider restructuring the delivery of Children's Emergency Services to decrease or even eliminate required overnight shifts for caseworkers and supervisors; (See page 55.) and
- Build on the foundation of its existing QA system of case reviews to better identify specific practice concerns in a timely manner, within all OCFS districts, and link those concerns to opportunities for supervisor feedback, mentoring, and potentially additional training for individual caseworkers and other district staff. (See page 56.)

Other Considerations

OPEGA recommends that OCFS, and the GOC as appropriate, consider the following additional areas noted, but not fully evaluated, in this review:

- Training of new caseworkers (See page 57.)
- Access to medical records and treatment information (See page 58.)

- Services for children and families in the CPS system (See page 59.)
- Prevention of child abuse and neglect (See page 59.)

III. Program Overview ---

The following section provides an overview of the Child Protection Services program, including the statutory framework and OCFS structure, as well as definitions and numbers of reports of child abuse or neglect.

A. Statutory Framework and Obligations

Maine’s Child and Family Services and Child Protection Act (MRSA Title 22 Chapter 1071, §§ 4001-4099) establishes the statutory framework for child protective services provided by the State through the Department of Health and Human Services. The stated Legislative intent of the Act (22 MRSA § 4003) is to:

- Authorize the department to protect and assist abused and neglected children, children in circumstances which present a substantial risk of abuse and neglect, and their families;
- Provide that children will be removed from the custody of their parents only where failure to do so would jeopardize their health or welfare;
- Require that reasonable efforts be made to rehabilitate and reunify families as a means for protecting the welfare of children, but prevent needless delay for permanent plans for children when rehabilitation and reunification is not possible;
- Place children who are removed from the custody of their parents with an adult relative when possible;
- Place children who are removed from the custody of their parents with as many of those children’s siblings as possible; and
- Promote the early establishment of permanent plans for the care and custody of children who cannot be returned to their family.

Under the Act the department is required to: “act to protect abused and neglected children and children in circumstances that present a substantial risk of abuse and neglect, to prevent further abuse and neglect, to enhance the welfare of these children and their families and to preserve family life wherever possible” (22 MRSA § 4003).

The law further requires that DHHS carry out the following duties:

- Receive reports of abuse and neglect and suspicious child deaths;
- Promptly investigate all abuse and neglect cases and suspicious child deaths coming to its attention;

- Establish and maintain a policy requiring caseworkers to receive information directly from any agencies, facilities, or persons involved with or providing services to the family and child;
- Determine in each case investigated whether or not a child has been harmed and the degree of harm or threatened harm by a person responsible for the care of that child by deciding whether allegations are unsubstantiated, indicated or substantiated. File a petition in court if, after investigation, the department determines that a child is in immediate risk of serious harm or in jeopardy, or if a petition is not filed, assign a caseworker to provide services to the family to alleviate child abuse and neglect in the home; and
- Determine, in the case of a suspicious child death, whether abuse or neglect was a cause or factor contributing to the child's death; and the degree of threatened harm to any other child for whom the person or persons responsible for the deceased child may be responsible now or in the future.

B. Structure of the Office of Child and Family Services and Child Protective Services

Child protective services are delivered by the department through the Office of Child and Family Services (OCFS). The scope of OCFS goes beyond child protection as reflected in the mission of the Office which is: "joining with families and the community to promote long-term safety, well-being, and permanent families for children." In addition to administering child protective services, OCFS is responsible for:

- Foster care, adoption, and kinship services;
- Child care, including regulating child care facilities and providers and assisting Maine families in accessing and paying for child care;
- Children's behavioral health services; and
- Children's licensing and investigation services.

While child protective services are just one component within OCFS, it is also the case that OCFS is just one component within the broad child welfare system that spans multiple branches and levels of government as well as the private sector. This system relies on a broad network of actors and partners including OCFS, the Office of the Attorney General, local law enforcement, the courts, schools, child care providers, medical providers, and mental health, substance use, and other service providers and community members.

Within OCFS, the Associate Director of Child Welfare Services oversees the Child Welfare Services division. Services are delivered through eight OCFS districts across the state. Each district is responsible for CPS, including investigations and permanency work, in a particular geographic region as shown in Table 1. OCFS also has a centralized Child Protective Intake Program that receives reports and performs intake services for the whole state. Under the direction of the

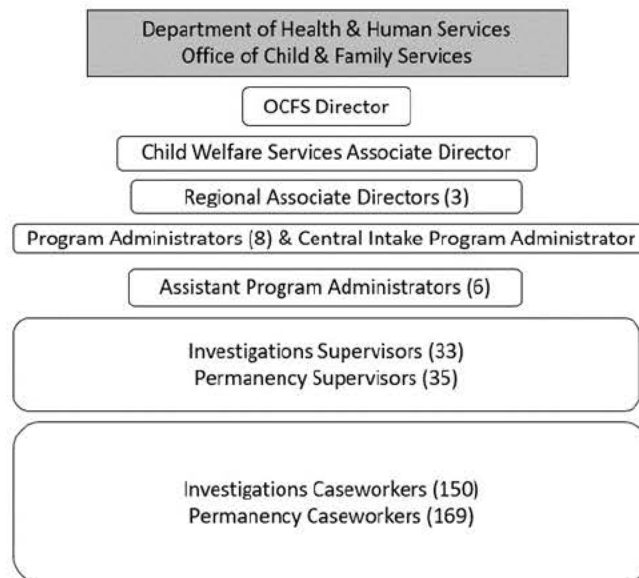
Associate Director, the division has three Regional Associate Directors (RADs), each responsible for three districts (or two districts and child protective intake).

Table 1: Child Protective Services Districts & Offices		
District	Counties	Office Location(s)
District 1	York	Biddeford & Sanford
District 2	Cumberland, Sagadahoc	Portland
District 3	Androscoggin, Franklin, Oxford	Lewiston
District 4	Knox, Waldo, Lincoln	Rockland
District 5	Kennebec, Somerset	Augusta, Skowhegan
District 6	Penobscot, Piscataquis	Bangor
District 7	Hancock, Washington	Ellsworth, Machias
District 8	Aroostook	Caribou, Houlton
Central Intake	Statewide	Augusta

Source: Maine Office of Child and Family Services.

Program Administrators & Assistant Program Administrators, Child Protective (investigations) Supervisors, and Child Protective (investigations) Caseworkers have key roles in the investigation of child abuse and neglect allegations. These positions are filled by professional social workers. See Figure 1 for titles and numbers of staff lines associated with OCFS positions.

Figure 1. Child Protective Services Investigations: Staff Roles



Source: Point in time data from OCFS, January 2022

Program Administrators (PAs) oversee child welfare services in the district offices. Some districts, depending on the size, also have an Assistant Program Administrator (APA). The roles and responsibilities of PAs and APAs include managing supervisors, serving as liaisons with the OCFS central office, communicating policy decisions and directives to district staff, overseeing day to day operations and the quality of casework in their district, working with their region’s Assistant

Attorneys General to prepare for court proceedings, collaborating with local law enforcement, and participating in community initiatives. The PAs and APAs we interviewed had all worked their way up from caseworker to supervisor to their current administrator position.

The next key level of staff consists of the supervisors, who direct, oversee, and monitor the activities of caseworkers and support staff, assign cases, and provide guidance and support to caseworkers in decision making. Supervisors are responsible for resolving critical and crisis situations on cases, including decisions to seek removal of children. Most supervisors have prior experience working as caseworkers.

Investigations caseworkers and supervisors are responsible for engaging families to assess for child safety, abuse, neglect, and safety threats. They conduct investigations, make decisions and develop appropriate plans for children, focusing on their safety needs and preservation of family relationships, when appropriate. When needed, they petition for protective custody and placement of children. They are expected to make factually supported safety decisions in a timely and thorough manner to assure child safety. Investigations caseworkers are responsible for maintaining accurate case record documentation of investigations, as well as following federal and state laws, mandates, policy, and timeframes to achieve child safety, well-being, and permanency.

C. What is Child Abuse and Neglect?

The OCFS policy manual defines child abuse or neglect as “a threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these...by a person responsible for the child.” This definition is derived from the Maine Child and Family Services and Child Protection Act (22 MRSA § 4002(1)). Investigations conducted by OCFS child welfare staff are limited to abuse or neglect committed by a caregiver.²

Examples of the main types of child abuse and neglect include:

- **Emotional abuse:** Caregiver actions likely to lead to child’s significant anxiety, depression, withdrawal, or aggressive behavior; brutal or intimidating acts or threats of suicide or harm to others; consistently scapegoating the child; or exposure to domestic violence;
- **Physical abuse:** Non-accidental physical injury, unexplained and suspicious injury, or actions likely to cause physical injury, including shaking a young child;
- **Sexual abuse:** Any sexual act on a child by an adult in the home, exposure to sexually explicit conduct or materials, sexual exploitation, or a known sexual abuse perpetrator lives with child; and

² Except in cases of child sexual exploitation or human trafficking

- **Neglect:** Caregiver not meeting basic needs and has refused assistance; not protecting child from physical, emotional, or sexual harm by others; truancy of children ages seven through grade six; caregiver absence or abandonment; or involving child in criminal activity that involves danger of serious injury.³

What Child Abuse and Neglect Is Not

Some situations may indicate that a family or a child needs community services or support, but do not meet the definition of child abuse or neglect. Examples include:

- Living in poverty, including lack of food, clothing or shelter that is not injurious to the child
- Accidental injuries, even if regular and recurring
- Parental prenatal substance use
- Physical or mental impairment of the parent, including substance use, if it has little or no impact on the child
- Isolated incidents of domestic violence when the child was not present
- Physical discipline, like spanking, as long as it does not cause bodily injury

D. Reports of Suspected Child Abuse and Neglect

During the four-year period 2018-2021, Child Protective Services received roughly 25,000 reports per year of alleged child abuse and neglect from members of the public. In the most recent year, 2021, there were 26,584 reports (See Table 2). More than one-half (56%) of those reports were “screened out” through the intake review process as not meeting the threshold for investigation. To meet the threshold for CPS investigation, allegations must demonstrate credible concerns that child safety is at risk. Nearly four out of ten reports (37%) were referred to district offices for investigation. Additionally, 1% were linked to existing CPS cases or investigations, 4% were deemed appropriate for investigation, but low risk, and referred to a contract agency for family assessment, and the remaining 2% of reports were special circumstances, such as substance exposed infants or children who are part of a federally recognized tribe in Maine.

³ Children’s Bureau Fact Sheet, *What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms*, www.childwelfare.gov/pubpdfs/whatiscan.pdf

Table 2. Child Protective Services: Reports Received in 2021		
Reports of Suspected Child Abuse and Neglect	Number	% of reports
Total	26,584	
Inappropriate for Investigation (screened out)	14,787	56%
Appropriate for Investigation	9,808	37%
Assign to contract agency ⁴	1,003	4%
Link to existing case for investigation	398	1%
Other disposition	588	2%
Source: Maine OCFS data provided at OPEGA's request		

E. Investigation Findings and Outcomes

CPS investigations seek to determine whether child abuse or neglect occurred. All investigations end in one of three possible findings:

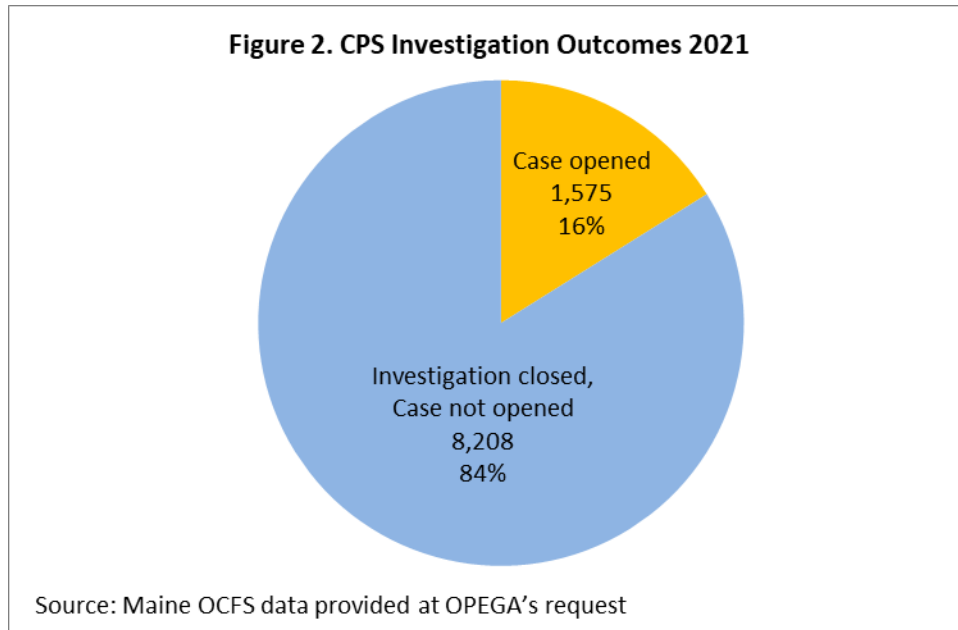
- **Unsubstantiated** means the caseworker and supervisor have determined that it is more likely than not that *no* abuse or neglect occurred.
- **Indicated** means that it is more likely than not that *low or moderate severity* abuse or neglect occurred.
- **Substantiated** means that it is more likely than not that *high severity* abuse or neglect occurred.

In Table 3, data from 2021 show that 71% of CPS investigations ended in an *unsubstantiated* finding; 11% of investigations ended with an *indicated* finding suggesting the likely occurrence of low to moderate abuse or neglect; and the remaining 18% ended in a *substantiated* finding of likely high severity abuse or neglect. These figures were similar to the pattern of findings in recent years.

Table 3. CPS Investigation Findings Made in 2021		
Finding	Total (9,783)	% of investigations
Unsubstantiated	6,937	71%
Indicated	1,076	11%
Substantiated	1,770	18%
Source: Maine OCFS data provided at OPEGA's request		

All CPS investigations also end in a decision about whether or not to open a service case. Most investigations result in a closed case with no further CPS involvement (see Figure 2). If there are remaining safety threats or future risk of maltreatment, the case will open for prevention services or rehabilitation and reunification.

⁴ This contracting practice is phasing out in the first half of 2022. CPS will now handle these low and moderate risk cases internally. Staffing levels of investigations caseworkers are increasing to address the additional work.



IV. Common Misconceptions Regarding Child Welfare —

Over the course of this review in interviews and surveys, OPEGA asked OCFS staff, mandatory reporters, parent representatives, and others involved in child protection efforts to identify any misconceptions they sense the general public may have regarding child protective investigations. Many misconceptions were noted—particularly those regarding the role and authority of OCFS, the child protective process, and child welfare in general. To the extent these misconceptions are widespread, they may limit individual and collective understanding of the realities of child welfare, leading to unreasonable expectations and missed opportunities for improvement. As policy makers consider the current state of child protection services in Maine and potential changes to policy and practice, it is important to acknowledge and understand misconceptions that may exist. Below, we describe five concepts in child welfare that are associated with the misconceptions reported to OPEGA.

Misconception 1: Caseworkers alone make child safety decisions.

Decisions made in a case are based on the information gathered by a caseworker and through a collaboration between the caseworker and their supervisor, and sometimes others, using Structured Decision-Making (SDM) tools. Caseworkers do not unilaterally make decisions regarding a child's safety. Before and during the initial visit to the home, caseworkers gather information. Whenever possible, the caseworker contacts their supervisor before leaving the home to discuss the information gathered and the current circumstances of the family. The supervisor and the caseworker then together make the preliminary safety decision (PSD), which determines if it is safe for the child to remain in the home or if the child is in danger of immediate risk of harm and should

be removed. This decision is made using the Structured Decision-Making (SDM) Safety Assessment Tool. The caseworker and supervisor are guided by the tool and the supervisor is responsible for documenting the use of the tool. In some cases, the caseworker and supervisor may seek input on the preliminary safety decision from other CPS staff, such as the district Program Administrator. If it is determined at that decision point that the child is unsafe and should be removed from the home, the caseworker is then required to present evidence and obtain a Preliminary Protection Order (PPO) that must be agreed to and signed by a judge in order to take effect.

Throughout the 35-day investigation period, the caseworker continues to collect information about child safety and risk and completes a Risk Assessment Tool designed to determine the safety threats and future risks of maltreatment. On the basis of information collected and the Safety Assessment and Risk Assessment Tools, a decision is made through collaboration with the supervisor whether to open a case with the family at the end of the investigation.

Misconception 2: OCFS decides on its own whether a child is removed from their home.

The removal of a child from their home is a legal action by the State and is decided by a State District Court. The removal of a child from their home is a legal action by the State and is decided by a Maine District Court. For this legal action to be taken, the state (DHHS) is required to provide sufficient evidence of abuse or neglect to meet legal requirements. CPS cannot act to remove a child into state custody without a court order, even on a temporary basis. Before the Court will order a removal, the Court must determine that immediate risk of serious harm or jeopardy to the child exists based on evidence presented by DHHS and that DHHS has made reasonable efforts to prevent removal of the child. Having a solid case with proper evidence is necessary to meet the high threshold required by the Court to justify a child's removal from their home. Ultimately, the courts—not DHHS/OCFS—have the final say on whether or not children are removed from their homes.

Misconception 3: CPS caseworkers have authority to enter a home and compel parents to cooperate with an investigation.

Generally, a family's engagement with caseworkers during an investigation is voluntary. Parents can decline to speak with caseworkers or to allow them into their home. Additionally, parents may decline to allow their children to be interviewed. They may also choose not to sign releases permitting caseworkers to obtain information from their medical, mental health, and substance use treatment providers. Parents also do not have to participate in any services recommended by DHHS. The Department, with the advice of the Office of the Attorney General, may seek a court order to compel the parents to engage in some of these activities. With parent engagement being largely voluntary, CPS caseworkers instead rely on social work skills to build rapport with parents and encourage their participation with the agency and investigation process. Over the course of the review, we heard that there is growing awareness among families that engagement with CPS is voluntary, and more families are declining to allow access to their homes by DHHS.

Misconception 4: Caseworkers have ready access to timely and accurate information on cases.

While CPS is tasked with making decisions about the safety of a child, caseworkers are often working with limited information. Information may be limited by parents' lack of engagement in the process and their right not to participate in interviews and meetings with CPS. Additionally, individuals are not always truthful when interacting with caseworkers. Caseworkers also may have difficulty finding contact information or actually locating families and collateral contacts. Caseworkers also may encounter difficulty obtaining information from a family's service providers, as this typically requires a release signed by the relevant family member. The family member may not grant that release, records may not be provided in a timely manner, or providers may not want to risk potential damage to their relationship with that family member by reporting to CPS. Caseworkers require timely and accurate information, which is not always easily attainable or readily available, to aid in determining the safety of the child.

Misconception 5: Adverse outcomes are the fault of caseworker error or flawed processes.

Adverse outcomes occur for complex reasons and can occur despite quality staff and processes in place. When a tragic outcome occurs, such as a child death, there is an observed tendency to jump to the conclusion that either a CPS worker missed some critical piece of evidence or the department's process itself is fundamentally flawed. However, this reasoning misses other critical factors at play. First, there are limits on the actions the department and its caseworkers can take during an investigation. As noted above, for example, DHHS cannot enter a home without permission and a court order is required to remove a child. Second, even if all steps of the process are completed by the caseworker and supervisor as prescribed, and the resulting decisions are the best decisions that could be made at the time with the information available—there may still be an adverse outcome. Conversely, a minimally completed investigation process, or even a case where the family refuses to participate, may not result in an adverse outcome.

While the concern that follows a child death and the related desire to prevent any such deaths from ever happening again is understandable, there is no philosophical approach, set of policies and procedures for child welfare practice, or actions—even an investigation that is completed to the letter of policy—that can provide absolute assurance that a child won't be harmed in the future. Even with the best information available, it is not possible to predict future outcomes with absolute certainty. However, there are opportunities to improve the child protective system to put caseworkers and supervisors in position to make the best decisions possible.

