Maine

CHILD WELFARE SERVICES OMBUDSMAN

9TH ANNUAL REPORT • 2011

CHILDREN'S OMBUDSMAN

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I AM PLEASED TO INTRODUCE THE CHILD WELFARE OMBUDSMAN'S REPORT FOR 2011. We have had the privilege of working the Department of Health and Human Services – Office of Child and Family Services (DHHS – OCFS) and other agencies of state government on some exciting areas of policy development and many cases that have helped families and children who are challenged by abuse and neglect.

Our staff has been involved in several areas of policy development at OCFS Division of Child Welfare. We worked with the OCFS child welfare staff on critical improvements in services for families and youth. Our Assistant Ombudsman participated in the training for the Maine Child and Family Services Fact Finding Interview Protocol, to best understand the Department's work toward stronger case assessment forensic interviewing skills. She also helped OCFS strengthen the Department's policy regarding the Youth History Policy, including the Life Book Process, and she continues to work with the Policy Committee on the revision of the OCFS policy manual.

Maine's successful work in the development of child welfare practice has been widely recognized. OCFS Program staff has been invited to share their knowledge and expertise in several other states and in Europe. The highlights of Maine's work this past year include:

- Continued reduction in the numbers of children in state custody
- More reliance on kin families to keep children safe
- On-going efforts to address racial inequity through partnerships with minority communities
- Positive relationships with families through programs like Parents as Partners
- Implementation of Extreme Recruitment, a new effort to increase permanency rates for older youth in care

As a result of these efforts, more children have been placed in safe and familiar homes and, at the same time, the cost of care has been reduced significantly.

Challenges still face DHHS as it works to improve Maine's child welfare system. Areas of concern include:

- Educational stability of youth in care
- Improved consistency in safety planning
- On-going support for kin families when children do not enter state custody
- Appropriate use, and follow-up of psychotropic medication for youth in care
- Stronger engagement and reunification efforts with birth fathers

Recently, we have published a report on educational stability called, "2011 Fostering Connections and Educational Stability." The report makes recommendations for ensuring educational stability for children in state custody and children placed voluntarily with relatives.

We look forward to 2012 and the opportunity to continue working with DHHS, providers, families, youth and local communities to improve outcomes for children, youth and families in Maine's child welfare system.

Yours truly,

G. Dean Crocker
Child Welfare Services Ombudsman

WHAT IS *the Maine Child Welfare Services Ombudsman?*

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

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

MERRIAM-WEBSTER ONLINE defines an *Ombudsman* as:

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

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

The Ombudsman may open cases for review based on the following:

1. The involvement of the Ombudsman is expected to benefit the child or children who are the subject of an inquiry or complaint in some demonstrable way.
2. The complaint appears to contain a policy or practice issue the resolution of which may benefit other children and families.

The Ombudsman will not open a case for review when:

1. The complaint is about a child welfare case that is in Due Process (Court or Department Administrative Review or Hearing). The Ombudsman will provide information, if requested, to the caller.
2. The complaint is about a Court Order.
3. The complaint is about a Department staff person and no specific child is alleged to have been harmed by the staff person's action or inaction.
4. The primary problem is a custody dispute between parents.
5. The caller is seeking redress for grievances that will not benefit the child.

More information about the Ombudsman Program may be found at http://www.mekids.org/ombudsman

POLICIES AND PRACTICES *within Maine Child Welfare Services*

Each year the Child Welfare Services Ombudsman Program identifies several child welfare policies and practices within the Maine Department of Health and Human Services (DHHS), Division of Child Welfare Services, that require further development. This year, the Ombudsman Program recommendations to the Department are in the following topic areas: educational stability of youth in care; consistency with safety planning; kinship family support; continued protocol improvement for use of psychotropic medications for youth in care; increased involvement and improved reunification practices for biological fathers; and permanency for older youth in care.

A summary of the Ombudsman Program recommendations, with the Division of Child Welfare's responses, are provided below:

RECOMMENDATIONS

EDUCATIONAL STABILITY FOR CHILDREN/YOUTH IN STATE CUSTODY

When children are brought into state custody they experience multiple losses and changes. Often these changes include relocation to a new school. Young people who have to switch schools as a result of their initial placement into foster care, as well as those children/youth that undergo multiple placements once in state custody, are likely to suffer increased stress including academic and social disruptions. These disruptions can have long-lasting effects which may result in delays in graduating and even higher drop-out rates.

With the passage of LD 1532, "An Act to Align Education Laws with Certain Federal Laws" in 2010, DHHS is charged with determining the educational placement of a child who is in state custody based on the "best interest" of the child. Although this change affords greater chances for a child to remain in their "home school" (the school they attended at the time of placement or re-placement), if it is indeed in their best interest, there are still steps to be taken in order for the Office of Child and Family Services (OCFS) to ensure academic stability for the children and youth in their care.

The 2011 "Fostering Connections and Educational Stability Report," published by the Maine Children's Alliance, provides recommendations to DHHS/OCFS, the Maine Department of Education, and Maine's child welfare stakeholders. Specific recommendations are made in the areas of communication, school placement, younger children in state care, special education, and safety planning. The report closes with general recommendations for systems change, including systems for academic data collection that do not existent for Maine's children in state custody at this time.

While LD 1532 has afforded Maine's children greater opportunity to remain in their home school after entering state custody, more work is needed to ensure that the child/youth's best interest is served in all academic placement decisions.

The Ombudsman Program recommends a thorough review of the Maine Children's Alliance Fostering Connections Report by the Office of Child and Family Services, with a plan for implementation of the report's recommendations.

THE DEPARTMENT'S RESPONSE:

While acknowledging that there is a continuing need to improve our practice in the area of increasing positive educational outcomes for children in care, the Department has already implemented several steps toward this goal. In 2005, the School Transfer policy written through the collaborative efforts of youth, DHHS, Department of Education (DOE), Keeping Maine's Children Connected (KMMC), and the Child Welfare Training Institute (CWTI) was finalized as child welfare policy. This policy emphasizes the importance of maintaining connections for children and stresses the importance of ensuring efforts are made to find placement within the child's own school district whenever possible. If placement is not available within the child's own school district, efforts will be made to place near the original school district and attempt to arrange for the child to continue attending the school of origin. When it is necessary to transition to a new school, the policy provides guidance regarding ensuring immediate transfer of school records; ensuring the child has the opportunity to say good-bye to teachers and peers in the school of origin; and ensures the child has the opportunity to visit the new school prior to attendance. The policy also provides guidance to staff in ensuring that the child is afforded with access to non-academic school experiences, by reminding staff to sign the Athletics/Field Trip Release form which then allows the resource parent to sign off on all individual permission forms, thereby ensuring the child has the ability to participate in school sports, activities, and field trips. The Department takes additional steps each fall to remind casework staff to sign these releases at the beginning of each new school calendar year. This year, this important reminder was provided through a message to staff on the opening page of the MACWIS system.

With the implementation of the Fostering Connections to Success and Increasing Adoption Act of 2008, the Office of Child and Family Services and Services focused increased attention upon maintaining the student in the school of origin whenever it is determined to be in the best interests of the student to remain in that school. State statute was enacted to allow the Department, through collaboration with the school unit and the Department of Education, to determine which school unit could best meet the needs of the child and inform the school superintendants of this determination.

Through prompt collaboration with Department of Education (DOE) and Keeping Maine's Children Connected (KMCC), documents were developed and finalized for standard use in carrying out our mutual responsibilities under the Fostering Connection Act. Among those documents was an Informational Letter dated September 9, 2010 addressed to all Superintendents, Principles, and Special Education Directors sent by Angela Flaherty, Commissioner of Education which described the Amendment to Title 20-A which aligned State statute with the federal legislation. The letter detailed the process by which best interest determinations are made, as well as noted the Department's responsibility to fund transportation costs to and from the school of origin, other than transportation costs specifically identified in the student's IEP.

An Educational Checklist was developed and disseminated to all Child Welfare staff to serve as a guideline in facilitating the process of determining which school placement meets the best interests of a student placed by DHHS with an adult who is not the student's parent or legal guardian. The checklist walks a

caseworker through many of the factors for consideration in making the best interest determination. The checklist includes recommended next steps to follow based upon whether the best interest decision is to remain at the school of origin or to transfer to a new school.

A letter template was developed to assist caseworkers in notifying school superintendents of the best interest determination. The letter not only confirms the decision made as a result of collaborative discussion, but it also provides a rationale for the legislation by stating that it is designed to improve educational stability for children and youth in foster care by requiring states to ensure that placement of a child in foster care takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement. It is aimed at ensuring that the child welfare agency coordinates with schools to ensure that child remains in the school of origin if it is in the best interests of the child to remain in that school.

While Child Welfare Services has for several years included in its pre-service training for caseworkers a component focused upon strengthening Positive Educational Outcomes for Children in Care, there has been increased focus during this training session upon implementation of Fostering Connections. The training is delivered jointly by a Child Welfare Staff and by Susan Lieberman of KMCC. The training includes the opportunity for participants to work in teams discussing scenarios which allow them to practice exploring some of the factors which go into determining Best Interest of the Student. The participants are trained in how to use the KMCC website in order to utilize the liaison network in the process of identifying key individuals within the school systems who can assist with exploring what a school program can offer to a child. Discussion often focuses upon transportation and some of the creative ways in which this frequent barrier is overcome, allowing the child to remain in the school of origin.

The training focuses upon the importance of adults who are close to the child participating in key events, such as Parent Teacher Conferences and attending school sports and activities in which the child participates. Encouragement is offered to invite both the birth parent and resource parent to attend significant school events, whenever possible.

When it is necessary for a child to transfer to a new school, the training encourages caseworkers to ensure credits are transferred, including partial credits; to ensure school records requested and transferred, to ensure IEPs are scheduled for students receiving special education and ensure surrogates are assigned for those students, and to ensure a peer buddy is assigned to support the student becoming acclimated to the new school environment. Caseworkers are encouraged to support the student in having a safe adult within the school identified and a safe place to go if necessary. Caseworkers are informed of the effects of school disruptions in terms of creating gaps in learning key skills such as math, which requires consequential steps. Caseworkers are instructed that the due to the negative effects caused these gaps, the student's school day is not to be disrupted unless absolutely necessary.

In addition to the training provided to new caseworkers, the Department and KMCC are participating in attending staff meetings in district offices to discuss these educational issues with all caseworkers and supervisors. Efforts are made to include in these discussions a special education director from one of the local school districts. These district trainings are proving to be very effective in educating staff about Fostering Connections, school stability and the importance of collaborative efforts. Encouragement is offered for participants to assist with dissemination of information about Fostering Connections

through respectfully and patiently sharing of information with others in the community who may not yet have a full understanding of the Act and its significance in ensuring school stability and increasing positive educational outcomes for children in care.

As a result of trainings offered by the Department and KMCC, requests have been forthcoming to present information to other community groups. One such invitation came from a domestic violence shelter in Portland which is interested in sharing information with parents and staff about strategies to ease the effects of school disruption.

In November 2011, representatives from the Department, from the Courts and from KMCC attended a conference sponsored by the Children's Bureau in Washington DC which was focused upon Child Welfare, Education, and the Courts. All 52 states were represented by teams of collaborative partners invested in implementing steps to enhance educational outcomes. Our Maine team returned from this conference with some concrete steps to work toward this goal. Some of the work identified by the Maine team involves amendments to the new court form to include more focus upon the student's educational progress and supports in place. Another action plan involves the Maine team presenting information at the statewide conference of judges in May 2012. The Team will also review the process involved in providing access of caseworkers to on-line grade and attendance reports for children on their caseloads. The team plans to continue its work through video-conferencing.