V. Child Welfare Philosophy and the “Pendulum Swing” —

Through interviews with stakeholders, reviews of federal and state laws, analyzing data related to high profile child deaths in Maine, and researching trends in child welfare practice, we observed a continuum of child welfare philosophies that emphasize child safety and family preservation to varying degrees. The Due Process Clause of the U.S. Constitution grants parents the fundamental rights of care, custody, and control of their children, and the Supreme Court has affirmed this right so long as a parent adequately cares for their children. Maine’s Child and Family Services and Child Protection Act recognizes that “the right to family integrity is limited by the right of children to be protected from abuse and neglect” (22 MRSA §4003).

Protecting the safety and well-being of children is a concept that enjoys universal support throughout the child welfare system as well as the community at large. However, how best to protect children and where family preservation stands in the equation is a point of considerable debate and contention between competing philosophies. Below, we present our understanding of these child welfare philosophies and the various reactions to high profile child deaths in Maine.

While there is a continuum of child welfare philosophies, three approaches became most apparent over the course of our work:

1. Family preservation is in the best interest of the child, and family preservation efforts should begin well before CPS involvement. Proponents of this philosophy would advocate for stronger social service programs and welfare benefits to support families, far less CPS involvement, and even fewer removals of children—particularly in cases of neglect.
2. Family preservation should be emphasized to prevent the removal of a child once CPS is involved with the family and to reunify families following the removal of a child. Proponents believe current levels of CPS involvement with families are appropriate.
3. Child safety should be emphasized to protect children, and more CPS involvement with families, including the removal of children, is necessary to ensure that safety.

Within and across the many stakeholders engaged in the child welfare system, people have strong beliefs and opinions on which philosophy and approach is best. These beliefs and opinions are shaped by individual experiences, perspectives, risk tolerance, and their role in the system. There is no one approach or philosophy that “fits” for all.

Shifts in child welfare policy and practice over time have often been described as a “pendulum swing” between different ends of the philosophical continuum – that is, between a priority on family preservation (preventing the removal of children and increasing

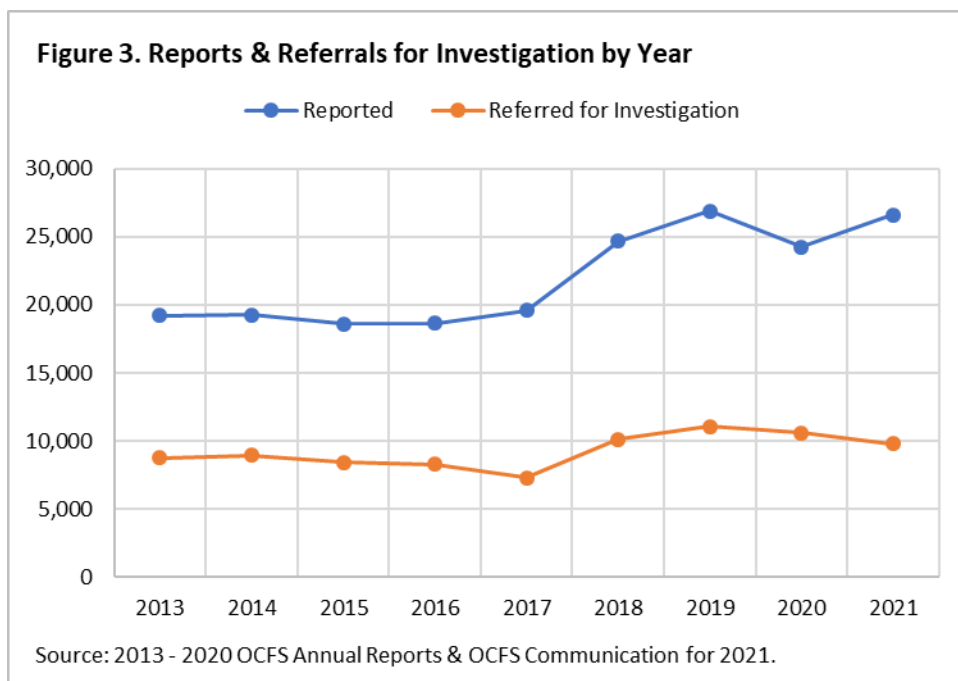
reunification) and a priority on protecting child safety (even if that indicates removal of a child from the family).

However, unlike a true pendulum which has smooth and predictable swings, changes in child welfare policy and practice are often sudden and reactive attempts to course correct in response to elevated concerns, whether that be an alarmingly high number of children in state custody or an adverse event—most notably, a child death at the hands of their caregiver. When something as tragic as a child death occurs, there is a groundswell of media attention, public outcry and demands for action. This may generate various reactions among different stakeholders in the CPS system, with varying degrees of impact on actual child welfare practice.

A. Reactions Following Child Deaths in 2017-2018

Looking back at the two high-profile child deaths in Maine in 2017 and 2018, we observed three distinct reactions as outlined below. All three reactions reflected an increased emphasis and priority on the safety of the child.

Increased Reports of Potential Child Maltreatment. When there are high-profile cases, such as child deaths, an increased awareness of the potential signs of child maltreatment may yield more reports made to state child welfare agencies by both mandated reporters and other individuals. In turn, as the pool of reports increases, the number of reports “screened in” for investigation is likely to increase. This is evident in Maine data for the numbers of reports made and those screened in for investigation in the years preceding and following those deaths as shown in Figure 3 below.



Both reports made and reports referred for investigation trended upward from 2017 through 2019 and reports made appear to show another increase contemporaneously with the most recent child deaths in 2021.

OCFS Policy and Practice Changes. In June of 2018, following the two child deaths, OCFS issued the first of a series of policies by memo. The June 2018 policy clearly emphasized that decisions made by OCFS must consider the child’s best interests, needs, and safety. The policy also stated that OCFS was reviewing the practice of child protection assessments and would “be returning to an emphasis on investigation rather than assessment.” Two other policies by memo followed in July and October of 2018. The July 2018 policy emphasized the need for CPS Program Administrators and Assistant Program Administrators to approve decisions regarding child safety. The October policy emphasized that supervisors must review each case to determine that the safety and risk concerns have been adequately addressed. These policies by memo also served as a bridge to the replacement of the OCFS “Child Protection Assessment” policy with a new version in 2018 titled “Child Protection Investigation Policy.” A comparison of the content and text of the two policies reveals that the 2018 policy is much more investigatory in nature, includes more prescribed processes and prominently features the use of Structured Decision-Making (SDM) tools.

The tone and messaging of these changes may also have had an impact on practice and decision-making by OCFS staff. Many of those interviewed or surveyed by OPEGA for this review described OCFS staff as working from a place of fear in the aftermath of the 2017 and 2018 deaths, and, consequently, making decisions based on what they believed would ensure child safety over family preservation, albeit with some remaining risk.

Statutory Changes and Other Legislative Actions. In 2018, the Maine Legislature enacted a Governor’s Bill amending the Child and Family Services and Child Protection Act (22 MRSA, § 4003(3)) in a way that reflected a desired shift in the priority given to family preservation as an outcome.⁵ Specifically, the bill removed the language “give family rehabilitation and reunification priority” and replaced it with “require that reasonable efforts be made to rehabilitate and reunify families.” However, the impact of this change appears limited. The underlying state and federal child protective laws, and the standards applied by the courts when making such determinations, remained unchanged.

In addition to the statutory changes in 2018, the Maine Legislature enacted a bill which added a number of additional staff positions to CPS.⁶ Overall, two regional associate directors, eight case aide support staff, 16 caseworkers, and 16 supervisors were added. An additional 33 caseworker positions were added through the state budget enacted in 2019.

⁵ LD 1922, 128th Legislature.

⁶ LD 1923, 128th Legislature.

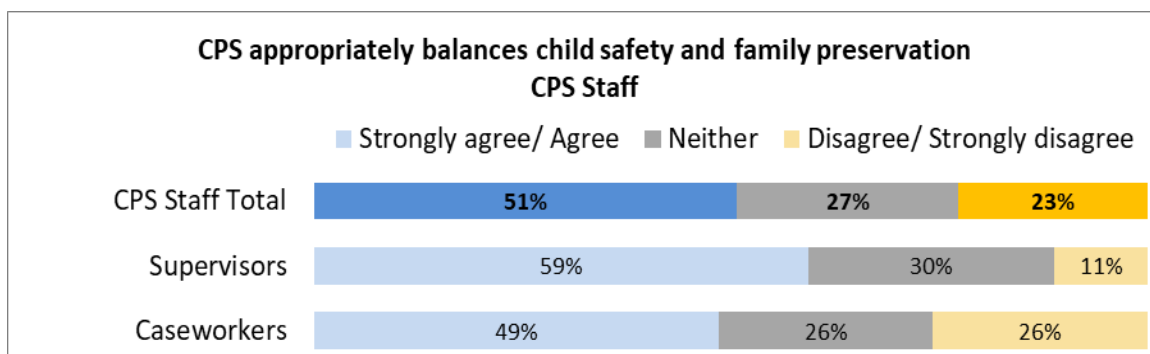
B. Reactions Following Child Deaths in 2021

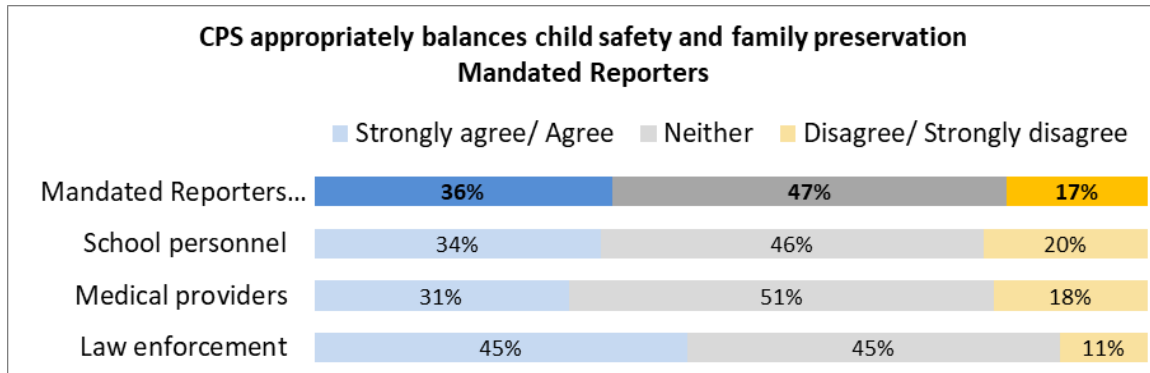
When several tragic child deaths occurred in June of 2021, there was immediate media attention and calls for action. In the weeks immediately following, we observed swift Legislative and departmental reaction. The Legislature initiated this review, and DHHS contracted with Casey Family Programs to conduct a review and analysis of the June 2021 child deaths and recommend changes to the state’s child welfare system. In terms of department policy and practice, OPEGA has not observed the same type of reactive changes as those that occurred in 2018. Over the past year, OCFS appears to be taking a more measured approach, working with various organizations to identify where improvements may be made. On the Legislative front, there have been eight bills, to date, introduced in the 2nd Regular Session of the 130th Legislature that propose to change some aspect of the child welfare process. The department has also proposed additional caseworker and supervisor positions in the Governor’s proposed supplemental budget for FY2022-23.

C. Stakeholder Perspectives

We asked CPS staff and mandated reporters about their perceptions of the balance between child safety and family preservation by CPS. We found that about one-half of caseworkers and supervisors surveyed agree that CPS appropriately balances child safety and family preservation, with supervisors more often (59%) agreeing than caseworkers (49%). Overall just over one-third of mandated reporters (36%) agreed that the balance is appropriate, while nearly half (47%) had a neutral rating – they neither agreed nor disagreed that the balance is appropriate.

Survey respondents who disagreed that the balance is appropriate had the opportunity to provide comments. In these comments we observed that CPS staff who disagreed more often indicated that child safety is too heavily weighted over family preservation, while the mandated reporters more often indicated that family preservation is too heavily weighted relative to child safety. CPS staff cited inconsistency in practice, high workloads, required timeframes, and lack of placement options as impediments to achieving an appropriate balance.





D. Summary

In discussion and debate of child welfare in Maine and nationally, child safety and family preservation are often treated as two opposing goals; however, they are not mutually exclusive. In fact, Federal and state laws and policies have reflected both family-oriented and child safety principles. Since the 1980s, Title IV-E of the Federal Social Security Act has required states to make reasonable efforts to preserve families to prevent or eliminate the need for removing a child from their home and to make it possible for a child to safely return home and reunify with their family. In the 1990s, language was added to Title IV-E through the Adoption and Safe Families Act of 1997 that still required that the same reasonable efforts be made, but additionally specified that the child’s health and safety was of paramount concern. Maine law is similar, with the Maine Child and Family Services and Child Protection Act (22 MRSA, §4003(2) and (3)) requiring that children be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare. The Act also identifies family rehabilitation and reunification as a means for protecting the welfare of children.

Regardless of the prevailing child welfare philosophy at any one time, each CPS case is unique and requires a thorough investigation to allow caseworkers, supervisors, and Program Administrators to make the best decisions possible for the child based on the circumstances of child and family—whether that is removing the child from the home or addressing safety concerns to keep the child in the home. The investigation provides the basis for those critical decisions and is the focus of the remainder of this report.

VI. Investigation Processes

The structure, process and expectations for investigations of alleged child abuse and neglect are detailed in several OCFS policies. OPEGA reviewed these policies and interviewed OCFS management to understand how investigations are designed to be conducted. We observed that OCFS investigations policies are well-defined and contain numerous tools and reference materials to help guide caseworkers in collecting information to assess the safety of children. There are multiple points throughout the investigation process in which the safety of children is assessed, and the

decisions made at these points are based on current information available to the caseworker. Supervisors are involved at multiple points in the investigation process and serve as a valuable resource to caseworkers during the course of an investigation. Structured Decision-Making tools are employed at critical points in the process to objectively and consistently assess safety and risk to children. While the policies are well-defined and comprehensive, we observed that the extent to which investigation practices are *sufficiently thorough* is more ambiguous. This will be discussed further in the Quality Assurance Case Reviews section on page 36. Below we provide a detailed description of how investigations are expected to be conducted by caseworkers.

A. Report Assignment

Individuals report situations of suspected child abuse and neglect to OCFS Central Intake via a statewide, 24-hour, toll-free number. OCFS intake workers collect information about the person making the report, the family, and the nature of suspected abuse or neglect. Intake workers use the Structured Decision-Making Screening Response Priority Tool (SDM SCRPT) to document the allegation and determine the necessary response time. The screening tool helps intake workers determine the screening decision, which may be:

- Screened in as appropriate report. For a report to be appropriate for investigation, there must be: an allegation of abuse or neglect as defined in policy; a caregiver must be the subject of the allegation;⁷ and the child must reside in Maine or the abuse has occurred in Maine.
- Screened out as an inappropriate report. Allegations that do not meet the definition of abuse or neglect are deemed inappropriate for investigation. Risk factors are assessed to determine if it is appropriate to refer the report to prevention services or community intervention programs.
- Screened out requiring a response. Special cases of screened-out reports that require a response include:
 - Service Requests – such as a request from another state for Maine to conduct courtesy interviews of a child located in Maine, or requests pursuant to the Interstate Compact on the Placement of Children⁸;
 - Concerns in an out-of-home facility; or
 - Safe Haven⁹ reports in cases of infant abandonment.

⁷ An exception to the requirement that a caregiver (also known as a person responsible for the child) must be the subject of an investigation is when there is a threat to a child's health or welfare caused by child sex trafficking by any person, regardless of whether or not the person is responsible for the child.

⁸ Interstate Compact on the Placement of Children is a statutory agreement between all 50 states, the District of Columbia and the US Virgin Islands that governs the placement of children from one state into another state. It provides for the movement and safe placement of children between states when the children are in state custody.

⁹ A Safe Haven provider is either (1) a law enforcement officer, (2) staff at a medical emergency room, (3) a medical services provider, or (4) a hospital staff member at a hospital – who accepts a child less than 31 days old from someone voluntarily relinquishing the child and expressing no intent to return for the child (22 MRSA §4018).

For reports screened in as appropriate for investigation and for screened-out reports eligible for referral to programs or services, intake workers consult the SDM SCRPT to determine the response time which is 24 hours from receipt of the report for emergency reports, or 72 hours for non-emergency reports. A report is screened using the decision tree in the Intake Tool which results in a determination of whether a 24- or 72-hour response is appropriate based on the allegations. Each type of abuse (physical abuse, neglect, emotional maltreatment, and sexual abuse) has an individual decision tree. Under certain circumstances, an override to the tool may be applied to reclassify a 72-hour response to a 24-hour response and vice versa.¹⁰

If it appears that the child is in immediate risk of serious harm, or the screening tool indicates the need for a 24-hour response, the intake worker contacts the intake supervisor immediately. These reports are reviewed and assigned to the appropriate district office as soon as possible. District staff may decide that the report requires a more immediate response than within 24 hours and direct the caseworker to respond immediately.

An intake supervisor reviews and approves all intake worker decisions by the end of the worker's shift. Screened-in reports are then sent to the appropriate district supervisor for assignment for investigation (see page 10 for numbers of reports of suspected child abuse or neglect received by Central Intake in 2021). District supervisors review the reports received from intake and assign them to investigations caseworkers.

The last step in completing the intake report is determining if there is a need to refer a suspected criminal act of child abuse to the District Attorney responsible for the geographic area in which the alleged crime occurred.

B. Activities Prior to Going Out in the Field

Once assigned, there are a number of activities that caseworkers perform prior to going out in the field. These activities are designed to help identify, obtain, and review relevant and fundamental information about the family, and provide a basic framework for the investigation going forward. These activities are outlined in OCFS's Assignment Activities Tool, which is completed in collaboration with the caseworker's supervisor, and now documented in Katahdin, the information system that recently replaced the Maine Automated Child Welfare Information System (MACWIS).

The activities described in the Assignment Activities Tool include the following:

1. Safety and risk factors: Identification and documentation of safety factors, risk factors, and safety threats based on 1) the reported information, and 2) a review of the family's previous history with CPS.

¹⁰ Examples of an override from a 72-hour response into a 24-hour response include law enforcement request for immediate response, forensic considerations which would be compromised by a slower response; reason to believe that the family may flee. Examples of an override from a 24-hour response to a 72-hour response include: child safety requires a strategically slower response or child is in an alternative safe environment.

Safety Factors – the presence of parent/caregiver conditions or actions of protection that decrease the likelihood that child abuse or neglect will occur in the future.

Risk Factors – the presence of parent/caregiver concerns, child behaviors, conditions or past history that may increase the likelihood that child abuse or neglect will occur in the future.

Safety Threats – the immediate risk of serious harm to the child due to the presence of parent/caregiver concerns, child behaviors, conditions or past history.

2. Types of abuse or neglect: Identification and documentation of the types of child abuse or neglect based on the allegations, as well as other possible types of abuse based on the family's prior CPS history, and the potential impact to the child.
3. Alleged perpetrator: Identification and documentation of who is alleged to have perpetrated the abuse and if they serve in a caregiver role.
4. Out of home parents: Identification and documentation of all out of home parents and how to locate them.
5. Criminal history: Review of the criminal history for each person responsible for the child including State Bureau of Investigation reports, Bureau of Motor Vehicles reports, National Sex Offender Registry, and information from other law enforcement agencies.
6. Need for law enforcement: Determination of whether law enforcement or another caseworker should accompany the caseworker into the field to conduct the investigation.
7. Alternative hypotheses: Identification and discussion of alternative hypotheses that could account for the allegations and how these alternative explanations will be explored during the investigation.
8. Child interview notification: Determination of whether to conduct an interview without prior notification for any child(ren) involved in cases where prior notice would increase the threat of serious harm to the child or another person.
9. Critical case members: Establishment of a list, in order of priority, of the critical case members (children in the home, parents/caregivers in and out of the home, and caregivers reported to be abusing or neglecting the child), and collateral contacts (people who have knowledge about the family's situation which may support or corroborate information provided by parent/caregiver) to interview. In most cases, the caseworker will first contact the person who alleged the abuse or neglect, then interview the child, followed by non-abusing parent/caregiver, then alleged abusing parent/caregiver, and lastly, collateral contacts.
10. Other investigation activities: Identification of other investigation activities required to assess child safety as determined by the identified safety threats, risk factors, and safety factors. Some examples are contacting code enforcement, consulting with a Child Abuse and Neglect Medical Expert, or contacting CPS in another state the family resided in.