The Department is aware that collaborative efforts need to be on-going to focus upon the ability to transfer school records electronically; to focus more attention on ensuring there are adequate and reliable transportation resources available to ensure students attending the school of origin are regular in their attendance; to focus more attention upon preventing the need for disruptions during pre-school years when children are attending daycare; and to focus more attention to the formalizing educational over-sight in court documents to ensure judges are aware and asking questions about school attendance and progress. The Child Welfare, Education, and the Courts conference provided a jump start for many of these initiatives, and it will be important for collaborators to continue focusing on these important issues to ensure we continuously improve our practice.

KINSHIP FAMILY SUPPORT

The Department has increasingly utilized extended family members to support children, at risk in their parent(s) care, in an effort and to decrease stress and trauma that can result from placing children with strangers. However, more often than not, these kinship families are left with little or no guidance regarding the child welfare system and lack the information and resources necessary to best meet the children's needs.

The Ombudsman Program has received a variety of complaints in this area including issues related to kinship providers not being able to enroll the children in school, not having the resources to financially meet the children(s) needs, and not understanding the legal system without a caseworker to guide them, and often no financial means to hire legal counsel.

Although OCFS does not have designated funding to support kinship families, they do have an obligation to ensure that resources are available for these families, given that it is these individuals who are keeping the children out of risk and keeping DHHS from assuming custody.

The Ombudsman Program recommends that OCFS develops policy and protocol around kinship placements that are voluntary, and not state custody placements. The policy should clarify that, when caseworkers are involved in making this arrangement, their responsibility does not end when the child is established in kinship care. We recommend training and protocol regarding what caseworkers can, and should do to ensure that kinship families can address the needs of these children in their care, with adequate resources available for them to do so. We have specific concerns related to the educational stability of these children/youth placed in kinship homes via safety planning.

As stated above, LD 1532 offers educational stibility to children/youth in state custody, as it allows them to remain in their home school even if they change school districts due to placement. However, children voluntarily placed with relatives or other caregivers do not have the legal support to assure that their educational best interest is served, and many have to change schools even if it is detrimental to their educational stability. OCFS should develop a procedure in which caseworkers work with families and schools to ensure that children in voluntary kinship placements are afforded the opportunity to remain in their home school, if in their best interest, even if they are not in the same school district.

LD 978, An Act to Amend the Probate Code Regarding Powers of Attorney, Education of Children and Guardianship is a bill that was carried over from the First Regular Session of the 125th Legislature. It will be addressed in 2012. We encourage OCFS to support this bill to better protect the educational interests of children/youth in these voluntary placements. The Departments and kinship stakeholders should work with the Committee to ensure that the final language of the bill provides educational opportunities that are in the best interest of children in kinship placements and that their caregivers are afforded the right to appeal educational decisions regarding access.

THE DEPARTMENT'S RESPONSE:

As part of our ongoing performance and quality improvement reviews, we identified the same concerns about the inconsistent approach used by Department staff in providing post-placement support to kinship caregivers. Although a multi-disciplinary work group is in the process of revising policy in this area, because of the urgent need several steps have already been taken to provide staff with clear guidance. These include the development and dissemination of a policy document entitled, Kinship Caregiving Considerations, a caregiver letter that is given to all kinship care providers and a caregiver agreement outline that can be used to develop specific agreements related to medical care education, visitation, financial support and discipline. The Kinship Caregiving Considerations document includes lists of important questions that caseworkers must review with kinship caregivers. Casework supervisors are checking to see that these questions are addressed in each kinship placement. For those agreements made via safety planning, a secondary review process was put in place to assure that agreements specifically address how the child's medical and educational needs will be met, as well as how financial support and visitation will be arranged.

As stated in our response above, the Department is fully committed and continues to work collaboratively with the Department of Education to improve educational stability for all children involved with the child welfare system. Some of that work may include providing information to the legislative committee at work session, upon their request.

SAFETY PLANNING

The Department has increasingly utilized safety plans to reduce the number of children coming into state custody, while trying to ensure safety for the children/youth through a collaborative/voluntary approach with the birth parent(s). Safety plans are often the best option for the child. However, last year's Ombudsman report noted two specific areas of concerns regarding safety planning.

The first, and primary, safety plan concern identified in the 2010 Ombudsman report was that, frequently, the parent(s) did not agree to the plan voluntarily. Often the parent(s) disagreed with the DHHS determination that the child was at risk. They felt pressured to sign a safety plan because they believed that, if they failed to do so, they would lose their children via a court order. Secondly, the safety plans are intended to be a short-term approach, per policy, but in cases reviewed, the plans often were extended for a long period of time.

In 2011, the Ombudsman Program continued to receive complaints from families about the Department's use of safety planning. The Ombudsman Program found that the two specific areas identified, in 2010, continue to be a problem. An additional safety planning concern has been identified this year: in reviewing cases, an inconsistent approach to safety plans has emerged, not only amongst OCFS Districts but even from caseworker to caseworker.

Frequently families were not given clear information about what happens after the safety plan was created, and in some cases the caseworker created a plan with a family and then dropped out of the picture completely while the family was still disrupted.

The Ombudsman Program recommends that OCFS create a specific protocol for the safety planning policy that will: better address a consistent approach to this type of case; establish and monitor an appropriate length of time for safety plans to be in place; and determine how follow up will occur and who is responsible for each step of the follow up needs. The policy/protocol should also address how to determine "voluntary" participation in a safety plan. If a parent does not believe there is risk, and is only agreeing to a safety plan due to a threat of removal of the children to state custody, then caseworkers need to be clear that safety planning is not an appropriate option.

THE DEPARTMENT'S RESPONSE:

As with the related area of kinship caregiver support, OCFS has identified safety planning as an area needing more clear guidance and has taken actions to provide this. As mentioned in the response above, a multi-disciplinary work group is currently revising the policy regarding safety planning to more clearly address the specific issues that have become problematic. That is, the voluntariness of these agreements, their duration and the information and support provided to alternate caregivers.