Additionally, there are other required activities for specific situations:

- Child sexual abuse: If there are allegations of child sexual abuse, child interviews are completed at a Child Advocacy Center (CAC), which is a child focused, facility-based

program where law enforcement, child protection, prosecution, and advocates work together, and the forensic interview is conducted. If the CAC is unable to complete the interview within the required response timeframe, the caseworker develops a plan to interview the child in consultation with law enforcement.

- **Indian Child Welfare Act:** If the report identifies that the family is part of a federally recognized tribe in Maine and that the Indian Child Welfare Act (ICWA) applies, the caseworker notifies the tribe within 24 hours to determine whether they want to participate in investigation activities.

While the Assignment Activity Tool is to be completed prior to initiating investigation activities, this is not always possible. In extenuating circumstances, the tool is completed by the end of the next business day. These include times when caseworkers are providing after hours and weekend emergency coverage, emergency calls taken while in the field, and reports that require an immediate response.

C. Initial Contact with Critical Case Members

Within the assigned response times, caseworkers locate and interview all critical case members, as well as conduct a home visit.

Locating critical case members. These include the child identified as the potential victim, any child reported to be or found to be residing in or visiting the home, any child of a parent/caregiver residing in the home where the abuse or neglect is alleged to have occurred, and the primary caregivers responsible for the child's care. Caseworkers are to make every effort to locate all critical case members using the strategies contained within the Activities to Locate Tool, and to document those efforts. Strategies referenced in this tool include searching OCFS records and other state agency records; contacting relatives, friends, providers, employers, landlords, etc.; and performing internet searches.

Child interview. Parents/caregivers are asked to consent to the caseworker's interview of the child except in circumstances where prior notice would increase the threat of serious harm to the child or another person. For initial interviews with a child, caseworkers use a Fact-Finding Child Interview Protocol and Fact-Finding Child Interview Template. These tools provide guidance on the structure and conduct of interviews in a manner that builds rapport, explores the allegations or concerns that prompted the interview, and also explores any new allegations or concerns mentioned by the child during the interview. The interview also seeks to understand the child's perspective of how things are going at home, concerns regarding the specific allegation, the impact to the child, and identifying other potential sources of information and evidence. Caseworkers document the physical description of the child and any injuries or marks. All initial interviews with children are audio recorded and documented in the template. If a parent or caregiver refuses to allow their child to be interviewed, the policy dictates that the caseworker must consult with their supervisor, Program Administrator (PA), and Assistant Attorney General (AAG) regarding next steps.

If a child is nonverbal, the caseworker conducts a physical observation of the child. For infants, the caseworker will observe a diaper change. For an older, nonverbal child, a non-abusing caregiver must be present and consent to observation of the child. If the non-abusing caregiver does not allow for this and will not allow for a primary care provider or emergency department exam, and there is suspicion that the child might have physical injuries, the caseworker and supervisor consult with their PA and an AAG to determine the next steps to ensure child safety, including possible court action.

Interviews with adult critical case members. For interviews with adult critical case members, caseworkers use forensic interview techniques, gathering information for use in a legal setting. They also use motivational interview techniques, which help engage families and seek to ensure that parents/caregivers understand why OCFS is investigating their family. These interviews:

1. Determine the parent/caregiver's understanding of and explanation for the allegations;
2. Understand the family system, including background history, current family relationships, concerns related to domestic violence, substance use or mental illness, current medications, and parental rules or discipline;
3. Gather information about the family's relatives and other supports; and
4. Obtain signed releases of information to make referrals for the family to health providers and other state agencies and to obtain information from the family's medical providers.

Parents/caregivers are interviewed separately, unless doing so would increase the likelihood of potential harm to the child(ren) or an adult parent/caregiver. Interviews of parents/caregivers may be audio recorded.

Home visit. Caseworkers conduct a home visit where each child primarily resides and the location where the allegations were alleged to have occurred (if different than the child's primary residence) to determine whether the environment is safe. During this visit, caseworkers look for potential safety hazards such as substances, weapons or objects accessible to children that may endanger their health or safety; lack of adequate water or utilities; excessive garbage, household materials, or rotting food that threatens health. For children under the age of one year, the caseworker's visit includes completing Safe Sleep and Period of Purple Crying Checklists to ensure the family has a safe sleep environment for the child and the parents/caregivers are educated on the crying patterns of babies. Caseworkers provide parents/caregivers with required pamphlets: the OCFS Practice Model, Guide to Child Protection Services, and the Child Welfare Ombudsman.

D. Preliminary Safety Decision

While still out in the field during the initial contact, the caseworker contacts their supervisor by phone to make a preliminary safety decision (PSD) together. The PSD is the determination of whether it is safe for each child to remain in the home or if the child is in immediate risk of harm and needs to be removed from the home. This decision is guided by the Structured Decision-Making (SDM) Safety Assessment Tool, which is completed by the supervisor and cannot be

overridden. The tool includes three sections: Factors Influencing Child Vulnerability, Safety Threats, and the Safety Decision.

- Factors influencing child vulnerability. First, factors that influence child vulnerability are assessed, such as if the child is under age six, has diminished developmental or cognitive capacity, or a significant, diagnosed medical or mental disorder.
- Safety threats. Next, the worker and supervisor determine if any of the established “safety threats” are present that may place a child in immediate danger of serious harm. See Appendix B for a comprehensive list of safety threats.
- Safety decision. The PSD has three potential outcomes as shown below:

Safety Decision Outcomes
<p>Safe: A child is considered “Safe” when no safety threats have been identified, and the child is not likely to be in immediate danger of serious harm, based on currently available information. The child stays in the home while the caseworker completes the investigation.</p>
<p>Safe with Plan: The child is considered safe, provided a plan, known as a Safety Plan, is in place. This occurs when one or more safety threats are present, and safety interventions have been planned or taken with the parent/caregiver. The child will remain in parent/caregiver’s care and custody.</p>
<p>Unsafe: The child is considered unsafe. One or more safety threats are present and there is an immediate risk of serious harm to the child. The caseworker files a petition for a preliminary protection order (PPO), which is granted by a judge in order to remove the child from the home. If it is after court hours, a judge is notified and decides whether or not to order removal. If a child is determined to be unsafe and time is needed to write and file the petition, the caseworker may collaborate with law enforcement by asking them to invoke a six-hour hold in which law enforcement takes temporary custody of the child. If a child is removed via a PPO, the parents have the option of a hearing on removal held in seven to 14 days. Caseworkers and supervisors may consult with the Assistant Attorney General for their district office to determine whether there is enough evidence to file for an immediate removal prior to filing the petition.</p>

E. Safety Planning and Team Decision Making

A safety plan is a short-term detailed set of action steps to address and control safety threats identified. The plan is created with a family and their supports and outlines planned interventions to assure the safety of a child who will remain in the care or custody of their parent. Safety plans cannot last more than 30 days. A Family Team Meeting (FTM) is scheduled and held within the 30-day safety plan to ensure the plan is being followed and the child remains safe in their parent’s care and custody. An investigation cannot be closed with a safety plan in place.

There may be situations where it is appropriate to develop a short-term alternative care plan (lasting no longer than five days) with a family to prevent the need for removal of a child. Short-term alternative care plans are used when a safety threat exists which may be resolved within five days to allow the child to return home safely (for example, a safety threat exists due to an unexplained injury and the input of a child abuse pediatrician is not immediately available to determine if the injury may be inflicted). The short-term alternative care plan involves a family member, friend, or other person

familiar with the child who agrees to care for the child briefly either in the child's home or the individual's home. Background checks are conducted on the potential caregivers and a walk-through of the home where the child will be staying is conducted. Short-term alternative care plans can only be entered into after a Team Decision Making meeting, and the Regional Associate Director must be notified.

In addition to short-term alternative care plans, Team Decision Making is used in other limited circumstances that may arise during the preliminary safety decision—such as a child death and serious injury investigation or placing a child temporarily in a hotel. In these circumstances, specific OCFS personnel (most commonly a Regional Associate Director) are consulted.

Initial decisions about safety planning and filing a preliminary protection order are made in consultation between the caseworker, supervisor and program administrator or assistant program administrator. A pre-removal FTM is convened when possible. The FTM includes all parents/caregivers, the caseworker, and the supervisor (who may participate remotely). The purpose of the FTM is to address safety threats, promote engagement with the family, and explore relatives and other informal supports as options for placement, and visitation.

F. Continued Investigation Activities

OCFS has an established 35-day timeframe for completing investigations, and within this timeframe, there are a number of tasks that investigations caseworkers must perform as they continue to collect information related to the case and the family, several of which are noted below:

- Interview collateral contacts. The caseworker works with the family to determine who may have knowledge about the family and may support or corroborate information provided by the family. The caseworker and supervisor decide together who the caseworker interviews. Collateral contacts may include neighbors, medical providers, school personnel, and others.
- Account for all children. Caseworkers must account for the whereabouts and safety of all biological or adopted children of any parent who has allegations of abuse or neglect against them.
- Identify relatives. Caseworkers should gather information from both children and parents about any maternal and paternal relatives and any siblings to the child(ren) and document the types of support they (or in the case of child's siblings, their caregiver) may provide.
- Assess other adults. Throughout the investigation, caseworkers assess any adults whose relationship with the children is such that they could potentially be considered a de facto parent under Maine law (Title 19-A § 1891).
- Establish a timeline of events. Based on information collected in interviews, the caseworker establishes a timeline of events related to the alleged maltreatment to identify any gaps that need further exploration and to ensure adequate support for all decisions and findings.
- Identify substance use concerns. Using a questionnaire and answers from both the parent/caregiver and collateral contacts, caseworkers determine whether there are substance use concerns for each parent/caregiver and if a referral to treatment services is needed.

- Investigate add-on reports. If there are new reports during the course of the investigation, these allegations are added to the open investigation. For these allegations, the caseworker and supervisor complete a new Assignment Activities Tool, and the caseworker performs additional investigation activities to address the new allegations. If these allegations have already been addressed in the current investigation or if re-interviewing the child is not in the child’s best interest, the caseworker and supervisor may complete a waiver for these activities that must be approved by the program administrator.
- Plan of safe care for infants. If the report involves a substance exposed infant, the caseworker must follow policy guidance regarding a Plan of Safe Care for that infant and the parents/caregivers who are using substances and caring for the child.

Assessing child safety is a critical consideration throughout the entirety of the investigation and not only during the preliminary safety decision. Caseworkers continually consider safety threats, particularly whenever a change in the family’s circumstances poses a safety concern and the need for possible protective interventions. Additionally, caseworkers and supervisors review the SDM Safety Assessment Tool before closing an investigation to ensure that all safety threats have been addressed, planned for, or resolved.

This continued analysis of child safety throughout the investigation may result in a preliminary protection order (PPO) being filed during the completion of the continued investigation activities. In order for the Department to seek a PPO, there must be an immediate risk of serious harm to the child. If immediacy does not exist but concerns worthy of filing a jeopardy petition are present, the Department may file a child protection petition (also known as a jeopardy petition) that contains the allegations sufficient for court action and a request for specific court action. Examples of requested court action include ordering the child into the custody of the Department and ordering the parent/caregiver to participate in services necessary to ameliorate child safety concerns.

G. Determination of Findings

At the conclusion of the investigation, the caseworker and supervisor decide whether child abuse or neglect occurred based on the facts gathered during the investigation and the results of the SDM Safety Assessment and the SDM Risk Assessment. The determination of whether abuse or neglect occurred are called “findings” and there are three possible options: unsubstantiated, indicated, and substantiated. See page 10 for investigations findings in 2021.

- Unsubstantiated: the caseworker and supervisor have determined that it is more likely than not that *no* abuse or neglect occurred.

For investigations in which the caseworker and supervisor have determined it is more likely than not that abuse or neglect *did* occur, the case is either:

- Indicated: it is more likely than not that *low or moderate severity* abuse or neglect occurred; or
- Substantiated. it is more likely than not that *high severity* abuse or neglect occurred.

Based on the facts of the investigation, a final decision is made that includes the appropriate finding(s) of whether the child has been abused or neglected, and, if so, the type of harm the child experienced, who caused that harm, the timeframe it occurred, and the impact to child. This final decision also includes whether the investigation will be closed or a case will be opened. All findings are communicated to parents/caregivers verbally and in writing. In both indicated and substantiated cases, parents/caregivers are also informed of their right to ask for a review or appeal of that decision and how to request that review.

H. Assessing Risk of Future Maltreatment

Prior to closing the investigation, the caseworker completes the SDM Risk Assessment tool to determine the likelihood of future maltreatment and the appropriate actions that OCFS will take. This tool guides the worker through the selection of a series of potentially applicable risk items (for example: age of youngest child in home, prior investigations, domestic violence in the household in the past year) and supplemental items (for example: primary parent/caregiver denies the abuse or neglect occurred despite credible evidence). The resulting total of the selected items generates a scored risk level of low, moderate, high, or very high. Scored risk levels may be overridden—but only to a higher risk level—in accordance with any defined policy overrides (such as a case involving non-accidental injury to a child younger than age two) and any discretionary overrides, which are used when the caseworker and supervisor agree that the risk score does not accurately portray the household’s actual risk level.

After any overrides are applied, the final risk level classification is determined, and this classification, along with the SDM Safety Assessment Tool outcome, determine which of several actions OCFS may take, which may include:

- Closing a case: This means there is no further CPS involvement. Caseworkers document a summary of the reason for the investigation, all those living in the home, all services family is receiving, recommendations made by OCFS, reason for closure, and any referrals made to community services.
- Opening a case: This means there is continued CPS involvement with the family upon completion of the investigation. There are two major types of open cases¹¹:
 1. Prevention Services Case¹². A case in which the family remains involved with child welfare services after an investigation with a finding of child abuse or neglect and the child remains in the care and custody of the parent/caregiver. This allows child welfare to provide additional intervention services to address child abuse or neglect concerns. These cases may or may not have court-ordered services.

¹¹ Additionally, CPS may open a case for young adults on voluntary extended support agreements, known as V9s, or for other circumstances such as an Interstate Compact for the Placement of Children (ICPC) request from another state, requests for home studies from the courts for non-child welfare adoptions, or administrative purposes during the investigation to pay for expenses, such as drug screens.

¹² At the time of this report, the use of Alternative Response Program (ARP) is being phased out, with all contracts with DHHS ending by June 30, 2022. Previously, referrals to this community-based intervention service were a potential action that could be taken at the end of an investigation.

2. Reunification Case. A case in which the family remains involved with child welfare services after an investigation with a finding of child abuse or neglect in which the child is removed from the care and custody of the parent/caregiver and placed in DHHS custody. This includes cases where children enter the Department's custody through a preliminary protection order or a child protection petition. This allows OCFS to provide additional intervention services to address child abuse or neglect concerns and help the family increase child safety, achieve permanency, and ensure the well-being of their children.

The supervisor reviews the caseworker's documentation to ensure that all information critical to support decision-making is included and ensures the investigation has complied with policy and all required information is documented appropriately. If so, the investigation is approved by the supervisor. The investigation is then either closed or opened as a case and transferred to the appropriate CPS unit for prevention or reunification services. See page 10 for investigations outcomes in 2021.

VII. Training and Supervision of Caseworkers ---

We interviewed OCFS staff and contracted training staff to understand how investigations caseworkers and supervisors are trained and their perspectives on the sufficiency of the training, particularly for new investigations caseworkers. We learned that caseworkers and supervisors have not been satisfied with training, and that training at OCFS is currently in transition. In this section, we provide a description of the training program that most current OCFS workers underwent, their assessment of that training, and a description of the changes associated with the newest training systems at OCFS. We also observed the importance of the supervisory role in overseeing caseworkers' investigations.

A. Recent Training Programs

In October 2019, OCFS entered into a cooperative agreement with the University of Southern Maine's Cutler Institute to assist in redesigning caseworker and supervisor training. At that time, a training group within OCFS was responsible for conducting, or contracting out for, all aspects of training for caseworkers and supervisors. In July 2020, the Cutler Institute began co-leading new worker training with the in-house OCFS trainers. The system under which most current caseworkers and supervisors were trained consisted of an initial "Foundations" course for new caseworkers, a period of job shadowing for new caseworkers, ongoing training classes for all caseworkers, and a Supervisor Academy.

The training program included a general curriculum for new workers comprised of the Foundations course and a period of job shadowing that extended to the end of their first year on the job. Refresher training on various topics was also offered to more experienced caseworkers, and supervisor training was also part of the curriculum. With the transition to the cooperative agreement

with the Cutler Institute, much of this general framework will continue. As described further, below (see page 31), the Cutler Institute will provide the initial Foundations training and the in-house training staff will be able to focus more on specific needs of the different geographic districts. In addition to delivering training, the Cutler Institute is also contracted to review and revise child protective policies and aid in integrating new policies into the training curriculum.

Initial Caseworker Training. The initial training requirements for a caseworker through the first year on the job included orientation, the core Foundations five-week training course, activities to be completed prior to being assigned cases, and other activities to be completed at various stages within the first year. Prior to being assigned an investigation or case, a caseworker must complete certain activities including: job shadowing, documenting interviews, reading active cases of specific types, and discussing each of these activities with their supervisor. Some version of the activities will continue to be required even with the Cutler Institute delivering the Foundations course.

The previous five-week Foundations training course included both class time and practice time. Both caseworkers assigned to investigations and caseworkers assigned to permanency work participated in the training together. Topics included investigation techniques, use of Structured Decision-Making tools, and working through a simulated case scenario from start to finish. The course also included information on use of the child welfare information system (MACWIS)¹³ as well as health information privacy regulations and data security training.

Other training for new caseworkers, in the first six months of employment, include classes in legal aspects of child welfare, an introduction to the Indian Child Welfare Act, social work ethics, and psychosocial assessment. During the first six months, a new caseworker must also conduct at least two investigations, job shadow a jeopardy hearing, job shadow a monthly face-to-face contact with a child or their parent/caregiver in a case with the goal of reunification, and job shadow a monthly face-to-face contact with a child or their resource parent in a case with the goal of adoption. More training occurs in the latter part of a new caseworker's first year, including a course on child welfare trauma, a course on the children's behavioral health system in Maine, and participating in on-site training with the Office for Family Independence and other programs that assist families.

Ongoing Training. Ongoing training for staff has been, and will continue to be, provided by the OCFS training group. Ongoing training includes social work ethics classes which are required to maintain licensure, training on new OCFS policies, and training related to special projects such as the rollout of the SDM tools. In addition, district offices within the OCFS may request training for their staff to address specific topics or needs.

Supervisory Training. Supervisors are provided training through a program called the Supervisor Academy. This program, which is mandatory for supervisors, consists of three, three-day modules which cover the administrative, educational and supportive aspects of supervision at OCFS. There

¹³ OCFS' Maine Automated Child Welfare Information System (MACWIS) database system, recently replaced by a new system named Katahdin.

were additional, advanced supervisory and leadership training courses created and offered in 2016 and 2017. These courses were put on hold because the rollout of SDM tools took precedence, and they have not been re-instituted.

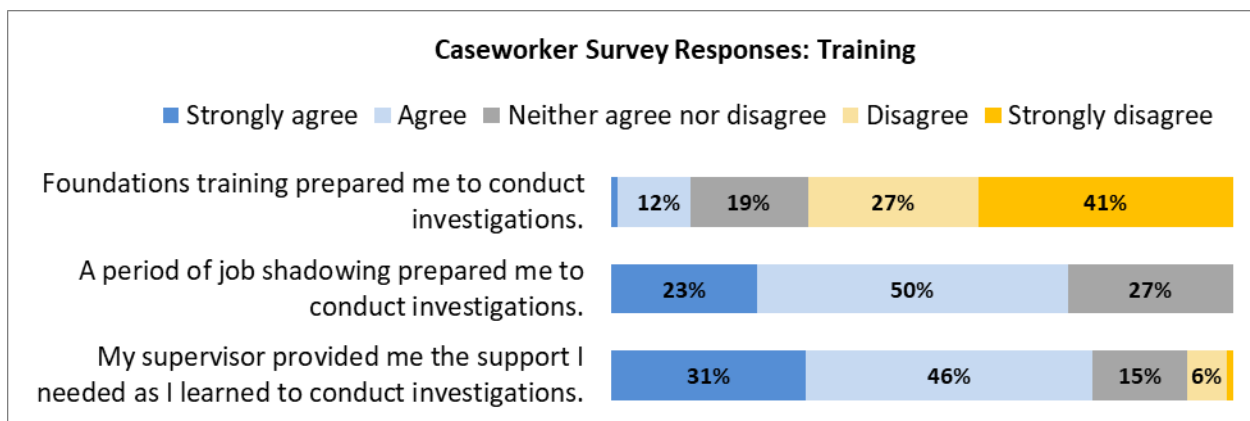
In 2019, OCFS started “coaching training” for supervisors and managers specifically geared to techniques for coaching the OCFS staff under their supervision. According to OCFS training staff, these focused, one-hour sessions have been positively received as specific, targeted and useful. OCFS, in collaboration with the Cutler Institute, is currently developing a supervision framework which includes supervisor competencies, a supervision policy, the Supervisory Academy, and a toolkit with resources such as those related to coaching.

Supervisors have an important coaching role in the training and supervision of OCFS caseworkers. The supervisor is required to review and discuss the trainings with workers at various points throughout their first year. The supervisor’s role in training is also evident in many of the caseworker survey responses described in the following section.

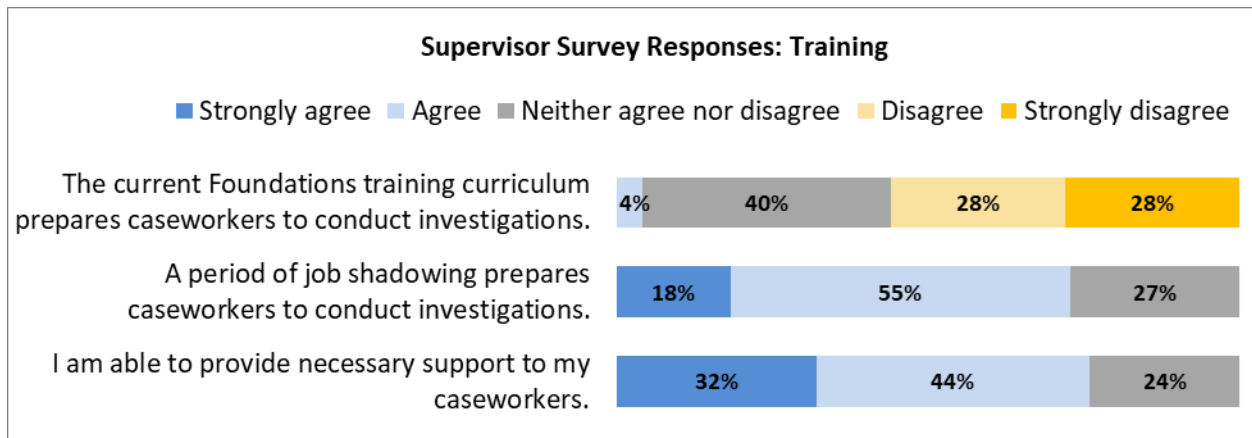
B. Perspectives on Efficacy of Training and the Role of the Supervisor

OPEGA’s surveys and interviews of caseworkers and supervisors provide further insight into the efficacy and relevance of OCFS training and its interaction with caseloads, job turnover, and policy changes. There was wide agreement across caseworkers and supervisors that the Foundations training that has been provided to new caseworkers has not prepared caseworkers to conduct investigations. Support from supervisors and job shadowing, however, have helped prepare caseworkers for this work.

Caseworkers report that supervisors provide necessary support in preparing them to conduct investigations. Seventy seven percent of caseworkers surveyed said they agreed or strongly agreed that their supervisor provided them the support needed as they learned to conduct investigations. Most caseworkers reported that job shadowing component of training prepared them to conduct investigations (73% agreed or strongly agreed). In contrast, only 13% of caseworkers agreed that Foundations training prepared them to conduct investigations. More than two-thirds (68%) disagreed with the statement that “Foundations training prepared me to conduct investigations.”



Supervisors surveyed responded remarkably similarly to caseworkers regarding the value of the components of caseworker training in supporting and preparing caseworkers. Seventy-six percent of supervisors reported that they are always or usually able to provide necessary support to caseworkers, and 73% reported that job shadowing prepares a caseworker to conduct investigations. There was also strong indication that supervisors do not see Foundations training as valuable in preparing caseworkers to conduct investigations: no supervisors strongly agreed and only 4% agreed that Foundations prepares a caseworker for that task.



These survey results on supervisor support, job shadowing and Foundations training for caseworkers are borne out in the open-ended survey responses and interviews conducted by OPEGA. When asked to describe what training would help caseworkers prepare for investigations, both caseworkers and supervisors frequently mentioned: increased job shadowing, preferably with an experienced worker; mentoring opportunities with supervisors or experienced workers; and an increased focus on the investigations process in Foundations. Other suggestions offered by fewer survey respondents include: observing investigations from start to finish before having cases assigned and more supervision and smaller caseloads at first. A few caseworkers surveyed noted specific training that would be helpful, including better preparation for the court and legal aspects of investigations and training on conducting interviews.

Caseworkers and supervisors are of the same mind regarding the need to focus on the practice aspects of getting caseworkers ready for conducting investigations. Comments provided by caseworkers and supervisors also indicated that a more stable workforce, lower caseloads, and to a lesser degree, better knowledge of laws and policies governing the work, would have a beneficial effect in the training of new caseworkers.

C. New Training Programs

Beginning January 2022, a redesigned Foundations training course was launched with split tracks for investigations and permanency workers. Based on interviews with OCFS management and a representative of the Cutler Institute, the new training program is expected to include changes in how training is monitored and delivered, changes in the structure of the Foundations training

course, and efforts to more fully integrate departmental policies into the training curriculum. The new training system for new hires maintains the focus on the supervisor as a central figure in the training. Developing a “learning continuum” from inexperienced caseworker training through supervisory training is a stated goal of the new system.

OCFS and the Cutler Institute now jointly manage an online Learning Management System (LMS). The delivery of training in an online platform necessarily increased during the Covid-19 pandemic. OCFS management observed increased attendance in certain training classes when offered on-line to staff with high caseloads. The LMS allows OCFS and Cutler Institute to deliver training more efficiently to a geographically diverse staff. Current work is being done to determine the best delivery method for each type of training, among the following options: live in-person class; live virtual class; or recorded presentation.

Going forward, OCFS plans to continue to conduct some training in-person, including the Foundations class. The redesigned Foundations class will incorporate revised OCFS policies as they are adopted.¹⁴ The modifications to Foundations that are underway appear to address some of the comments and suggestions that were reported in OPEGA’s surveys of caseworkers and supervisors. In the restructuring, Foundations will be extended from five to six weeks, and investigations caseworkers and permanency caseworkers will be trained together for only the first two weeks. This portion of the course will cover topics relevant to both types of caseworkers, such as ethics, Structured Decision-Making tools, family and youth engagement, and other theoretical aspects of child abuse prevention. The course will then split into two tracks for the remaining four weeks. Each training track will focus on aspects that are unique to the investigation or permanency role, respectively.

The investigation caseworker training component introduces the investigations policy materials. The training also becomes very procedural so that the trainee gains confidence by knowing the specific procedures and tasks that must be accomplished along with the policies behind them. The procedural element of the training includes practice opportunities for how to initially approach a family, interviewing adults, interviewing children, role playing, and simulation of the various needed skills. Cutler and OCFS are planning to provide a field guide reference for caseworkers once they have completed their Foundations course.

The role of the supervisor continues to be central to Foundations training. In developing the curriculum for caseworkers, the Cutler Institute is planning to coordinate with supervisors to create job shadowing opportunities for new hires that correspond to what they are learning in the classroom through Foundations. According to both the Cutler Institute and OCFS management, they want to extend the period of time and increase the level of knowledge and practice before new caseworkers go into the field independently with their own caseload. They believe that helping new

¹⁴ OCFS is currently in the process of consolidating and revising child welfare policies, with the assistance of the Cutler Institute.

caseworkers get a better start and feel more confident going to the field is likely to improve job satisfaction and retention.

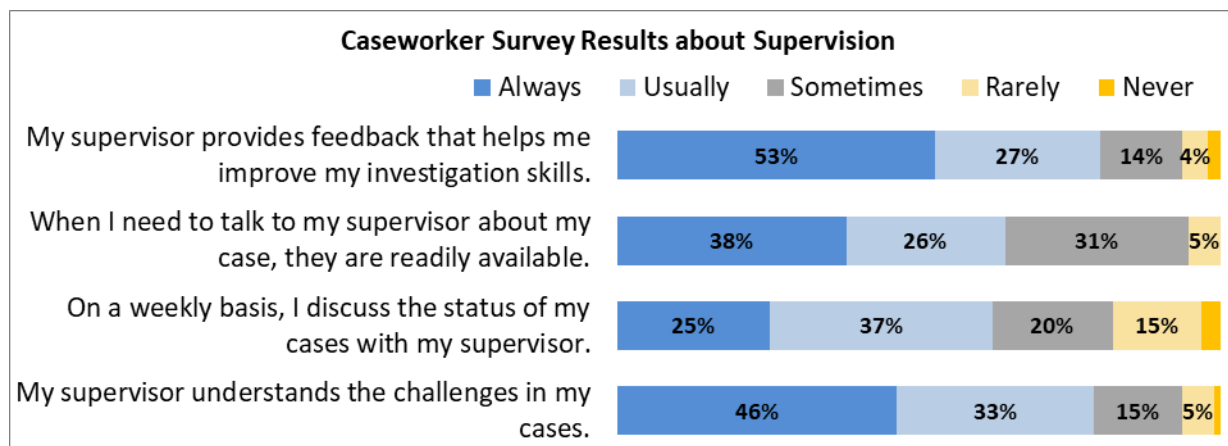
By continuing to include supervisors in new caseworker training, OCFS management hopes to align the new caseworker training with the coaching aspect of supervisory training and practice. This learning continuum integrates the training for caseworkers and supervisors and builds competency in the supervisor’s educational role.

D. Supervision of Caseworkers

Key elements of the OCFS supervisor position include training, mentoring and support of both new and more tenured caseworkers, along with more managerial and administrative functions. The administrative function for supervisors is significant and includes managing casework assignments, guiding the case process, and decision-making at critical points in the investigation.

The relative inexperience of new caseworkers going into the field independently, after initial training and job shadowing, calls for continued mentoring and support from OCFS supervisors. Nearly nine out of ten caseworkers (89%) surveyed reported they were assigned their own case for investigation within two months of completing the Foundations class. Of the supervisors we surveyed, 60% either “always” or “usually” make themselves available to go to the field with new caseworkers and another 16% “sometimes” make themselves available.

From the caseworker perspective, we see further evidence of the supervisor’s key role in mentoring and support. When caseworkers were asked who they rely on when unsure of a course of action, nearly all (93%) reported they rely on their own supervisor and (52%) reported they also rely on another supervisor besides their own. Large majorities of caseworkers reported additional forms of support from supervisors, as shown in the figure below.



In interviews with OCFS supervisors and management, we heard that supervisors have significant administrative tasks related to child protection investigations. Supervisors must assign investigations to caseworkers within a short timeframe to ensure a timely response (either 24 or 72 hours) and

must continually monitor the whereabouts of caseworkers for their safety. The supervisor is also directly involved with a caseworker in making the preliminary safety decision during an initial home visit once a case is assigned and initial interviews have been completed (see also page 23). During the time the caseworker is in the home, the supervisor stays in contact, until a preliminary safety decision for each child is made. The supervisor continues to provide case management, monitoring, and caseworker support throughout the 35-day investigation period and is involved in all major decisions, including decisions regarding findings of an investigation, closing an investigation, opening a prevention service case for family assistance, or opening a family reunification case after a Preliminary Protection Order has been issued by a judge of the court. While the supervisor is involved in all of these decisions, the experience level of the individual caseworker determines if, and to what extent, the supervisor must be involved in the various activities leading to those decisions.

VIII. Role and Structure of Quality Assurance

OCFS has an established Quality Assurance (QA) Program that conducts internal case reviews. The QA Program's primary function is performing individual case reviews using the federal government's Child and Family Services Review (CFSR) model to measure progress in meeting the goals established in the state's Program Improvement Plan (PIP).

QA efforts are conducted by a team of nine QA Specialists who are supervised by one QA Program Manager and who typically have prior experience as OCFS caseworkers or supervisors. The QA Specialists are each assigned and housed in one of the district offices (including intake) to ensure each office has direct access to QA staff. QA staff are trained in the child welfare system and policies and can easily navigate the child welfare information system (previously MACWIS, now Katahdin) to find and review all relevant documentation. QA specialists conduct detailed, thorough assessments of the cases to ensure OCFS conformity with the high standards of the federally-required quality improvement process.

A. Child and Family Services Review¹⁵

The CFSR is the mechanism through which the U.S. Department of Health and Human Services (US DHHS) exercises its oversight of state child welfare agencies to ensure conformity with federal requirements and to promote continuous improvement in child welfare. Administered by the Children's Bureau, within the US DHHS' Administration for Children and Families, the CFSR assesses state performance across two areas: 1) child and family outcomes and 2) underlying systemic factors that influence child and family outcomes. Each of these areas include specific items that are measured and assessed.

¹⁵ This is covered in greater detail in OPEGA's January 2022 Oversight of Maine's Child Protective Services Information Brief.

The CFSR process incorporates three components—a statewide assessment, stakeholder interviews, and case reviews—to complete the review of a state’s performance in meeting federal standards. The case review component of the CFSR, which is used by Maine both during the federal review period and on an ongoing basis, is a critical tool for understanding how well OCFS conducts investigations of reported and alleged child abuse or neglect.

CFSR Performance Standards: The federal government, through the Children’s Bureau, has set high standards for state child welfare agencies based on the understanding that only the highest standards of performance should be acceptable in working with our nation’s most vulnerable children and families. For a state to be in substantial conformity with a particular CFSR outcome, 95% or more of the cases reviewed must be rated as having substantially achieved the outcome. For an item to be rated as a strength, 90% of reviewed cases must be rated as a strength for that item.¹⁶ These high standards also reflect the Bureau’s interest in ensuring that states have incentives to dedicate ongoing attention to improving outcomes and performance.

CFSR Case Review Process: For the federal CFSR process, 65 case reviews are conducted on a sample of 40 foster care cases and 25 in-home services cases from a six-month period, randomly selected according to a methodology established by the Children’s Bureau. States have the option to conduct the case reviews for the CFSR provided they meet certain criteria, including that they use the federal Onsite Review Instrument and Instructions (OSRI) and agree to federal secondary oversight of a percentage of cases to ensure accurate application of the OSRI and quality of case ratings. Maine is a state that uses this option.

In Maine, CFSR case reviews are conducted by experienced QA staff in OCFS working in teams of two, using the OSRI. The OSRI is organized by item, with each item linking to an associated child and family outcome. Within each item there are multiple questions to be completed; taken together, the responses to these questions determine whether the item is rated as a Strength or an Area Needing Improvement. The OSRI provides item- and question-specific definitions and instructions for staff conducting the case reviews. QA staff also complete OSRI item-specific training modules to ensure that they are maintaining the integrity of the tool during case reviews. For each individual case review, the assigned QA staff examine and document information from the OCFS case file relevant to the specific questions, items, and outcomes being assessed. For each case review, interviews are also conducted with children, parents, foster parents, caseworkers, and other professionals.

B. Program Improvement Plan

Any state that has not achieved substantial conformity for each of the child and family outcomes and systemic factors must develop and implement a Program Improvement Plan (PIP) to address these areas. Development of a PIP is standard practice for states – in fact, no state achieved

¹⁶ Two outcomes only contain one item; for these items, 95% of cases reviewed must be rated as a strength to have substantially achieved the outcome.

substantial conformity with all seven outcome areas and systemic factors in round three of the CFSR. The state PIP is comprised of two major sections:

- Key Activities, which includes descriptions of the agency’s goals, strategies, and key activities designed to improve outcomes; and
- Measurement Plan, which outlines the PIP goals by item and describes how cases will be sampled and goals will be measured.

In monitoring the PIP, the QA Program samples and conducts case reviews for 65 cases (40 foster care and 25 in-home service cases) each six-month reporting period, and reports the results to both OCFS management and the federal government. Since the 2017 CFSR, there have been eight reporting periods to date.

IX. Quality Assurance Case Reviews ---

In our analysis of the QA case reviews, we observed indicators of a lack of overall thoroughness and completeness of CPS investigations in meeting the performance standards of the federal CFSR process. The standards and expectations of the CFSR system are very high, and meeting them requires exceptionally thorough and comprehensive work by CPS staff to evaluate risks to children posed not only within the family but also by other individuals who may potentially have unsupervised contact with the children. We did observe that caseworkers generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns and the most critical and relevant individuals related to the allegations.

In determining how well OCFS conducts initial investigations, we used a two-part approach to assess various aspects of the process and to identify potential issues or areas of concern. First, to leverage the structure, sampling, and rigor of the ongoing case reviews conducted in connection with the CFSR process and the PIP – as well as the expertise of the staff conducting that work – we looked to the results and accompanying narrative descriptions of the ongoing case reviews conducted by the OCFS QA Program. Limited by time, we placed a particular emphasis on those items and questions most relevant to child safety during the investigation period and for those cases in which the initial investigation was captured in the period under review. Our observations are presented in this section. See Appendix A for more detail on the methodology.

Second, we sought out the perspectives of those most closely involved with CPS investigations to provide insight as to how well these investigations are performed and to identify potential issues and areas of concern relative to child safety. See Section X. Perspectives on Elements Impacting Investigations.

A. Case File Review Approach

OPEGA looked at case review results for three key items that are most relevant to child safety during investigations in the Onsite Review Instrument and Instructions: timeliness; risk and safety assessment and management; and quality of caseworker visits with child. These correspond to items 1, 3 and 14 of the CFSR (see Table 4). Our review of QA ratings and scoring for these items included both an analysis at the item level as well as more specific review of areas where federal expectations are not being met. We looked at CFSR and PIP results for the items to obtain a broader overview of how well investigations are being conducted. Then, to obtain a case-level view of system weaknesses, we further examined specific questions in relevant investigations cases where the answers contributed toward an item rating of “Area Needs Improvement”.

Table 4. Items Assessed		
Item	Description	Purpose
Item 1	Timeliness of Initiating Investigations of Reports of Child Maltreatment	To determine whether responses to all accepted child maltreatment reports received were initiated, and face-to-face contact with the child(ren) made, within the timeframes established by agency policies or state statutes.
Item 3	Risk and Safety Assessment and Management	To determine whether the agency made concerted efforts to assess and address the risk and safety concerns relating to the child(ren) in their own homes or while in foster care.
Item 14	Caseworker Visits with Child	To determine whether the frequency and quality of visits between caseworkers and the child(ren) in the case are sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals.

Source: Child and Family Services Reviews Onsite Review Instrument and Instructions, January 2016

For these two approaches we examined case review results for two samples:

- CFSR Cases: 65 cases, including 40 foster care cases and 25 in-home services cases were sampled from a six-month period for the CFSR-Round 3 completed in 2017 and the most recent six-month PIP reporting period; and
- Investigation Cases of Interest: 200 in-home service cases were sampled and reviewed by the QA Unit over eight reporting periods spanning from April of 2017 to March of 2021. 109 of those reviewed cases capture the initial investigation within the period under review.

B. Results for CFSR and PIP Cases

In the 2017 CFSR, Maine received an overall rating of Area Needing Improvement for each of the three items we reviewed, as none met the applicable standard for percentage of cases rated as a strength. Each of these required a PIP goal to be set. For timeliness (Item 1), the PIP goal was met in March 16, 2020. As such, we did not assess Item 1 any further, and instead focused our efforts on

the other two selected measures, risk and safety assessment (Item 3) and caseworker visits with child (Item 14). The State has not reached its PIP goal for either of these items (See Table 5).

For risk and safety assessment and management (Item 3), only 40% of cases were rated as a strength in the 2017 CFSR, and the PIP goal was set at 47%. In the most recent six-month reporting period, however, only 29% of the 65 sampled cases were rated as a strength. For the measure of caseworker visits with the child (Item 14), 63% of cases were rated as a strength in the 2017 CFSR, and the PIP goal was set at 70%. In the most recent reporting period, only 35% of the 65 sampled cases were rated as a strength.