Because of the urgency of this need, while awaiting the completion of policy revision, the Department has developed and issued to staff a document, entitled Safety Planning Guiding Principles. This document outlines a framework for deciding whether or not a safety plan is appropriate, assessment activities that must be completed before agreeing to alternate caregivers, a specific plan for follow-up contact to assess the safety plan and guiding questions to assure caregivers have a full understanding of what must happen after the safety plan is created. Family team meeting facilitators and caseworkers have been trained to work with families to develop agreed-upon harm and danger statements that articulate in the families'

words the specific harm that the children have experienced and the future danger they are exposed to. As another means to measure the families' perspectives on the level of voluntary participation in the plan, facilitators now ask each family member to "scale" from 0-10 how much participation he or she had in the plan. Each person's scale is documented on the family team meeting summary. We know from experience that these measures will only be effective if supervisors provide close oversight of the safety planning process. We continue to provide coaching and support to supervisors so that they may effectively provide this oversight.

USE OF PSYCHOTROPIC MEDICATIONS FOR YOUTH IN CARE

In the 2010 Ombudsman report, the Ombudsman Program raised a serious concern about the Department's Division of Child Welfare and Children's Behavioral Health Services use of anti-psychotic medication with children and youth in state custody. Throughout 2010, DHHS held a stakeholder work group, which included participants from Project Youth MOVE and the Youth Leadership Advisory Team (YLAT). The workgroup created a Consent Worksheet and Youth Guide "Making a Choice." This past year, OCFS continued to develop policy and protocol around this crucial issue, including an ongoing effort to engage and educate the medical community about the use of anti-psychotic medications for youth in care.

The Ombudsman Program recommends the further development of policy, training of staff and the medical community, and oversight of medication practices by OCFS, to ensure the safety and wellbeing of children in care who are prescribed these high-risk medications.

THE DEPARTMENT'S RESPONSE:

The Department has provided statewide training on the use of the Consent Worksheet and the Making a Choice Guide for youth which is available on Adobe Connect for ongoing viewing. The District Operations Managers are ensuring that there is collaboration in the districts with Children's Behavioral Health staff to review children currently prescribed antipsychotic medications and develop plans of communication with prescribing practioners.

The Department is actively involved in the workgroup that developed out of LD 646, An Act to Ensure the Safety of Children in the MaineCare program who are Prescribed Antipsychotic Medications. Currently two main options are being discussed in the workgroup for ensuring guideline implementation that includes the expanded use of Prior Authorization; or the requirement that mental health agencies and hospital clinics develop Continuous Quality Improvement (CQI) programs focused on the guidelines.

The workgroup has asked Dr. Tweed, Children's Behavioral Health, to contact personnel from the three of the major outpatient prescribing agencies (CSI, Maine Medical Center Outpatient Clinic, Acadia Outpatient Clinic) to discuss potential guidelines and elements of a CQI program that would be meaningful, effective, and not too burdensome. If possible, this feedback will be used to prepare a proposal to be presented at the next meeting of the workgroup.

This workgroup supports ongoing efforts to train Child Welfare caseworkers in antipsychotic consent guidelines and recognizes that the Health and Human Services Committee will be very interested in the progress of this project. Agreed that efforts to train the CW caseworkers and efforts to implement treatment guidelines

(and an associated CQI process) for providers must be complementary and synergistic. The Department as active members of this group will support all recommendations to improve oversight of youth and children on antipsychotic as well as psychotropic medications.

IMPROVED WORK WITH BIOLOGICAL FATHERS

This past year the Ombudsman Program has noted an increase in calls from birth fathers concerned about the Department's treatment of them in the role of their children's lives. There are cases in which caseworkers have not made an effective effort to locate the children's birth father; cases in which the father was located but not given a fair chance to reunify with their children; and even a case in which the father was in jail (short-term) and told that, because of his incarceration, he cannot ever have a relationship with his child. The OCFS has made strides in improving their engagement with birth fathers, yet it remains clear that there is more work to do and that, in some cases, there is a clear bias towards reunifying children with their mothers, even in cases where the mother may pose a great risk to the children and the father, minimal to no risk.

The Ombudsman Program recommends enhanced training with caseworkers around engagement with birth fathers, with specific work around biases that may be reflected in reunification with fathers rather than mothers. This work should include collaboration with the courts and other stakeholders to ensure that birth fathers are treated as equals in the parenting of their children, even if they have been absent until child welfare becomes involved. An absent parent does not necessarily equate to risk and oftentimes the children are found to be safer with the absent parent than with an abusive parent that has been present, if not able to be rehabilitated.

THE DEPARTMENT'S RESPONSE:

The Department fully recognizes the need to improve involvement of fathers in child welfare cases. In order to address this, the program manager of STRONG Fathers presented at the statewide supervisors meeting in 2011 to identify barriers and offer solutions in engaging fathers. Through assistance of Casey Family Programs the Division of Child Welfare has entered into an agreement with STRONG Fathers to provide a variety of services to fathers involved in child welfare and to do outreach. The following outlines the purpose and activities of that agreement:

PURPOSE. *The purpose of this Agreement is to develop and implement a unified approach to improving the manner in which Maine's Department of Health and Human Services interacts with fathers by creating and delivering a pilot project serving offices involved with Community Partnerships for Protecting Children (CPPC): Portland, Biddeford, and Bangor.*

PERFORMANCE MEASURES: *The Opportunity Alliance- STRONG Fathers will work with Department staff to examine and improve the manner in which caseworkers engage fathers in the permanency planning process. This will be measured by the following outcomes:*

- *More fathers are invited to Family Team Meetings*
- *More fathers attend Family Team Meetings*
- *Fathers report an increase in their ability to fully participate in the Family Team Meeting process*
- *Case workers report changes in the way they work with fathers*

- *Case workers report increased participation in the process by previously resistant fathers*

While this more intense effort of father engagement is beginning in three pilot areas, there will be outreach to all districts by staff from STRONG Fathers to encourage fathers becoming involved. We will continue to track success in this area.

PLACEMENT WITH DEPARTMENT EMPLOYEES

The Department has not revised its policy regarding the placement of children/youth in care with Department employees, since shortly after a tragedy in 2001 that resulted in a child's death in such placement. The policy currently in place reads:

> "Placement with Department Employees and AAG's [Assistant Attorney Generals]", was written 11/15/93. It states "Placement of a child who is in the care or custody of the Department or who is a case member in an open child protective case in the home of a Department employee or Assistant Attorney General may engender charges of conflict of interest or may complicate case planning and supervision. This policy, which is intended to prevent or minimize the impact of these, applies to placement of children in the care or custody of the Department and children who are case members of an open child protective case placed by either the Department or a licensed child placing agency."

This policy states that every three months the caseworker and supervisor will jointly review the case progress and plan, and every six months the Regional Program Manager will join in that review. In a 2011 review by the Ombudsman's Office, this policy was not followed when a child was placed with a Department employee this past year. The identified case clearly highlighted a variety of concerns that arose regarding the foster parent and her relationship and treatment of the birth family. These issues remained unaddressed by the caseworker. We suggest that these case issues might not have occurred if she had not been a DHHS employee.

The Ombudsman Program recommends a stringent review of the policy and protocols regarding the placement of children/youth with DHHS employees and AAG's. We suggest that policy be revised to clearly state that the policy relates to all DHHS personnel, not just OCFS employees and caseworkers.

THE DEPARTMENT'S RESPONSE:

We agree that this policy needs review and revision and that process has been underway, with consultation from the Attorney General's Office. Although the case cited by the Ombudsman's Office involved a failure to follow policy, we do see a need for the policy to be updated and more clearly written to provide the guidance necessary to prevent potential conflicts of interest. As with all policy revisions, the draft will be provided to the Ombudsman's Office for their review and feedback.

POSITIVE FINDINGS

The cases referred to the Ombudsman often reflect some of the most challenging situations in the child welfare system. Our goal in each of these situations is to support learning and improve outcomes for children and their families. We also use the review process to identify and highlight the good work found in each case.

In the section on policy issues we have shared some of the key issues for which we made recommendations for improvement. In this section we want to share recurring examples of good work from the eight DHHS district offices.

1. Increasingly, prompt assessment of relatives allows more children to be placed with relatives when they enter state custody. The trauma of removal is lessened significantly when children are placed with familiar people and places.

2. Evaluations can play an important role in developing care plans for children. The best evaluations result when evaluators are provided with good information. We saw examples of thorough preparation of information by caseworkers.

3. While paperwork is no one's favorite task, it is critical to good outcomes for children. We saw many examples of excellent documentation supporting timely and positive results for children.

4. Fathers not in the home have often been overlooked in the past. Today, we see more outreach to fathers enabling them to take an active role in assuring the safety and well-being of their children.

5. Often the most important work done by caseworkers is their work to facilitate and support the development of a team around the family. We continue to see more examples of very good team work and advocacy.

6. As noted in the data section, the percentage of Ombudsman Program referrals from DHHS increased significantly again this year. Caseworkers continue to do a good job of informing clients about the Ombudsman program.

CASE EXAMPLES
of the Child Welfare Services Ombudsman

SAFETY PLANNING AND FAMILY TEAM MEETING PROCESSES

This year, the Ombudsman Program reviewed many cases in which the Department opted to utilize a Safety Plan approach with the families. However, safety planning was not an appropriate action in all of these cases.

In one, a two-and-a-half-year-old boy was placed with his maternal grandmother due to his mother's substance abuse and history of untreated psychiatric concerns. Safety planning is intended to be a voluntary agreement between the parent/caregiver and the Department. Although the child's father, who was also unable to care for his son and keep him safe, wanted his son with the maternal grandmother, the child's mother did not. She had a contentious relationship with her mother and immediately began making allegations against her when her son was informally placed with his grandmother.

The caseworker scheduled a Family Team Meeting to discuss the child's placement and the mother's progress. Reports indicated that the mother's substance abuse and lack of mental health treatment was on-going. However, the entire meeting was focused on the mother's complaints and allegations about her own mother. The maternal grandmother became upset and left the meeting, and the rest of the team made a decision to move the child without assessing or confirming the mother's allegations. The child was relocated with police assistance without advance notice and without his clothes or possessions.

Although DHHS agreed that this little boy would be unsafe in his parents' care, they supported moving the mother and son to a shelter to await a placement for them together, at a comprehensive residential program. .The Ombudsman Program did not view this as an appropriate case for safety planning and did not find that DHHS intervention was keeping this child safe. Although the child's mother wants help, she consistently, and over a substantial period of time, has demonstrated an inability to change her behavior. The child has been in state custody already once, in his young life, and has sustained multiple moves back and forth from his maternal grandmother's home to his parent's. We suggest that, in this situation, the state needed to assume custody to truly protect this child and ensure safe care while reunification efforts were sought. The allegations against the grandmother should be assessed, as the child is attached to her and she has provided good, consistent care during his young life. If his parents continue to lack progress in their treatment and care of their son, his grandmother may be the best permanency option for him.

> THIS CASE HIGHLIGHTS the need for stronger assessment of whether or not safety planning is the most appropriate action to keep a child safe. It also highlights the issues inherent in not following the clear guidelines for Facilitated Family Team Meetings (FFTM). The focus of this FFTM switched to allegations against the grandmother rather than assessment and review of the mother's progress with the ability to safely care for her child.

CASE PLANNING

A mother called the Ombudsman's Office with a concern about the Department, and her Reunification Plan with her children, who were four years old and four months old at the time of referral. She stated that she and the children's father had met all of the requirements of the Reunification Plan, but the State was still not returning their children to their custody.