Table 5. Item Results				
Item	Applicable Cases	% Rated as Strength in CFSR	PIP Goal	Progress toward Goal
Item 1 Timeliness of Initiating Investigations of Reports of Child Maltreatment	26	73%	84%	Met 3/16/2020
Item 3 Risk and Safety Assessment and Management	65	40%	47%	29% as of 12/2021
Item 14 Caseworker Visits with Child	65	63%	70%	35% as of 12/2021
Source: 2017 Child and Family Services Review Maine OCFS Self-Assessment, Child and Family Services Program Improvement Plan, and OCFS QA case review results.				

C. Results for Investigations Cases

For the sample of 109 cases of interest (in-home cases with an initial investigation during the period under review), we looked at case review results for selected questions. For those cases where answers to questions suggested federal expectations were not being met, we reviewed the narrative rationales provided by QA staff both to better understand the expectations of the reviewers and to identify potential issues or areas of concern. As noted above, we did not review Item 1 regarding timeliness of initiating investigations in this analysis, as this PIP goal has been met.

Risk and Safety Assessment and Management. For “Risk and Safety Assessment and Management” overall, only 15 cases (13.8%) of 109 cases were rated as a Strength. Looking at specific questions that contribute to the overall item rating we observed that:

- In only about one-third of cases reviewed (34.9%) the assessment accurately assessed all risk and safety concerns of the children.
- When safety concerns were present, only 14% of cases reviewed had an appropriate safety plan developed, continually monitored, and updated (see page 24 for more information on safety plans) and in only 29% of cases, safety concerns were adequately addressed.

Table 6. Risk and Safety Assessment Results		
Total Item Results	Cases	Strength
Item 3 Risk and Safety Assessment and Management	109	14%
Specific Questions Pertinent to OPEGA Analysis	Cases	Result
<u>Question 3A:</u> Did the agency conduct an initial assessment that accurately assessed all risk and safety concerns for the target child in foster care and/or any child(ren) in the family remaining in the home?	109	35%
<u>Question 3C:</u> During the period under review, if safety concerns were present, did the agency: 1) develop an appropriate safety plan with the family and 2) continually monitor and update the safety plan as needed, including monitoring family engagement in any safety-related services?	86	14%
<u>Question 3D:</u> During the period under review, were there safety concerns pertaining to the target child in foster care and/or any child(ren) in the family remaining in the home that were not adequately or appropriately addressed by the agency?	82	29%
Source: OPEGA analysis of OCFS QA case review results. Notes: Questions 3A, 3C, and 3D of item 3 were identified by OPEGA as being most relevant to the investigations phase of OCFS involvement.		

Quality of Caseworker Visits with Child. Finally, we examined case review results for the cases of interest for Item 14 regarding caseworker visits with child, and specifically the component question 14B related to whether visits were of sufficient quality to address safety, permanency and well-being issues and promote these outcomes. This question was applicable for 106 cases. Of those, less than one-quarter (23.6%) were scored as “yes.”

In answering this question, reviewers consider the length of the visit, the location of the visit, whether the child was seen alone or with parents present, and the topics that were discussed during the visits. We note that this this item also encompasses monthly caseworker contacts throughout the entirety of a case, which was also frequently noted as an area needing improvement during the investigation.

Table 7. Quality of Child Visits		
Total Item Results	Cases	Strength
Item 14 Caseworker Visits with Child	109	19%
Specific Questions Pertinent to OPEGA Analysis	Cases	Result
<u>Question 14B:</u> During the period under review, was the quality of visits between the caseworker and the child(ren) sufficient to address issues pertaining to the safety, permanency, and well-being of the child and promote achievement of case goals?	106	24%
Source: OPEGA analysis of OCFS QA case review results. Notes: Question 14B of item 14 was identified by OPEGA as being most relevant to the investigations phase of OCFS involvement.		

D. Overall Observations

As we have noted, the standards and expectations inherent in the case review system set forth by the Children's Bureau for the CFSR are very high – particularly when initially assessing child risk and safety. These high standards and expectations are reflective of the belief that only the highest standards of performance should be acceptable in working with our nation's most vulnerable children and families, and ensure that states have incentives to dedicate ongoing attention to improving outcomes and performance. In practice, meeting these standards requires a high level of thorough and comprehensive work by caseworkers to evaluate risks posed not only within the family but also by other individuals who may potentially have unsupervised contact with the target child. This work includes evaluating potential risks based on the criminal and child protective histories of those individuals and any current, or prior, substance use, mental health, or domestic violence issues.

The QA case review results revealed a number of concerns related to meeting standards for thorough and complete assessment of risks to children and their safety in investigations. These concerns included:

- Who is assessed:
 - Not assessing all individuals who may serve in a caregiver role (even briefly or infrequently);
 - Not assessing all household members (even those residing with relatives who the child may only visit or stay with briefly);
- Safety Risks and Plans:
 - Not exploring all potential risk or safety concerns;
 - Not developing a safety plan or developing a safety plan that does not address all risks;
 - Not thoroughly assessing all individuals participating in the safety plan and relying on individuals to carry out and enforce the safety plan who are potentially incapable or unwilling to do so; and
 - Not monitoring and, potentially not updating, safety plans.

While these case review results indicate a lack of overall thoroughness and completeness in the conduct of investigations, we observed that caseworkers did generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns and the most critical and relevant individuals with respect to the reported allegations. These results, in conjunction with survey and interview results (see page 42), are consistent with an issue we identified around the heavy workload demands on caseworkers (see page 52), such that they are required to triage the investigation tasks associated with their assigned cases and also prioritize among their overall caseload.

Irrespective of the workload issue, we did note certain issues with caseworker practice in our analysis of the case review results for the 109 investigation cases of interest:

- Caseworkers may not always assess the risk or impact of a child’s behaviors to the safety of that child’s siblings. For example, in several cases, a child exhibited aggressive, violent or sexualized behaviors and it did not appear that the caseworker assessed the risks of these behaviors on siblings (particularly younger siblings) nor did those risks appear to be addressed.
- Caseworkers may not always interview children and/or parents separately to ensure potential victims may speak openly and freely. In some cases, it was noted that a child (the alleged victim) was interviewed in the presence of their parent(s). In other cases that involved families with histories of domestic violence, parents were sometimes jointly interviewed.
- Caseworkers may not explore reported concerns or relevant topics in interviews with children.
- Caseworkers may not gather enough information in lieu of an interview, in situations with non-verbal children.
- Caseworkers may sometimes rely too heavily on caregiver descriptions or accounts and not seek to confirm these accounts by contacting providers or others involved with the family.
- Caseworkers, occasionally may not be thinking critically when presented with conflicting information or unlikely explanations and may fail to explore these further and in a manner commensurate with the potential risk.

Although these issues were not widespread, they point to potential opportunities to improve the quality of caseworker practice. They are described further in Recommendation 3.

X. Perspectives on Elements Impacting Investigations —

To further understand how well investigations are conducted, and to identify potential issues and areas of concern relative to child safety, we sought out the perspectives of those most closely involved with CPS investigations: caseworkers, supervisors, mandated reporters, and representatives of statewide parent organizations. Through surveys and interviews we asked these individuals to share their perspectives on various issues related to investigations, with particular attention to issues that may affect investigation quality.

OCFS staff reported that their workloads are unreasonable and that they do not have sufficient time to understand risks to the child or the needs of the family. We heard that families are usually willing to engage with CPS during investigations, though they are sometimes unwilling to participate in services offered to help mitigate the risks to children. We also observed that the sharing of medical and treatment information appears to be a barrier to completing thorough and timely investigations.

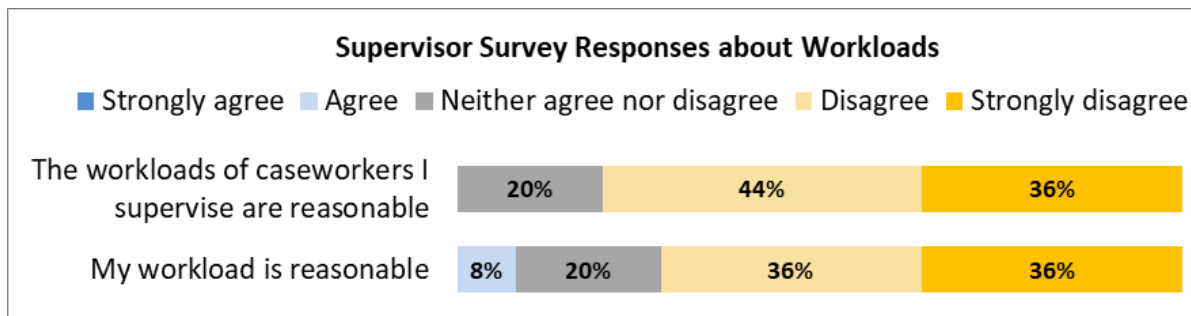
A. Workloads, Timeframes, and Completion of Tasks

In the four years since 2018 that OPEGA has been engaged in reviews of child protective services, there have been ongoing concerns related to the workload of caseworkers, the timeframes in which

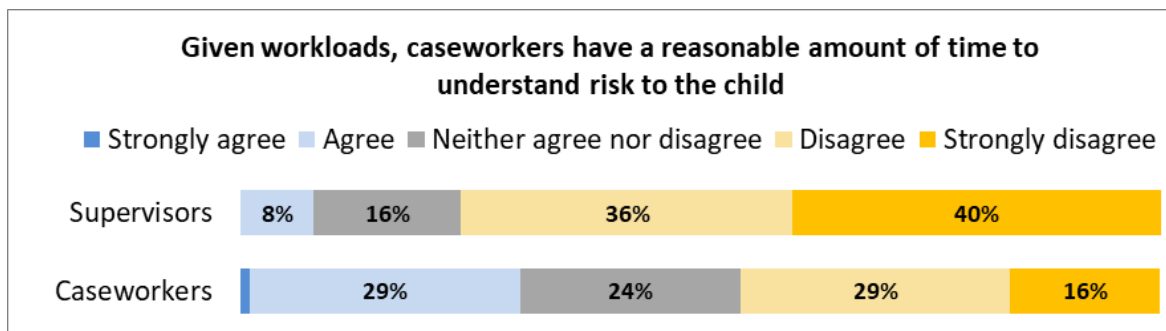
their work must be completed, the completion of all tasks required in an investigation, and the impacts of these issues on assessments of risk and child safety. In this review, we specifically sought out the perspectives of both supervisors and caseworkers and selected mandated reporters to better understand the reasonableness of caseworker responsibilities and how those responsibilities impact how well initial investigations are performed.

Workloads. In contrast to caseloads – which measure the *number* of cases assigned to a caseworker – workload is a measure that better reflects the *time* necessary to conduct the work inherent in each case, as well as other non-casework responsibilities. Because OCFS supervisors assign cases for investigation, work closely with caseworkers throughout cases, and help manage workloads, they generally have a broader view of workloads relative to multiple caseworkers.

In OPEGA’s survey of supervisors, no supervisors agreed that the workloads of caseworkers are reasonable, and 80% of respondents either disagreed (44%) or strongly disagreed (36%).¹⁷

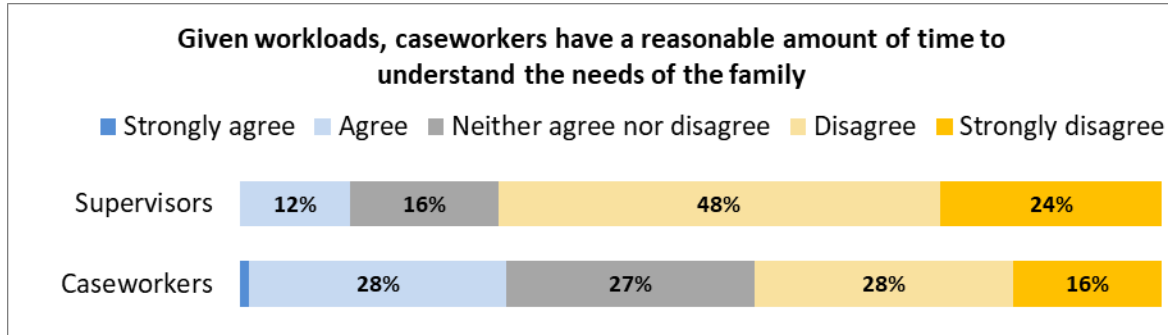


OPEGA included survey questions regarding caseworkers’ and supervisors’ opinions on whether critical aspects of their investigations are impacted given their workloads. Among caseworkers, only 30% of caseworkers agreed – given their workload – that they had a reasonable amount of time to understand risk to the child. Supervisors were even less favorable in their assessment when asked a similar question: only 8% agreed that the caseworker has a reasonable amount of time to understand the risks given this workload.



¹⁷ The remaining 20% of responses were neither agree nor disagree.

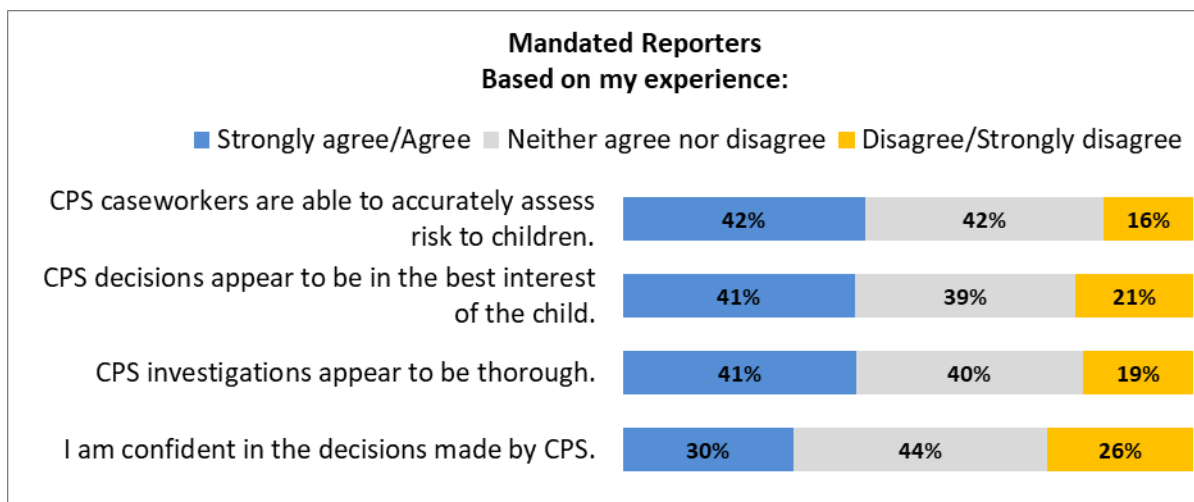
In terms of understanding the needs of the family, 44% of caseworkers believe that – given their workloads – they do not have a reasonable amount of time to understand those family needs. Again, supervisors were even less favorable in their assessment when asked a similar question with 72% disagreeing that the caseworker has enough time to understand a family’s needs given the workload.



Additionally, both caseworkers and supervisors frequently expressed workload concerns in their responses to various, open-ended survey questions. Both noted the following practice challenges that they attributed to unreasonable workloads:

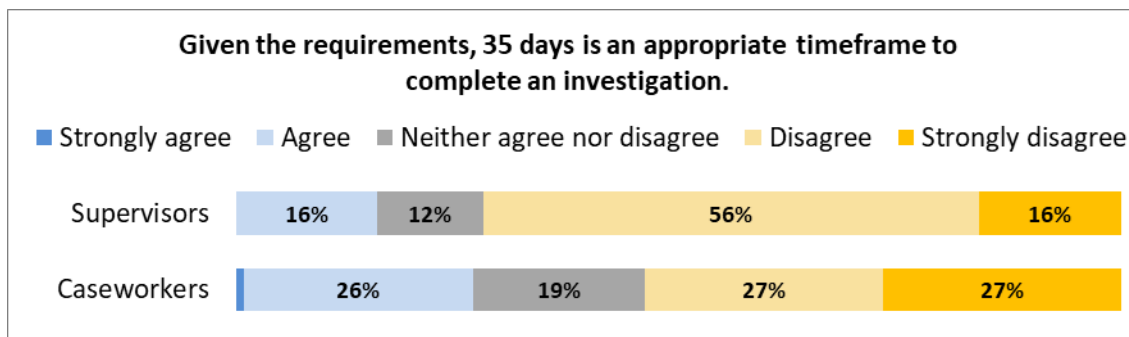
- inability to thoroughly assess risk and child safety in all cases;
- inability to follow-up with families after the initial contact;
- inability to obtain relevant records and/or contact all relevant collateral contacts;
- inability to thoroughly complete required documentation; and
- inability to effectively manage all priorities.

Based on their professional experience, we asked mandated reporters to rate their agreement with four statements relating to: risk assessment, the best interest of the child, thoroughness of investigations, and confidence in decisions. Significant proportions of respondents neither agreed nor disagreed with statements about the performance of CPS in these domains, suggesting that mandated reporters’ experiences with CPS investigations are inconsistent.



About two in five mandated reporters surveyed (42%) agreed that CPS caseworkers are able to accurately assess risk to children, another 42% neither agreed nor disagreed, and 16% disagreed. Mandated reporter response patterns were similar for the statements “CPS decisions appear to be in the best interest of the child” and “CPS investigations appear to be thorough.” When it came to confidence in decisions made by CPS, mandated reporters were not as positive, with 30% reporting agreement.

Timeframes. Relatively few investigations caseworkers and their supervisors agreed that 35 days is an appropriate timeframe for investigations. Considering the multiple requirements for an investigation, only 27% of caseworkers agreed or strongly agreed that 35 days is an appropriate timeframe to complete an investigation. Supervisors viewed the 35-day timeframe even less favorably, with only 16% of supervisors agreeing that the timeframe is appropriate.



In some instances, there are newly reported allegations (“add-on reports”) during the course of an investigation. When this happens, the new allegations are added to the open investigation and the caseworker must then perform additional investigative activities. These new allegations, however, do not restart the 35-day timeframe in which the original investigation was to be completed. When asked about add-on reports, 61% of caseworkers indicated that it is rarely (37%) or never (24%) manageable to complete investigations that have add-on reports within the 35-day timeframe. Supervisors were again less favorable in their assessment, with 80% indicating that it was rarely (76%) or never (4%) manageable for caseworkers to complete investigations within the 35-day timeframe when there are add-on reports.

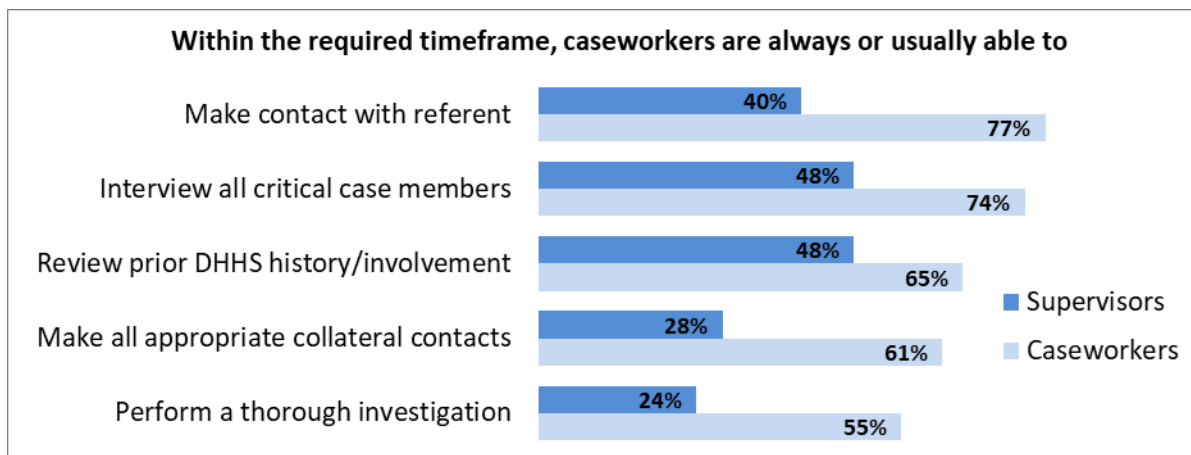
Completing Key Elements of Investigation. During the initial investigation, there are a number of required steps and tasks that are expected to be completed by the end of OCFS’s established 35-day timeframe. Through surveys and interviews, we sought to understand how often caseworkers and supervisors felt caseworkers were able to complete the following aspects of an investigation within the required timeframe:

- contacting the referent;
- interviewing all critical case members;
- reviewing prior DHHS history or involvement;
- making all appropriate collateral contacts; and

- performing a thorough investigation.