The reasons DHHS brought the children into state custody included: domestic violence; an unsanitary and unsafe living environment; and the continued presence of strangers in and out of the home. The oldest child also has significant medical needs.

Upon review, it became clear that there were issues with the way that the Reunification Plan was written. The plan listed a series of services, rather than measurable objectives. Services listed on the plan included: Child Abuse And Neglect Evaluation Program (CANEP) evaluations for both parents; supervised visits; engagement in doctor's appointments for both children; counseling for both parents; and medication management for both parents. Given that the parents engaged in, or completed each of these services, they believed that they had done everything necessary to bring their children home. What the Reunification Plan did not address, however, was what the Department was looking for in terms of how each of the parents needed to change or demonstrate that they had received what they needed to from the services listed, in order to successfully keep their children safe.

The Ombudsman's Office found that although the parents were indeed engaged in the prescribed services, they had made little to no observable progress in a year and a half. Both parents continued to miss counseling sessions; they did not remain with a consistent therapist or service provider for more than five months; the home continued to be unsanitary and unsafe with multiple break-ins; and visits with the children continued to be supervised, as the parents were still not keeping the children safe without assistance.

The State agreed, as a final step, to try a residential program for both the children and their parents and, if that did not work, then they determined it was appropriate to seek a Termination of Parental Rights order. After six weeks of residential support the parents were still unable to safely parent and opted to leave the program.

Although the Ombudsman's Office was in agreement with the Department's concerted efforts at Reunification, in this case, the Reunification Plan did not capture the necessary components of all of the work needed and, therefore, it made progress -- or lack thereof -- more difficult to track and to explain to the parents.

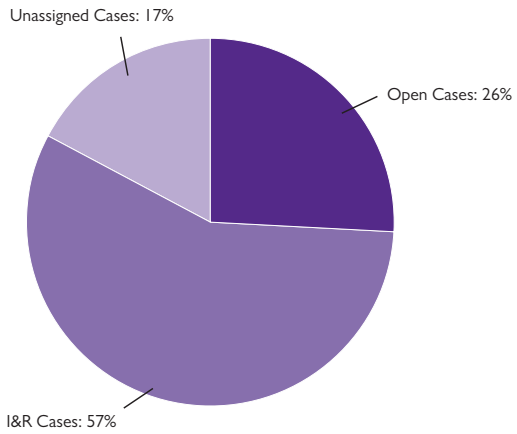
> THIS CASE HIGHLIGHTS the need for a consistent approach to case planning and training for caseworkers on how to write measurable, observable goals and objectives. Case planning should occur at Family Team Meetings, per policy, and should be written in understandable language for the families involved.

DATA
from the Child Welfare Services Ombudsman

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2010, through September 30, 2011.

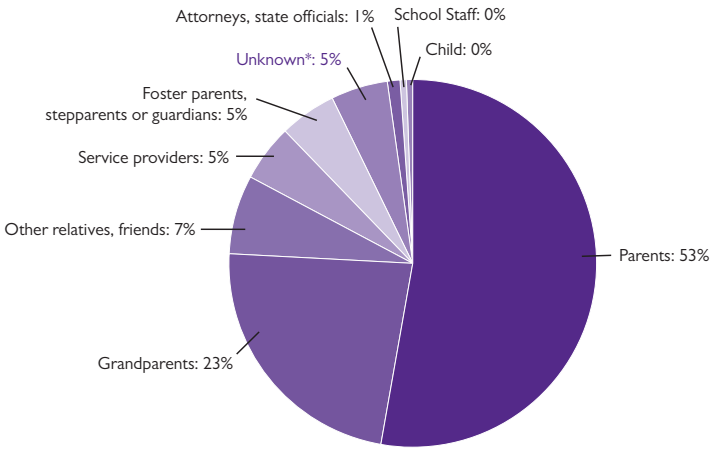
In Fiscal Year 2011, 282 inquiries were made to the Ombudsman Program, an increase of 23 inquiries from the previous fiscal year. As a result of these inquiries, 72 cases were opened for review (26%), 162 cases were given information or referred for services elsewhere (57%), and 48 cases were unassigned (17%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Reasons for not completing the intake process include the caller's phone being disconnected, no forwarding address left with the office, or the individual does not respond to attempts by the Ombudsman staff to gather more information.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



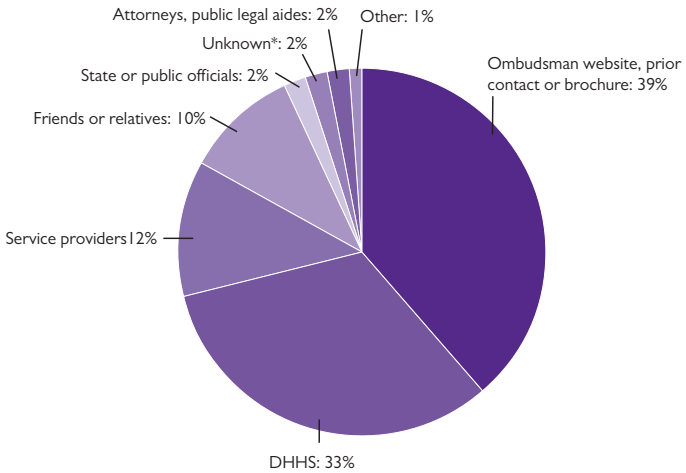
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2011, the highest number of contacts were from parents, followed by grandparents, then other relatives/friends.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

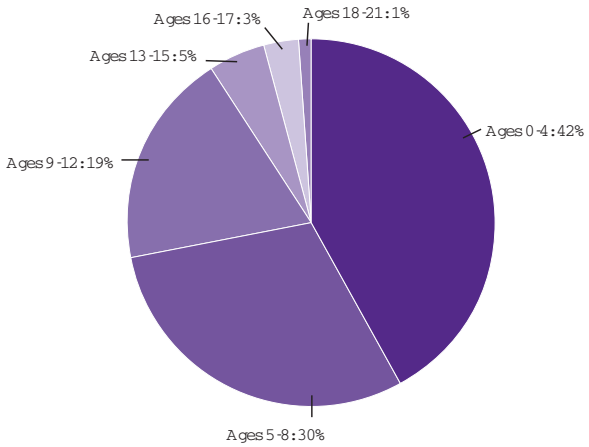
In 2011, of the 282 contacts of the Ombudsman Program, 39% learned about the program through the Ombudsman website, brochure or prior contact with the office. Thirty-three percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services (DHHS) up from 22% the previous year.