A majority of caseworkers indicated that they were always or usually able to complete, or achieve, these elements during the required timeframes. Supervisors were slightly less favorable in their assessment, with less than half indicating that caseworkers were always or usually able to complete these aspects of the investigation. Notably, no supervisors indicated that caseworkers were always able to review prior history, interview all critical case members, perform a thorough investigation or make all appropriate collateral contacts; and only 4% indicated that caseworkers were always able to contact the referent.

In the survey, 77% of caseworkers reported that they always or usually contact the referent. The supervisors reported this at 40%, which is more in line with estimates of how often this occurs based on the mandated reporters surveys (medical 40%, law enforcement, 39%, schools 31%). Interviews with OCFS suggest a potential cause of this difference is that caseworkers may perceive contact with a representative of the organization employing the referent as “contact with the referent”.

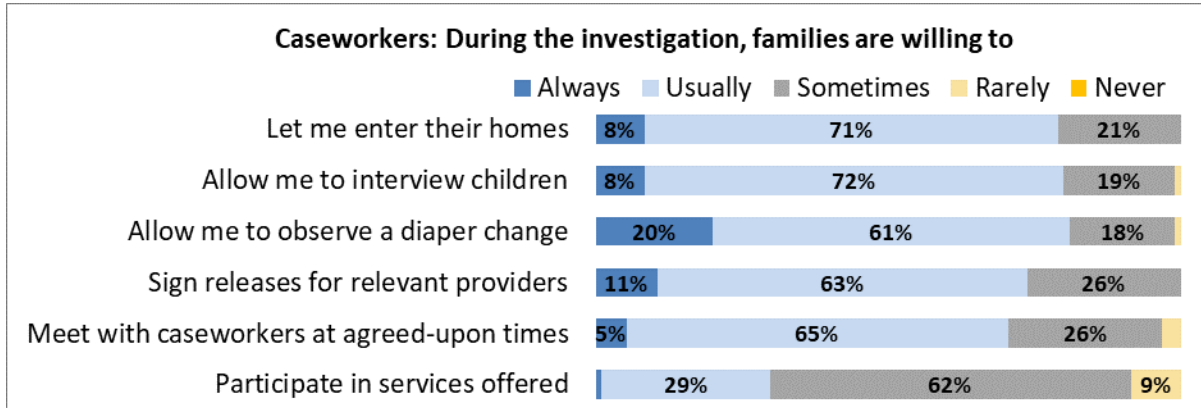


When assessing the thoroughness of the investigation, caseworker responses were generally much more favorable than supervisors. Overall, 55% of caseworkers reported either always or usually being able to perform a thorough investigation. In comparison, no supervisors reported that caseworkers were always able to perform a thorough investigation and only 24% indicated that caseworkers were usually able to do so.

B. Family Engagement

Family engagement is a critical component of CPS investigations as families have the best, most direct information, involvement and perspectives related to the allegations made and the safety of the child, as well as overall family functioning, challenges, strengths, and supports. We gathered CPS staff perspectives on the participation of families in various aspects of the investigation and services. In most cases, participation in a CPS investigation is voluntary for parents and families. Large majorities of both caseworkers and supervisors we surveyed indicated that, during the investigation,

families were either always or usually willing to engage and cooperate with caseworkers by letting caseworkers enter their homes, allowing them to interview children, allowing them to observe a diaper change, sign release forms for relevant providers, and meet with caseworkers at agreed-upon times. In comparison, families were less often willing to participate in services offered.



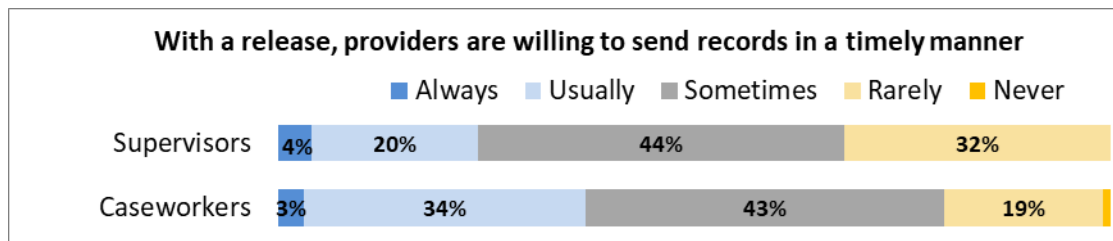
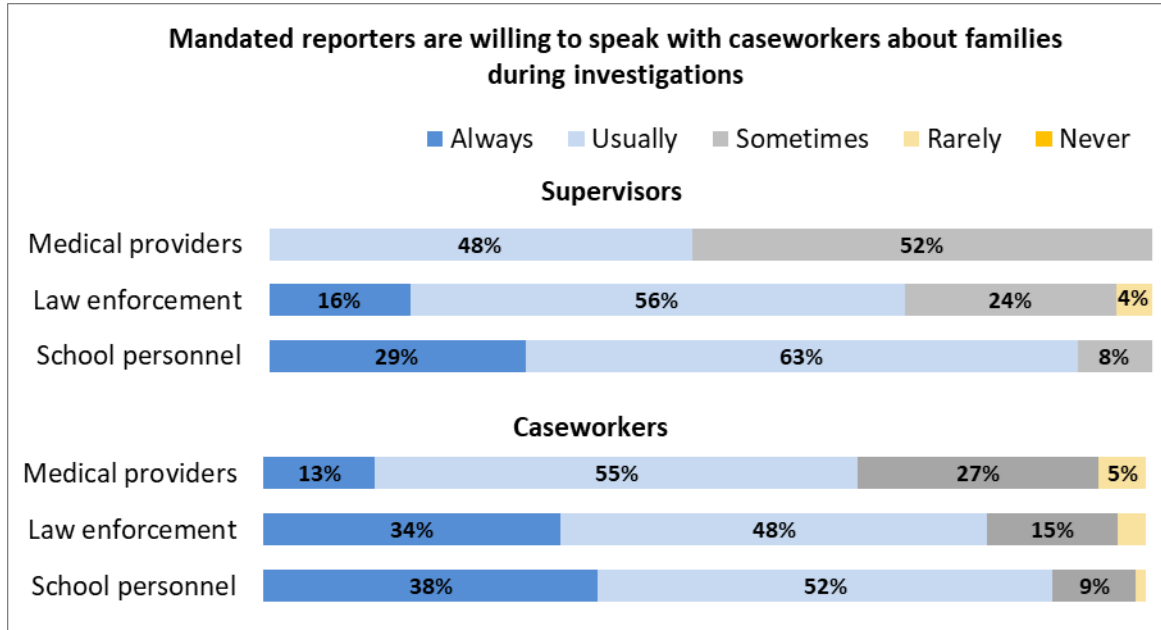
In addition to challenges around the family’s willingness to participate in services, caseworkers and supervisors also frequently expressed concerns related to the availability of services for families in their responses to various, open-ended questions. (For additional discussion of access and barriers to services, see page 51 and 59.)

C. Communication with Mandated Reporters and Service Providers

Mandated reporters and service providers (who may also be mandated reporters) have an important role as the front-line observers of child safety concerns and initiators of initial reports to OCFS that may lead to investigations. These individuals have critical information to share from direct experience with family members. The extent of engagement, communication and information sharing between mandated reporters and service providers and OCFS has important implications for CPS investigations. In this review we gathered information from caseworkers and supervisors about their communications with mandated reporters and service providers. We also surveyed three key groups of mandated reporters—law enforcement personnel, school staff, and medical providers—to obtain their perspectives.

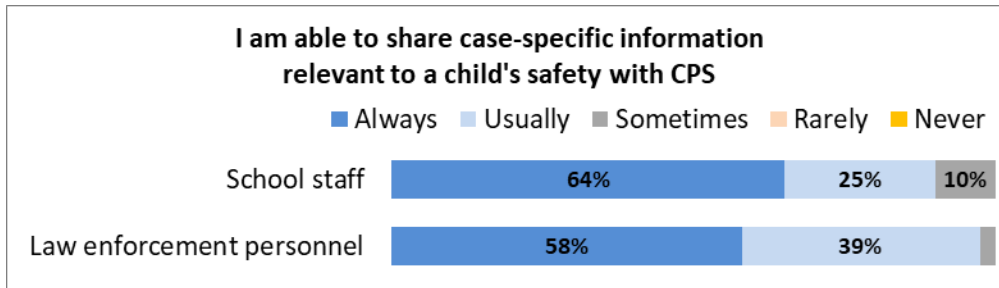
OCFS Staff Perspective. Caseworkers and supervisors reported that school staff and law enforcement personnel are more often willing to speak to OCFS staff about families during investigations, than are medical providers. Nearly 90% of both caseworkers and supervisors indicated that school personnel are always or usually willing to speak with them about families. A large majority of caseworkers and supervisors similarly state that law enforcement personnel are also always or usually willing to speak to them about families. OCFS staff reported that medical providers were less often willing to do so: 68% of caseworkers – still a large majority – but only 48% of supervisors indicated that medical providers are always or usually willing to speak with them about families. In terms of sharing records there may be even less communication. Only 37% of caseworkers and 24% of supervisors reported that medical providers are always or usually willing to

provide medical records even with signed release forms. They also noted that receipt of medical records is often delayed beyond the investigation timeframe. Some caseworkers reported that it is sometimes possible to speak with medical providers, but often not possible to obtain and review relevant medical records within the investigation timeframe – if at all.

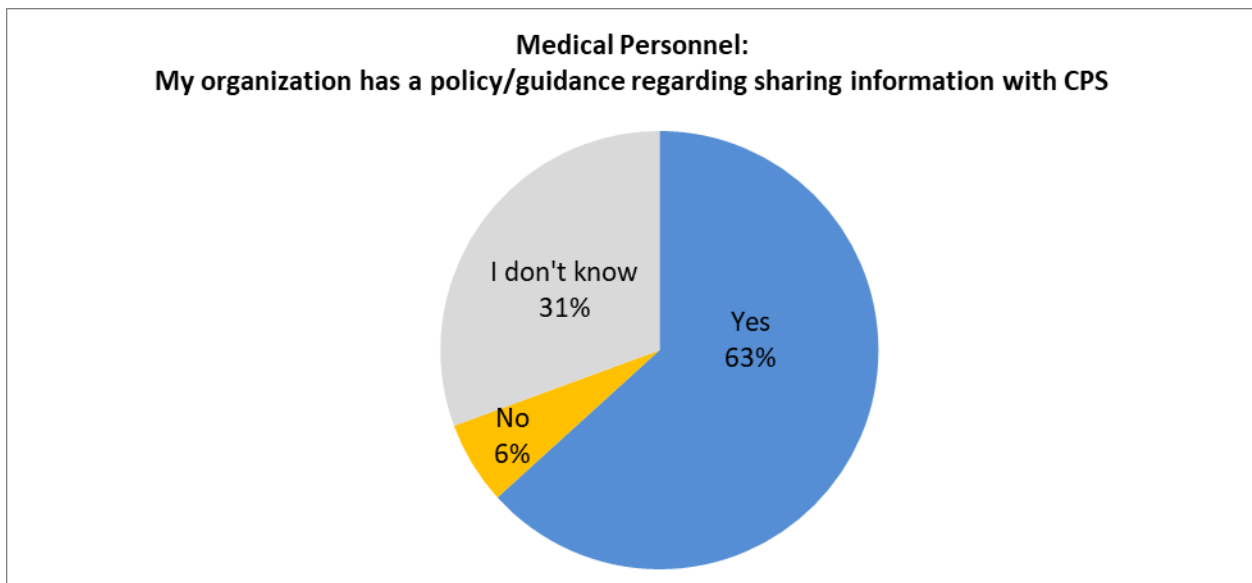


Supervisors and caseworkers both indicated that substance use and mental health providers for parents in families that are subject to investigation are the least willing among providers to speak with caseworkers or share records. They noted that some substance use disorder treatment providers require a subpoena to provide records. Respondents also gave examples of providers refusing to discuss parents’ treatment plans or attendance at treatment, providers requiring practice-specific release forms, and provider concerns that disclosing information will jeopardize their client. Among the supervisors interviewed and surveyed, several cited missing or delayed information from substance use disorder treatment providers as one of the main barriers to completing thorough and timely investigations, and one specifically noted that delays in sharing drug screen results can endanger children. An assistant attorney general we interviewed said the reluctance of service providers to communicate with case workers creates problems for getting evidence for court cases and that some health providers have ignored subpoenas to provide copies of records or to appear in court.

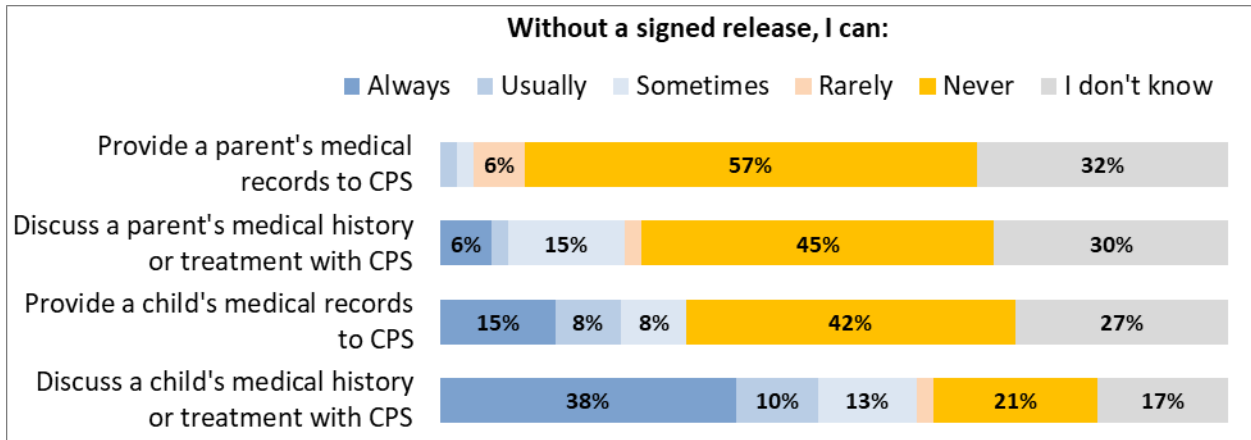
Mandated Reporter Perspectives. Most law enforcement (58%) and school staff (64%) reported that they are always able to share information relevant to a child’s safety with CPS. No respondent from either of those groups said that they rarely or never can share that information.



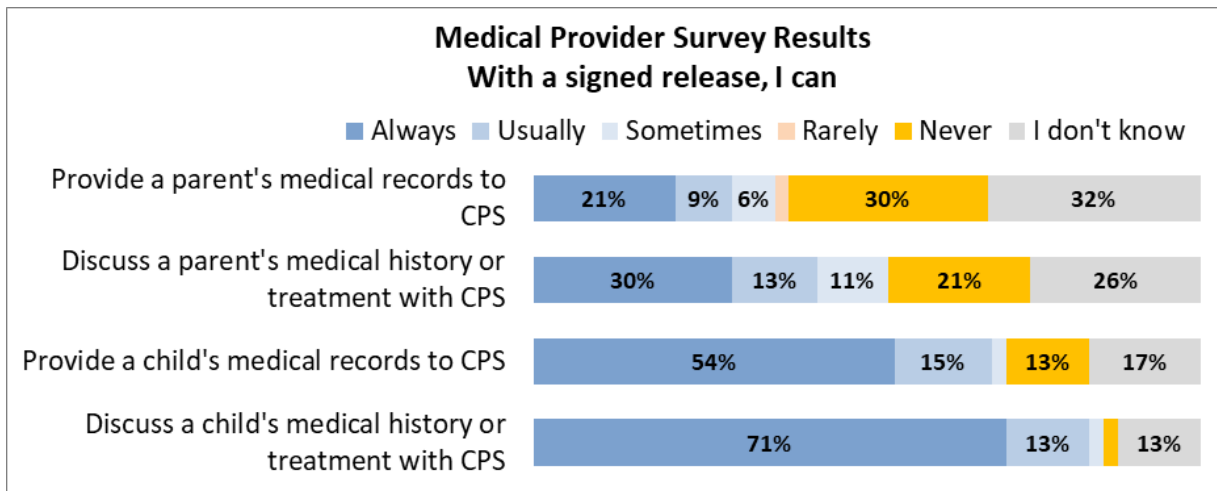
Medical providers surveyed diverged from other mandated reporters in their understanding of information they can share with CPS. Most medical providers (63%) said that their organization has a policy or guidance about what information they can share with CPS, but 30% don’t know if that exists, and a few respondents indicated that their organization does not have a policy.



Without a signed release form (see graphic below), medical providers were evenly divided about whether or not they can discuss a child’s medical history or treatment with CPS. Most medical providers indicated that either they cannot, or they don’t know, whether they can provide a child’s medical records, discuss a parent’s medical history/treatment, or provide a parent’s medical records to CPS without a signed release.



With a signed release form (see graphic below), strong majorities of medical providers indicated that they can always or usually discuss a child’s medical history or treatment and provide a child’s medical records to CPS. Only about one-third of medical reporters said they can discuss a parent’s medical history/treatment or provide a parent’s medical records with CPS even with a signed release. About one-quarter of medical providers indicate that, even with a signed release, they can never share or discuss parent’s medical information with CPS.



XI. Family Perspectives and Service Needs

Through interviews and surveys, we asked stakeholders and OCFS staff about the perspectives and needs of families involved in CPS investigations. We heard that parents and children may need support in understanding and navigating CPS investigations. We also heard themes emerge around barriers to services that would help protect the safety of children at risk for abuse and neglect, specifically around availability and access.

A. Parent Perspectives

In an effort to obtain the perspective of parents who have been involved in CPS investigations, OPEGA interviewed representatives of three different Maine organizations that work with and assist parents in various ways, including assisting parents in interacting with CPS. Given the scope of this review, these interviews were focused on interactions with CPS during the 35-day investigation period. The paragraphs that follow represent their points of view; while these are representatives of several parent organizations, they do not “represent” all parents in the CPS system.

Representatives of these groups described the experience of parents when CPS arrives to investigate an allegation of abuse or neglect. Parents and children were described as being scared, shocked, terrified or traumatized, to the point where some may not be able to think clearly or properly process what is happening at the time. We also heard that the term “investigation” can be distressing to parents as it is commonly used in law enforcement.

Parent reactions to a CPS investigation can range from extremely accommodating to very angry. The organizations we spoke to reported that, when the opportunity exists to do so, they coach parents to be truthful, respectful and assertive with the Department and to avoid being aggressive and combative. Interviewees noted that a risk for overly accommodating parents is agreeing to a service or treatment program that they are not ready for or may not have a way to access. A risk for an overly aggressive parent is making things more difficult for themselves in interacting with the department. Another challenge we heard was that parents may not recognize child safety risks and concerns raised by CPS as problems because it is what they have known and experienced in their families as both children and adults.

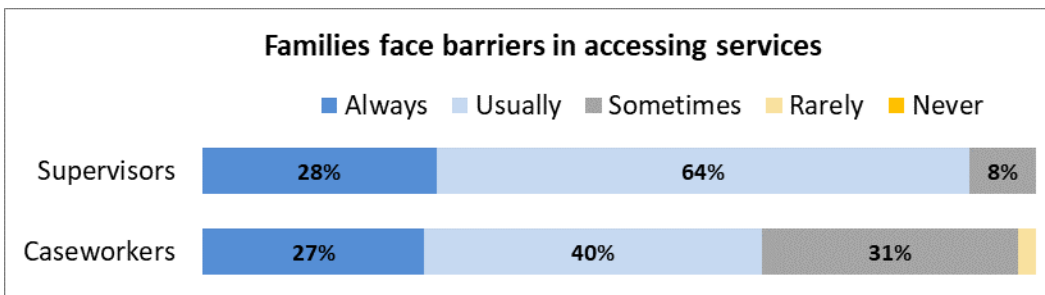
The parent representatives expressed that child safety is vitally important and should be the priority. They also emphasized the importance of recognizing that the investigation can be chaotic and traumatizing for the child even if it does not result in the child’s removal from the home, but especially if it does. Parent representatives reported that children need supports during investigations as well, including persons trained to work with children to comfort and assure them that they didn’t do anything wrong. They recommended that when a child must be removed from the home, the Department should seek to make the fewest number of placement changes possible, as each transition can be upsetting to a child.