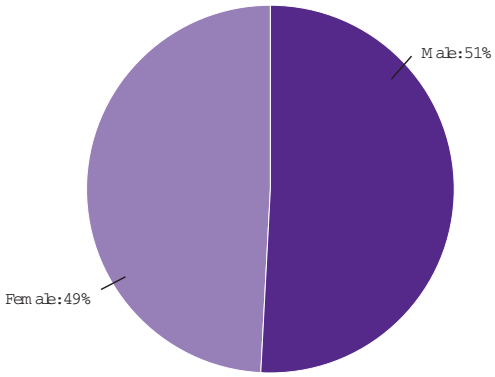


* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services.

WHAT ARE THE AGES OF CHILDREN INVOLVED IN OPEN CASES?

The Ombudsman Program collects demographic information on the children involved in cases opened for review. During the reporting period, 72% of these children were age 8 and under.





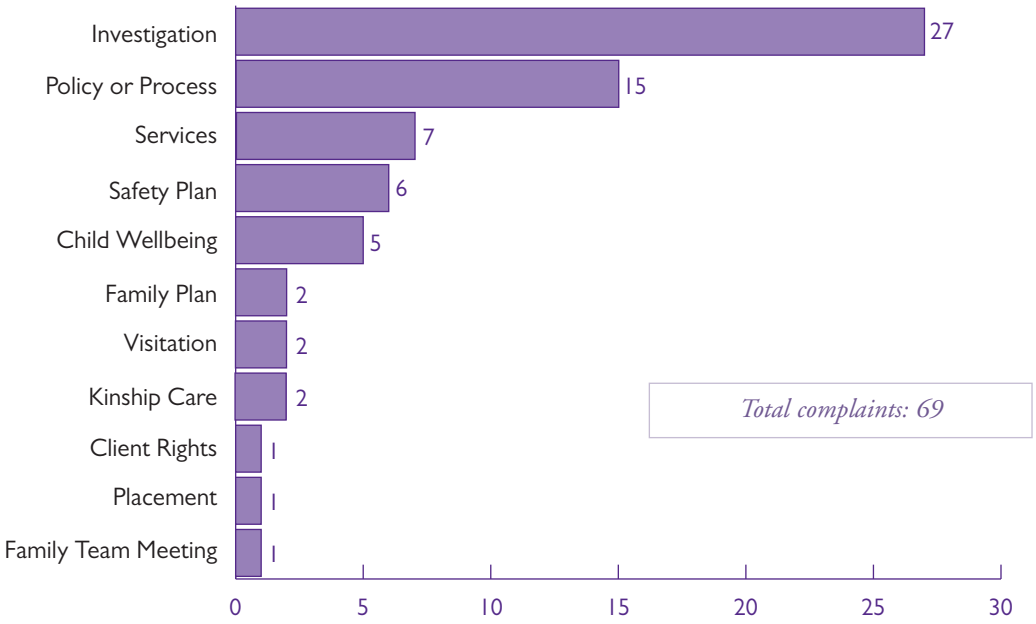
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT		CHILDREN	
DISTRICT #	OFFICE	CASES	NUMBER	% OF TOTAL	NUMBER	% OF TOTAL
1	Biddeford	11	12	17%	22	14%
	Sanford	1				
2	Portland	10	10	14%	30	19%
3	Lewiston	12	12	17%	27	17%
4	Rockland	5	5	7%	11	7%
5	Augusta	1	5	7%	15	10%
	Skowhegan	4				
6	Bangor	14	14	19%	23	15%
	Dover-Foxcroft	0				
7	Ellsworth	3	7	10%	14	9%
	Machias	4				
8	Caribou	0	6	8%	13	8%
	Houlton	4				
	Fort Kent	2				
CENTRAL INTAKE			**1**	**1%**	**2**	**1%**
TOTAL			**72**	**100%**	**157**	**100%**

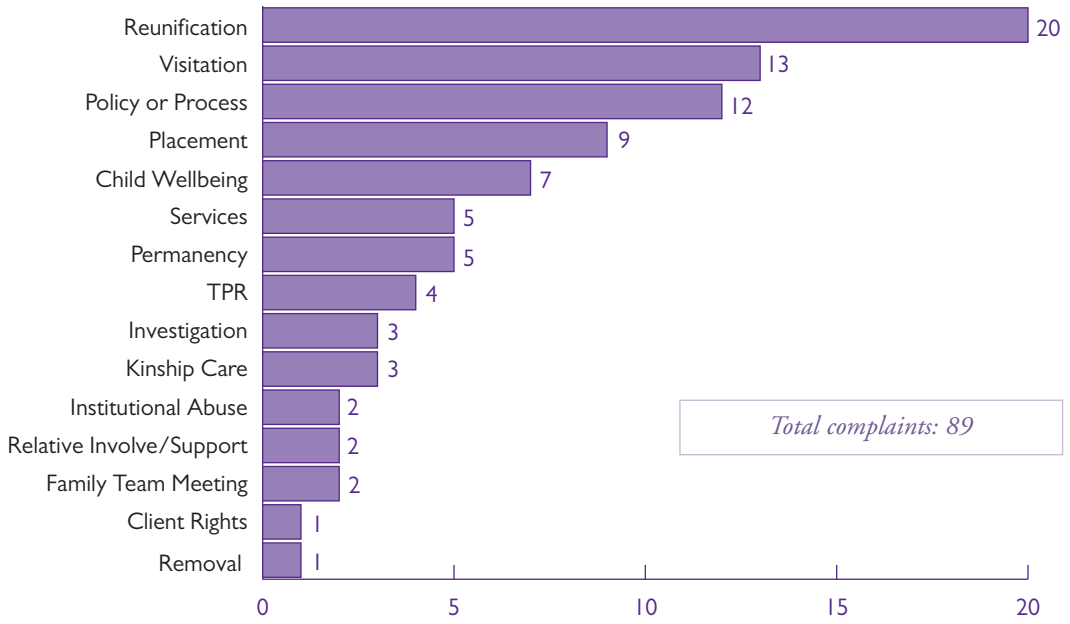
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 72 cases were opened with a total of 169 complaints. Each case typically involved more than one complaint. There were 69 complaints regarding Child Protective Services Units, 89 complaints regarding Children's Services Units, and 7 complaints regarding Adoption Services Units. Four complaints were categorized as "Other or Policy" and involved Client Rights, Reunification, and Policy/Process.