Parent representatives indicated that support for parents in these situations is vital to assisting the parents in understanding and navigating the investigation. Both natural supports such as family and community, and professional services, such as parent organizations and social service agencies, play important roles. Many families do not have much for natural supports around them, and may not be aware of the professional services available to them. Assistance from another parent who has been through a CPS investigation or other child welfare process successfully, can be another helpful resource for parents. The parent organizations we spoke to indicated that helping parents connect to these supports and services would be beneficial.

B. Services for Families

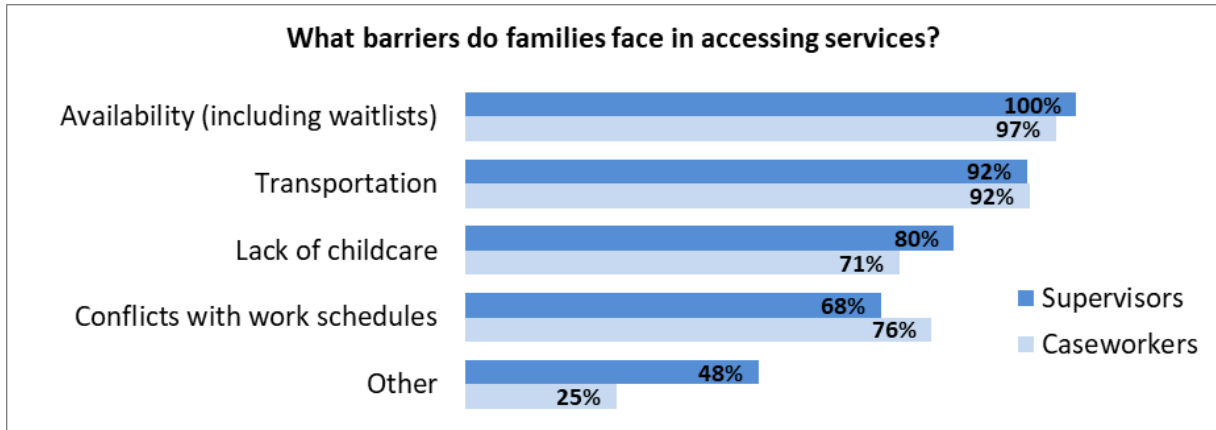
Through interviews with OCFS management and other stakeholders, surveys of caseworkers and supervisors, and in the results of the federal oversight of OCFS, it is evident that Maine families in the CPS system face a number of barriers to accessing services.

Interviews with caseworkers, supervisors and parent representatives, as well as survey responses of caseworkers, supervisors and mandated reporters, consistently indicate that accessing services is a struggle for families. As shown below, 100% of supervisors and 98% of caseworkers surveyed report families either “always” “usually” or “sometimes” face barriers in accessing services.



Availability. CPS staff and parent group representatives reported that, especially in rural areas, there is a very limited number of service providers, and providers that do exist have long waiting lists. Nearly all caseworkers surveyed (97%) indicated that “availability” was the most common barrier for families in obtaining services. All supervisors surveyed reported “availability” (including waitlists) as a barrier faced by families in accessing services. According to both supervisors and caseworkers, waiting lists are an issue even in geographic areas where there are more service providers. In surveys of CPS staff and mandatory reporters, lack of service availability – especially for mental health and substance use services – was noted as a challenge to keeping children safe. CPS staff noted this to be especially challenging during the investigation period due to the short time frame (35 days).

Other barriers. Transportation, child care, and work schedules are additional barriers for many families (see figure below). For families who do not have reliable transportation of their own, there are not many options, particularly in rural areas. Public transportation, outside of a few of Maine’s larger towns, is mostly non-existent, and there is limited availability of other ride services. Lack of child care was cited as a barrier for families by 80% of supervisors and 71% of caseworkers, and conflicts with work by 68% and 76% respectively. Other barriers reported by survey respondents include lack of ability to pay and lack of health insurance. CPS staff and parent representatives interviewed said that family members may also be reluctant to participate in services because they do not believe the services are necessary or fear a service provider may report unfavorable information to CPS.



Lack of access to services for Maine families has also been identified through the federal oversight and monitoring of OCFS, including in the latest federal Child and Family Service Review (CFSR)¹⁸ in 2017 and the Annual Progress and Services Report (APSR)¹⁹ for FY2022. In the 2017 CFSR, the State’s array of services available to children and families in the CPS system was rated as an area that needs improvement. Stakeholders interviewed at the time of the CFSR statewide assessment reported waiting lists for core services and major gaps in services available, particularly in rural areas.

OCFS has engaged in several efforts to address services access, including convening a State Agency Partnership for Prevention, which meets regularly to discuss service gaps. This organization is in the process of developing a statewide resource guide; convening a workgroup to review contracted transportation services and the efforts by Children’s Behavioral Health Services within OCFS continue to build the continuum of behavioral and mental health services for children. It is also partnering with community providers to increase knowledge of evidence-based services and address any barriers to effective service delivery.

XII. Issues and Recommendations

Issue 1: High Workloads Impact the Thoroughness of Investigations

Thoroughness of investigations, particularly in terms of thorough assessment of all risk and safety concerns, is an expectation and standard embedded in the CFSR process to ensure the safety and protection of children. In our analysis of OCFS Quality Assurance case reviews (see page 36), we saw that meeting the thoroughness standard across most aspects of investigations is an ongoing

¹⁸ Child and Family Services Reviews: Maine Final Report 2017. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families - Children’s Bureau. <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20CFSR%20Final%20Report%202017%20.pdf>

¹⁹ Annual Progress and Services Report FFY 2022. Office of Child and Family Services. Maine Department of Health and Human Services. <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20FFY%202022%20APSR%20Final.docx>

challenge for OCFS caseworkers. We did observe that caseworkers generally appear to be thorough and complete in the assessment of the caregivers, household members, and specific risks that were – in our opinion – most relevant and critical to the reported allegations. To be thorough in all aspects of an investigation, caseworkers need sufficient time and resources, including supervisor support. In survey and interview results, a strong theme emerged around workloads that are unreasonable for CPS staff. (See page 41 for detailed survey results on workload issues.) Notably, no supervisors agreed with the statement that the workloads of the caseworkers they supervise are reasonable, and only 8% of supervisors agreed that their own workloads are reasonable.

Caseworkers and supervisors also indicated that these high workloads impact their ability to understand critical elements within an investigation – the risks to the child and needs of the family. (See data on page 42.) Only 30% of caseworkers and 8% of supervisors agreed that caseworkers have a reasonable amount of time to understand risks to the child, and only 29% of caseworkers and 12% of supervisors agreed that there is a reasonable amount of time to understand the needs of the family.

Factors Contributing to High Workloads

We identified four, interrelated factors that impact overall workloads of caseworkers and supervisors: the number of investigations, staff resources, the tasks associated with each investigation, and required timeframes and deadlines.

1. The Number of Investigations

The number of investigations is determined by the intake screening process in which a report of alleged child abuse or neglect is screened “in” or “out” for investigation. Screening decisions are made by the Intake unit using the Structured Decision-Making Screening Response Priority Tool (see page 19 for additional detail).

In surveys and interviews, some OCFS supervisors and caseworkers indicated that valuable time is spent investigating reports that – in their opinion – did not appear to warrant an investigation. Specific examples of such reports included: reports of truancy without other abuse allegations, reports related to custody battles that may be more appropriate for family court than CPS, and reports with low risks associated with them. With a fixed number of caseworkers, if fewer reports are screened in as appropriate for investigation, caseworkers would, in theory, have more time available for each investigation and, in turn, the opportunity to complete a more thorough assessment of risk and safety concerns.

2. Staffing Levels

Another key element in workload is the number of staff available to cover the investigations. Holding the number of cases constant, a higher number of available caseworkers directly reduces the number of investigations per worker. Survey respondents and interviewees noted two

considerations related to staffing levels: the number of vacancies and the overall number of approved positions or “lines.”

Caseworkers and supervisors consistently mentioned the number of vacancies within their districts and related impacts of vacancies on the workloads of the remaining caseworkers. As of January 14, 2022, the vacancy rate among investigations caseworkers was 13.3% (20 vacancies out of 150 positions). Specific aspects of the expectations and burdens placed upon caseworkers that may be contributing to these vacancies are discussed separately in Issue 2.

Even with no vacancies, there still may not be enough caseworker positions to meet the demand for services and ensure reasonable workloads. In 2019, OCFS in collaboration with the Public Consulting Group (under contract to OCFS) developed a workload analytic tool to determine OCFS’s need for additional staff, which is now used by OCFS. In the 2022 Child Welfare Caseload and Workload Analysis report produced by OCFS, the workload analytic tool indicated a need for 33 additional caseworkers. In the prior 2021 report, the tool indicated a need for 42.5 additional caseworkers. We note that these counts of caseworker deficits includes positions for all CPS needs; not just for investigations.

3. Investigative Tasks

For each investigation, the amount of work required is a function of the required tasks and the complexity of the case. In surveys and interviews, some caseworkers reported that there are too many requirements to complete in an investigation. In our review of the investigation policy, the tasks required in the investigation policy appeared to be reasonable; however, there may be potential opportunities for the streamlining of tasks – particularly with the new implementation of the Katahdin child welfare information system – as well as opportunities to shift administrative work from caseworkers to case aides or clerical staff. While we did not evaluate the specific individual tasks required in an investigation within the scope of this review, we note that the breadth and depth of required tasks directly affects workload.

4. Investigation Timeframes

The timeframe available to complete an investigation also has direct implications for workload. OCFS policy requires an investigation to be completed within 35 days. Survey results show that the majority of caseworkers (54%) and even more supervisors (72%) do not agree that 35 days is an appropriate timeframe to complete an investigation, given the current workloads.

Additionally, when an investigation is open and another report of alleged abuse or neglect with respect to the same child is received by Intake, caseworkers are required to fully investigate this “add-on report” within the 35-day period established by the initial report. There is no extension, regardless of when the add-on report is received. This adds substantial additional tasks with no additional time. Strong majorities of both caseworkers (61%) and supervisors (80%) indicated that it is rarely or never manageable to complete investigations that have add-on reports within the 35-day timeframe.

- **Recommendation:** OCFS should take steps to address the workload issue to ensure that caseworkers, and supervisors, have the time necessary to conduct thorough investigations, including thorough assessment of safety risks to children and the needs of families.

First, OCFS should continue its work to evaluate workload using its existing workload analytical tool and any other appropriate methods. Second, OCFS should develop and implement new strategies to adjust some combination of the four factors identified above in a way that effectively reduces workloads of individual caseworkers. In particular, we recommend that OCFS:

- Complete its review of the required tasks and timeframes that has already begun in connection with the agency’s work with Collaborative Safety in the summer and fall of 2021²⁰; and
- Update the workload analytic tool as necessary to reflect current expectations for investigations and thoroughness.

Issue 2: After Hours Expectations for Caseworkers

To ensure child safety and respond to children in immediate risk, staff to deliver child protective services must be available around the clock. It is clear that CPS work can extend beyond the hours of a regular workday – and we consistently heard that caseworkers acknowledge and accept that their position is not a traditional 9-to-5 job. It is critical that CPS provides after-hours services in a way that does not create additional risks. In our research, we heard from OCFS staff at multiple levels that after hours demands pose risks for the quality and effectiveness of investigation work, as well as for staff turnover. The demands frequently cited were focused in the area of after-hours staffing, including both: after-hours coverage for new reports, known as Children’s Emergency Services (CES), and overnight supervision of children in hospital emergency departments and hotels.

CES provides coverage for reports that come into Central Intake on evenings, weekends, and holidays that are determined to require an immediate response (emergency reports). CES coverage also responds to emergency calls for children in care, such as placement emergencies. In each OCFS district, there is a caseworker and a supervisor assigned to be on-call for each CES shift. If an emergency report is received through intake, the CES caseworker must travel to the child’s location to conduct the investigation. This work may include, but is not limited to, engaging with law enforcement, conducting interviews, obtaining a court order from a judge, removing and transporting the child from the home, or finding an appropriate placement. From January to October 2021, the number of CES reports per month statewide ranged from 15 to 30. While the number of these reports is relatively limited overall, caseworkers described significant challenges and impacts of staffing any one CES report.

²⁰ Collaborative Safety Review of Maine OCFS, October 2021

In addition to CES shifts, there are times that investigations caseworkers are required to provide overnight supervision of a child who is in a hospital emergency department or hotel. In surveys and interviews, caseworkers, supervisors, and program administrators reported that CES shifts and these other overnight shifts create significant challenges for staff in managing the rest of their workload as well as managing their lives outside of work. Caseworkers are directed to consult with their supervisor after an overnight shift about adjusting their schedule for the following day. Sometimes, however, court obligations or other essential and time-sensitive priorities on investigations require caseworkers to work back-to-back shifts. In survey responses, caseworkers and supervisors described that CES requirements and other overnight shifts are unreasonable and contribute to staff burnout, and ultimately, job turnover. Working a back-to-back shift following an overnight may also affect the ability of the caseworker to accurately and thoroughly assess risks as part of investigations.

- **Recommendation:** OCFS should: (1) evaluate the nature and extent of after-hours work requirements and expectations currently placed on caseworkers by CES and other overnight shifts, and the risks to caseworker effectiveness and burnout; and (2) design and implement policy and program changes to address identified issues and risks. With respect to CES specifically, we recommend that OCFS consider restructuring the delivery of those services in a way that decreases or even eliminates the requirement of overnight shifts for caseworkers and supervisors.

We note that the Governor's FY2022-23 supplemental budget proposal (LD 1995), which is before the Legislature at the time of this report, proposes the addition of 16 Child Protective Services Caseworker positions and 3 Child Protective Services Supervisor positions within OCFS. We understand the intent of these new positions is that they are dedicated to night and weekend shifts.

Issue 3: Caseworker Practice Concerns

In the OCFS Quality Assurance case reviews (discussed further on pages 36-41), we noted some caseworker practice concerns that did not appear to be a function of workload challenges (as discussed in Issue 1 above), but rather departures from expected practice irrespective of workload. While these practice issues were identified relatively infrequently in the QA reviews, taken together they point to some areas where individual caseworkers fail to meet practice expectations. We observed departures from expected practices in three areas:

1. *Interviews and Information Gathering.*

Expected practice includes separating children and/or parents for interviews; thoroughly exploring reported concerns; gathering information when a child is non-verbal; and confirming accounts of caregivers by contacting providers or others involved with the family.

2. *Decision Making.*

Expected practice includes thinking critically when presented with conflicting information or unlikely explanations; and exploring conflicting/implausible information further in a manner commensurate with the potential risk.

3. *Safety Assessment and Safety Plans.*

Expected practice includes assessing the risk or impact of a child's behaviors to the siblings; sufficiently addressing all safety concerns in safety plans; and ensuring individuals involved in safety plans are willing and able to implement the plan.

The QA process within OCFS did successfully identify these concerns through the case reviews, which is important. However, we note two inherent limitations in the QA process that do not lend themselves to responsive and targeted corrective actions to address practice concerns, such as those noted above. These are: (1) the time lag between the QA review of cases and when the work actually occurred, which limits the timeliness of potential follow-up and corrective action; and (2) the limited sample size of cases reviewed, which limits OCFS's ability to identify whether issues are pervasive or limited to certain districts and/or workers.²¹

- **Recommendation:** OCFS should build on the foundation of its existing QA system to better identify specific practice concerns in a timely manner, within all OCFS districts. It should further link those concerns to opportunities for supervisor feedback, mentoring, and, potentially, additional training for individual caseworkers or other district staff.

XIII. Other Considerations ---

During the course of this review, we identified several topics that may warrant further consideration by OCFS or the GOC, but have not been thoroughly evaluated by OPEGA. These observations include areas in which OCFS is currently making substantial changes as well as some areas that were beyond the scope of this portion of the review. We recommend that OCFS, and the GOC, where appropriate, consider these observations as they continue to oversee and improve child protection services.

A. Considerations for the Office of Child and Family Services

1. *New Caseworker Training and Case Assignments*

As described in Section VII. Training and Supervising Investigations Caseworkers, interviews and surveys of caseworkers and supervisors showed wide agreement that training for new caseworkers was insufficient to prepare them for investigations work. Additionally, we heard concerns regarding the assignment of investigations to new workers.

First, Foundations training was cited by CPS staff as largely not meeting the needs of new caseworkers. Other oversight entities, such as the Child Welfare Ombudsman and the Maine Child Welfare Advisory Panel, have also noted concerns about caseworker training. Since 2020, OCFS has

²¹ In addition to the QA process, there is also a findings appeal process within OCFS in which investigation findings are viewed and feedback is provided to staff regarding practice, including areas in need of improvement that supervisors or training efforts can focus on.

worked with the Muskie School's Cutler Institute to revise the structure of Foundations training. The newly structured training began in January 2022, as OPEGA was ending the fieldwork portion of this review. While the revised structure appears to address many of the concerns cited by caseworkers and supervisors, it is too soon to assess the perspectives of staff on the new training program or evaluate its results.

Caseworkers and supervisors also reported problems with the process for case assignments. New caseworkers were described as often being assigned full caseloads shortly after completing Foundations training. Transitioning new caseworkers into the field in this manner fails to provide opportunities to learn how to perform investigations and can overwhelm new, inexperienced staff. Staff indicated that assigning full caseloads to newly trained caseworkers was out of necessity – there were not enough current caseworkers to provide a more gradual transition. We did not explore how OCFS is planning to assign investigations to new caseworkers in the future although the newly structured Foundations training has been extended from five to six weeks.

2. Access to Medical Records and Treatment Information

Throughout the course of our review, a theme emerged regarding challenges for caseworkers in accessing critical information during investigations. In both survey and interviews, respondents indicated inaccessibility of medical records and treatment information, in particular, as a barrier to completing thorough and timely investigations.

CPS workers indicated the reluctance of parents' substance use and mental health providers to speak with caseworkers or share medical records as a barrier to investigations. Staff noted that many providers are unwilling to discuss parents' treatment plans or participation in treatment. Similarly, the AG's office noted missing treatment information as a barrier to obtaining evidence for court cases. Additionally, some substance use and mental health treatment providers reportedly do not honor nor accept DHHS's releases that are signed by their clients, and, subsequently, do not provide any treatment records. We were told that these providers may instead require their own specific releases to be used, creating additional steps including: obtaining the provider release forms, returning to the home, and getting the parent(s) to sign them, and then finally submitting them to the providers.

In this report, we share some viewpoints of medical providers regarding the release of records (see page 48) based on our survey results. As the scope of the review did not incorporate a survey or interviews of substance use or mental health providers, we are not able to reflect their points of view on sharing patient information with CPS or why they may choose to not honor signed DHHS releases.

We understand that OCFS is currently convening multi-disciplinary workgroups with stakeholders to develop protocol agreements around information sharing, focusing on hospitals, law enforcement, and adult mental health providers.

B. Considerations for the Government Oversight Committee

1. Services for Families

Services for children and families in the CPS system also emerged as an area of concern in the course of this review. These concerns came through in interviews with OCFS management and other stakeholders, surveys of caseworkers and supervisors, and in the results of federal CFRS oversight. OCFS may refer families to services such as mental health counseling, in-home behavioral health services, substance use treatment, and case management, to help address risk to children. Lack of service availability, including waitlists, along with access barriers such as transportation, child care, and ability to pay, were cited as ongoing concerns. (See page 51 for discussion).

We note that within the scope of this review, OPEGA did not evaluate specific data on services in different parts of the state or the degree to which various factors contribute to service gaps. We also note that services for children and families is a concern not only during investigations but also during reunification, and that most of these services are outside of OCFS.

2. Prevention of Child Abuse and Neglect

Mandated reporters we surveyed, as well as parent group representatives we interviewed, expressed some frustration that the State is not investing more in efforts to prevent child abuse and neglect, particularly given that OCFS has seen increasing numbers of reports of abuse and neglect; that the OCFS workforce is struggling to handle the volume of investigations; and that there is a lack of services available to children and families during and after the investigation. OCFS staff we interviewed mentioned that many families subject to CPS investigations have repeated and multigenerational relationships with the child welfare system. Mandated reporters cited domestic violence, trauma, mental illness, and substance use as key ongoing challenges to families keeping children safe. Prevention efforts could play a role in addressing these interconnected issues contributing to child abuse and neglect.

Child welfare practitioners describe three levels of prevention: (1) primary prevention, which is directed to the whole population, (2) secondary prevention, which is targeted to families experiencing risk factors, and (3) tertiary prevention, for families in which child abuse or neglect has already occurred. OCFS is primarily engaged at the level of tertiary prevention. Federal and state child welfare experts recommend that states invest in and coordinate efforts at all three levels of prevention. According to the U.S. Centers for Disease Control, the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (for example, public health, education, social services, and the judicial system).

The State Agency Partnership for Prevention (mentioned on page 52) is a current collaborative effort between eight state agencies in Maine, including DHHS, to increase access, availability and knowledge of prevention services for families. The partnership has created an inventory of primary,

secondary, and tertiary prevention services and programs to support healthy and safe children and families across Maine, and considers where there may be gaps in services that need to be addressed.

XIV. Acknowledgements

OPEGA would like to thank the staff of Maine’s Office of Child and Family Services for their cooperation and assistance in developing this Review to the Government Oversight Committee. Many OCFS staff members provided data, participated in interviews, and responded to surveys; this review would not have been possible without their contributions. OPEGA also thanks the law enforcement, medical, and school staff who responded to our surveys. Thank you to other stakeholders who were interviewed for sharing their time and expertise.

Appendix A. Methodology

To complete this evaluation, OPEGA collected and analyzed data from multiple sources through multiple methodologies. We examined governing laws and policies, reviewed state and federal legislative history, administered five distinct surveys, and examined 109 case reviews conducted by the OCFS Quality Assurance (QA) program.

Review of Governing Laws and Policies. To develop an overview of the framework under which OCFS/DHHS delivers child protective services, OPEGA examined relevant state statutes, agency rules, and OCFS policies. In particular, OPEGA examined written OCFS policies governing the process for intake and investigations from the initial report of suspected child abuse or neglect to the determination of findings and the decision to close an investigation or open a services case. The policy review included several “policies by memo” that were promulgated in 2018 after the deaths of two children in late 2017 and early 2018, and other policies by memo distributed to OCFS staff through July 2021. We also reviewed the statutes governing OCFS, including but not limited to the Child and Family Services and Child Protection Act (22 MRSA Chapter 1071).

Interviews. OPEGA conducted interviews throughout this review to achieve several purposes:

- To understand key aspects of the structure, policies and processes within OCFS;
- To prepare for and develop survey instruments;
- To obtain additional context for survey responses;
- To develop an understanding of the relationship between OCFS’ Quality Assurance program and federal oversight by the Children Bureau of the U.S. Department of Health and Human Services; and
- To obtain a variety of perspectives of historical and current approaches to child protective services at the state level.

From OCFS, we interviewed caseworkers, supervisors, quality assurance personnel, program managers, and executive management (Regional Associate Directors, Associate Director of Child Welfare, and the Director of OCFS). OPEGA also conducted interviews with the Assistant Attorney General for the Child Protection Division and various stakeholders in Maine’s child welfare system representing:

- Maine’s Children’s Ombudsman office;
- Three organizations that support and advocate for parents involved with CPS;
- The National Coalition for Child Protection Reform;
- The Children’s Bureau of the federal Department of Health and Human Services; and
- The Cutler Institute, Muskie School of Public Service, University of Southern Maine.

OPEGA also sent a representative to the Safety Science Review requested by OCFS and conducted in conjunction with Casey Family Programs and Collaborative Safety in August 2021.

Surveys. To obtain a broader representation of the opinions of caseworkers, supervisors, and mandated reporters, OPEGA also conducted a series of five separate surveys of OCFS caseworkers, OCFS supervisors, school professionals, medical professionals and law enforcement professionals. For the surveys, OCFS provided OPEGA the email addresses of all investigation caseworkers and supervisors as well as any other caseworker with at least one active investigation. OPEGA used the online survey platform SurveyMonkey to contact individuals from these groups and request that they complete an anonymous survey. OCFS management was not informed of any survey responses – neither the individual responses nor whether the survey was returned. Over half (53%) of OCFS caseworkers responded to the survey, and 82% of supervisors responded.

Group	Type	Number of Survey Recipients	Number Responded	Response Rate
OCFS	Caseworkers	191	101	53%
OCFS	Supervisors	33	27	82%
Mandated Reporters	School Professionals	315	71	23%
Mandated Reporters	Medical Professionals	~209	57	27%
Mandated Reporters	Law Enforcement Professionals	~205	44	21%
	Maine State Police	~62	17	19%
	County/Local Law Enforcement	143	27	27%

The mandated reporters chosen for survey by OPEGA included professionals from schools, law enforcement, and medical providers. Given the size of the population of mandated reporters across the State, it was impractical for OPEGA to survey all mandated reporters within the scope of this review. For practical purposes, OPEGA selected mandated reporters in Kennebec County, for the survey population.

For the survey of school professionals, OPEGA obtained emails from the Department of Education data warehouse of all school staff in Kennebec County. We sorted the email addresses by staff position and, for the survey sample, included those positions most likely to be designated as mandated reporters. OPEGA sent emails to each individual in the sample through SurveyMonkey. The total number of surveys received by school personnel was 315. Of those, 71 responded to the survey yielding a response rate of 23%.

For the survey of medical professionals, OPEGA did not have direct access to email addresses. In this instance, OPEGA established contacts with the directors of the Emergency Department, Family Medicine, and Outpatient Director of Maine General Hospital and the Director of Care Management of Northern Light Hospital. These contacts forwarded OPEGA’s SurveyMonkey link and request to complete the survey by email to physicians, physician assistants, nurses and social workers, among others. The contacts either copied OPEGA on the email, or provided a count of staff who received the survey link. Approximately 209 medical professionals were contacted by email and OPEGA received 57 responses through SurveyMonkey (27% response rate).

Our survey method for law enforcement professionals was a hybrid between the methods employed for schools and for medical professionals. For county and local law enforcement agencies, OPEGA obtained email addresses through police or municipal websites or through email or telephone contact. For the 143 email addresses obtained, OPEGA sent messages to each of the email addresses through SurveyMonkey. For the Maine State Police officers of Troops C & D, however, we relied on an administrator from the State Police to forward the survey link; approximately 62 Maine State Police officers received the survey invitation in this manner. Nineteen percent of Maine State Police surveyed responded while 27% of county and municipal law enforcement personnel responded.

Table A.2 provides a breakdown of the different types of professionals among the survey respondents for each of the three mandated reporter surveys.

Medical		Law Enforcement		Schools	
Position	% of Respondents	Organization	% of Respondents	Position	% of Respondents
Emergency	58%	Municipal	55%	Guidance Counselor	32%
Pediatrics	23%	State Police	39%	Administration	31%
Family Medicine	14%	County Sheriff	7%	School Nurse	20%
Other	4%			Other	13%
Maternity/Obstetrics	2%			Social Worker	4%

Case Reviews. To incorporate a case review component in this review, OPEGA leveraged the structure, sampling, and rigor of the ongoing case reviews completed in connection with the CFSR process – as well as the expertise of the QA staff conducting that work. For the Round 3 CFSR period and the 8 reporting periods since then, we reviewed the results of case reviews conducted by the QA unit of OCFS following the federal OSRI protocol.

OCFS Quality Assurance (QA) sampled and examined 200 cases between April of 2017 and the end of March 2021. Of the 200, there were 109 cases that captured the investigation within the period of review. OPEGA examined these 109 cases involving investigations. For these cases, OPEGA reviewed results and accompanying detailed narrative descriptions and we calculated the percent rated as strength for each of 4 specific questions that are relevant to cases within the investigations phase. Table A.3 shows the details of that analysis. Through our review, we identified themes related to the thoroughness of investigations, any specific practice concerns, and the extent to which those are occurring.

Table A.3. Risk and Safety Assessment Review by Reporting Period Since the 2017 CF SR Report.								
Reporting Period	Item 3						Item 14	
	Question 3A		Question 3C		Question 3D		Question 14B	
	No. of Applicable Cases	% Strength	No. of Applicable Cases	% Strength	No. of Applicable Cases	% Strength	No. of Applicable Cases	% Strength
Apr '17 – Sep '17	16	38%	13	0%	14	36%	14	36%
Oct '17 – Mar '18	15	47%	12	25%	12	25%	15	27%
Apr '18 – Sep '18	10	40%	8	13%	6	17%	10	40%
Oct '18 – Mar '19	14	50%	12	17%	13	31%	14	29%
Apr '19 – Sep '19	14	29%	12	25%	11	45%	14	14%
Oct '19 – Mar '20	16	31%	12	0%	11	9%	15	13%
Apr '20 – Sep '20	13	38%	10	30%	8	25%	13	23%
Oct '20 – Mar '21	11	0%	7	0%	7	43%	11	9%
Total	109	35%	86	14%	82	29%	106	24%
Questions 3A, 3C, 3D, & 14B:								
3A. If the case was opened during the period under review, did the agency conduct an initial assessment that accurately assessed all risk and safety concerns for the target child in foster care and/or any child(ren) in the family remaining in the home?								
3C. During the period under review, if safety concerns were present, did the agency: (1) develop an appropriate safety plan with the family and (2) continually monitor and update the safety plan as needed, including monitoring family engagement in any safety-related services?								
3D. During the period under review, were there safety concerns pertaining to the target child in foster care and/or any child(ren) in the family remaining in the home that were not adequately or appropriately addressed by the agency?								
14B. During the period under review, was the quality of the visits between the caseworker and the child(ren) sufficient to address issues pertaining to the safety, permanency, and well-being of the child(ren) and promote achievement of case goals (for example, did the visits between the caseworker or other responsible party and the child(ren) focus on issues pertinent to case planning, service delivery, and goal achievement)?								
Source: OPEGA analysis of OCFS QA data.								

Appendix B. Safety Threats

Safety threats are indicators of immediate risk of serious harm to a child. Safety threats may be identified throughout the course of an investigation. There are 13 types of safety threats identified by OCFS as follows:

1. Parent/caregiver caused serious physical harm to a child or made a credible threat.
2. Parent/caregiver provided explanation for injury to the child that is inconsistent with credible supporting evidence or type of injury, and child's safety may be of immediate concern.
3. Parent/caregiver does not meet child's immediate needs for supervision, food, clothing, or medical/mental health care.
4. Parent/caregiver describes the child in predominantly negative terms or acts toward child in negative way and/or has extremely unrealistic expectations of the child that suggest child may be in immediate danger of serious harm.
5. Parent/caregiver fails to protect the child from serious harm or threatened harm by others, including physical/sexual/emotional abuse or neglect.
6. Parent/caregiver refuses or limits access to child or there is reason to believe family is about to flee and child safety is of immediate concern.
7. Parent/caregiver has seriously impaired ability to supervise, protect, or care for child due to current substance use.
8. Parent/caregiver has seriously impaired ability to supervise, protect, or care for child due to emotional stability, developmental status, cognitive deficiency, or current mental health.
9. Domestic violence exists in the home and is likely to cause emotional harm to the child.
10. Child sexual abuse, including sexual exploitation, is suspected or confirmed, and child's safety may be of immediate concern.
11. Household environmental conditions are hazardous and immediately threatening to the health and/or safety of the child.
12. Current circumstances, combined with information that the caregiver has or may have previously maltreated a child suggest child's safety may be of immediate concern, based on seriousness of, and caregiver's response, to previous maltreatment.
13. Other: Unique circumstances in the family result in a safety threat.

Source: OCFS Child Protection Investigation Policy, summarized by OPEGA.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner



Maine Department of Health and Human Services
Child and Family Services
11 State House Station
2 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 624-7900; Toll Free: (877) 680-5866
TTY: Dial 711 (Maine Relay); Fax: (207) 287-5282

MEMORANDUM

TO: Office of Program Evaluation & Government Accountability
FROM: Todd A. Landry, Ed.D., Director, Office of Child and Family Services
SUBJECT: OCFS Comments to OPEGA's March 2022 Report on Child Protective Services Investigations
DATE: March 22, 2022

The Office of Child and Family Services (OCFS) would like to begin by thanking staff of the Office of Program Evaluation & Government Accountability (OPEGA) for their efforts in completing their report on Child Protective Services Investigations.

OCFS agrees with and appreciates OPEGA's recognition and description of both the common misconceptions in child welfare and the "pendulum swing" that impacts the child welfare system. OCFS encounters these misconceptions at all levels in our work, and we believe this report offers important recognition of those challenges as the State continues efforts to improve child welfare services system-wide. As you are aware, in the wake of the fatalities that occurred in June 2021, there was increased attention and proposed changes to policy related to child welfare services. In response, the Department and OCFS have pursued a response to these fatalities that both identifies and acts on opportunities for improvement and avoids creating what some staff have termed "policy whiplash," as was the case following high-profile child fatalities in 2017 and 2018.

OCFS agrees with OPEGA's conclusion that the process for child protective services investigations is designed to be "comprehensive" and that OCFS utilizes tools to assist staff in making decisions about child safety. OCFS also agrees with the observation that although the Quality Assurance process has identified areas to improve to meet the Child and Family Services Review (CFSR) standards in thoroughness and completeness of investigations, staff are generally "thorough and complete in the assessment of the most critical and relevant risk and safety concerns and the most critical and relevant individuals related to the allegations." OCFS uses the feedback provided by the Quality Assurance Team to identify areas to further improve and has recently targeted several key initiatives to address practice consistency, some of which were identified in OPEGA's report. These include updated policy, guidance, and training on Family Team Meetings, investigation activities, use of Structured Decision Making (SDM) tools, and safety planning. OCFS is committed to continuing to learn from and develop solutions to address areas identified by the various entities that have regulatory oversight or advisory responsibilities related to the child welfare system.

Two of OPEGA's three recommendations share significant overlap with issues identified in 2021 by OCFS through engagement and discussions with staff, the review of child fatalities in

collaboration with Casey Family Programs and Collaborative Safety, and OCFS' own independent, continuous quality improvement efforts. To address concerns regarding workload and afterhours expectations for staff, the Governor has proposed additional staff for OCFS in her Supplemental Budget to provide afterhours and Children's Emergency Services (CES) coverage. OCFS believes this will relieve a significant burden from current staff, allowing them to focus on their day-to-day work, including participating in trainings and implementing new policies and protocols to guide their work. OCFS is also collaborating with staff and Casey Family Programs to review the investigation process and minimize duplicative work and study systems in other jurisdictions to determine if the current investigation timeframe is appropriate and helping achieve child safety goals. In addition, OCFS reports to the Health and Human Services Committee annually on Child Welfare Services Workload utilizing a tool developed in collaboration with the Public Consulting Group (PCG). The 2022 report, along with all previous reports is available [here](#)¹, under Annual Reports.

OPEGA also identified improved training and supervision of staff as a recommendation. As noted in the report, OCFS previously identified issues regarding training and, coinciding with the completion of this report, implemented an updated structure for training that OCFS believes addresses the concerns OPEGA and staff surveyed by OPEGA identified regarding the previous structure. This new structure builds upon models previously utilized by OCFS that staff have indicated were more effective in preparing them to work in child welfare. In addition, OCFS has reinstated the Field Instruction Program (FIP) in collaboration with the Muskie School at the University of Southern Maine, which provides social work students with a comprehensive internship experience. This opportunity allows students to graduate with experience working in child welfare and minimizes the amount of training required if they choose to become employed with OCFS. The FIP was previously a part of OCFS' training structure and many of the individuals who started with OCFS in the FIP are still with OCFS as employees and now hold leadership positions within child welfare.

This report benefits significantly from the input of stakeholders, including personnel from schools, law enforcement, and medical providers. OCFS notes some disparity when comparing those responses. This may be due, at least in part, to the level of involvement these stakeholders typically have after making a report to OCFS. Law enforcement personnel are frequently conducting parallel criminal investigations during an OCFS investigation and for both agency's investigations, medical expertise is often integral, particularly when there are allegations of physical or sexual abuse. As a result, OCFS staff generally have more contact with medical and law enforcement personnel than with school personnel. OCFS' contact with school personnel in an investigation with school-aged children generally occurs at the beginning of the investigation to gather information, and this may lead to a perception that additional work is not being completed by OCFS staff.

As identified previously, OCFS is already seeking to develop and implement changes to address Issues 1 and 2 identified in the report and has implemented updates to the format and delivery of trainings which were noted in Issue 3. We are committed to ongoing system improvement and appreciate the opportunity to take information learned from this report and incorporate it into these efforts.

¹ <https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/child-welfare-reports>

OPEGA also identified several “other considerations” for which OCFS would like to provide additional information:

- Training of new caseworkers – The issues with the New Worker Foundations Training that were identified by staff in OPEGA’s surveys align with concerns child welfare leadership have identified through discussions with staff, observed practice concerns, and quality improvement efforts. As a result, beginning in 2020, OCFS has utilized the expertise of staff at the Cutler Institute at the University of Southern Maine to update the training curriculum, length and format, as well as the activities new staff are required to participate in outside of Foundations. The updated Foundations Training was implemented at the beginning of 2022, and we are committed to ensuring it meets the needs of new OCFS caseworkers.
- Access to medical records and treatment information – This was an issue identified in the Casey Family Programs/Collaborative Safety review of child fatalities in 2021. That report included a recommendation to partner with medical providers and law enforcement to increase collaboration and information sharing. Last fall, OCFS developed a workgroup with leaders from the medical and law enforcement professions, as well as representation from the Office of the Attorney General. That workgroup is meeting regularly to seek solutions that address barriers to information sharing, including developing possible statutory changes that may improve collaboration and access to information.
- Services for children and families in the CPS system – Services for children and families are an integral part of the child welfare system as families seek to address concerns regarding child safety, permanency, and wellbeing. The Department is committed to improving the accessibility of high-quality evidence-based services for children and adults, including mental health treatment, substance use treatment, community-based services, and crisis care. Efforts include using increased federal funding to increase pay for the behavioral health workforce, completing rate studies and adjusting rates as needed, and developing and implementing comprehensive strategic plans for system improvement. OCFS has responsibility for the Children’s Behavioral Health Services (CBHS) system of care and reports annually on efforts to implement its strategic plan for children’s services. That report (and previous years’ reports) is available [here](#)². In addition, the Department released [guidance](#)³ regarding effective collaboration between behavioral health professionals and child welfare staff, including some of the benefits, barriers and solutions that will assist parents who are involved in the child welfare system.
- Prevention of child abuse and neglect – OCFS and the broader child welfare system are committed to preventing child abuse and neglect whenever possible. That commitment is reflected in OCFS’ ongoing implementation of the Federal Family First Prevention Services Act which, in part, implements evidence-based prevention services for families

² <https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/system-improvements-initiatives/childrens-behavioral-health-evaluation-improvement>

³ https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Guidance%20for%20Behavioral%20Health%20Providers%20FINAL.pdf?utm_medium=email&utm_source=govdelivery

where the children are at imminent risk of entering state custody. OCFS was the first state in New England to receive approval for its Family First State Plan and the first to begin implementing the services, which began in October of 2021. OCFS has worked closely with stakeholders throughout the child welfare system in the development and implementation of this plan and is devoting significant funding to these prevention services. Information on Family First and implementation is available [here](#)⁴.

Throughout OPEGA's report, OCFS noted significant overlap between issues identified by OPEGA and those identified through the Department's Safety Science review conducted last year in collaboration with Casey Family Programs and Collaborative Safety. OCFS has been working to implement the recommendations of that review since they were issued in October of 2021 and has received positive feedback from staff and stakeholders about the process. This includes a recommendation by the Child Welfare Ombudsman, made in her annual report, to implement a system for ongoing Safety Science reviews of child fatalities and other critical incidents. As a result, OCFS has continued to collaborate with Casey Family Programs and Collaborative Safety to implement the use of Safety Science in child welfare. Staff who will be dedicated to this work have been hired and are currently participating in training and the formalization of procedures. Through this work OCFS will continue to learn from this review process enabling child welfare to undertake targeted system improvement efforts.

⁴ <https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/system-improvements-initiatives/families-first-prevention-act/planning-implementation-updates>