Area of Complaint: **CHILD PROTECTIVE SERVICES UNITS**



Area of Complaint: **CHILDREN'S SERVICES UNITS**



HOW MANY CASES WERE CLOSED AND HOW WERE THEY RESOLVED?

During the reporting period, the Ombudsman Program closed 70 cases that had been opened for review. Of these cases, 13 were opened during the previous reporting period and 57 were opened during the current reporting period. There are 15 cases that remain open from the 2011 reporting period. The 70 cases closed during this reporting period included 163 complaints and those are summarized in the table below.

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

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

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

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

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

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

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

RESOLUTION	CHILD PROTECTIVE SERVICES UNITS	CHILDREN'S SERVICES UNITS	ADOPTION UNITS	OTHER	TOTAL
Valid/Resolved	12	19	0	0	31
Valid/Not Resolved*	2	8	0	0	10
1. Action cannot be undone	2	5	0	0	7
2. Dept. disagrees with Ombudsman	0	0	0	0	0
3. Change not in child's best interest	0	3	1	0	4
4. Lack of resources	0	0	0	0	0
Not Valid	53	59	5	5	122
Ongoing	0	0	0	0	0
TOTAL	**67**	**86**	**5**	**5**	**163**

* Total of numbers 1-4

LOOKING AHEAD TO 2012

Each year we identify areas in which we anticipate a focus of our work. For 2012 we are in agreement with the federally required Program Improvement Plan (PIP) and will work collaboratively with Office of Child and Family Services (OCFS) to achieve its goals and objectives.

STRATEGY 1 OF THE OCFS PIP: Implementation of Statewide Practice Model Implementation Initiative (PMII)
Goal: To promote sustainable systematic changes in the interviewing process of OCFS staff through stronger case assessment interviewing skills. (This is now the Maine Child and Family Services Fact Finding Interview Protocol developed in consultation with Dr. Debra Poole, expert in forensic interviewing).

STRATEGY 2: Improve and sustain the frequency and quality of Family Team Meetings.
Goal: To improve and sustain Maine's child welfare practice in order to achieve safety, permanency and well-being outcomes for children and families.

STRATEGY 3: Improve supervision
Goal: Strengthen child welfare supervision to ensure better safety, permanency, and well-being outcomes for Maine children and families.

STRATEGY 4: Improve OCFS sharing of responsibility with the community to help families protect and nurture their children.
Goal: To determine key services needed to impact Maine child welfare practice in making progress in safety, permanency, and well-being outcomes. This needs to be determined in a financially responsible manner given Maine's budgetary challenges/limitations.

The Ombudsman's Office reviews OCFS cases based on the complainant's areas of concern, yet we also look at the entirety of the case to ensure appropriate case planning in relation to OCFS policy and procedure. The above-stated PIP goals will guide our reviews as we seek to ensure a collaborative effort with OCFS in determining outcomes in these areas.

Our office will ensure that we highlight areas, in each case that we review, that display progress with the PIP goals, and that we also identify areas of needed improvement. Along with specific case highlights, we can also better determine progress and whether or not there is continuity of care and services across the OCFS Districts.

The Ombudsman's Office will continue to work collaboratively with the PIP Committee on the goals and provide feedback, based on the cases reviewed for 2012, to address any ongoing needs.

ACKNOWLEDGMENTS

As the ninth year of operation is completed, the Maine Child Welfare Services Ombudsman Program would like to acknowledge the many people who have helped assure the success of the mission of the Ombudsman Program to support better outcomes for children and families served by the Child Welfare System. Unfortunately, space does not allow listing all the people and their contributions.

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

Senior management staff in the Office of Child and Family Services, led by Therese Cahill-Low, for their ongoing efforts to make family support the focus of child welfare practice, to keep children safe, and to assure integration of the children's behavioral health system.

Susan Getman, Senior Director, Strategic Consulting Services of Casey Family Programs, for her support and consultation on child welfare policy (most notably for 2011, her work to support stronger engagement with fathers and also the reinstitution of parental rights) and connection to Casey Family Programs' national resources on child welfare policy and practice.

In addition to the traditional Ombudsman's work that Maine Children's Alliance does, the Fostering Connections grant-work, this year, afforded the Ombudsman Program a unique opportunity to better understand the challenges to educational stability for youth in care. Although this study was completed at the request of Annie E. Casey Foundation through Maine Children's Alliance, the Ombudsman Program is now better able to support strong policy for children and youth in the child welfare system, to have educational success. We would therefore like to pay special acknowledgement to the following individuals/groups for their contributions to this study:

Annie E. Casey Foundation
Dr. Win Turner, PhD – Consultant
Jeff Carty – Consultant
Nancy Connelly – Department of Education
Richard Totten – Consultant
Virginia Marriner – Department of Health and Human Services/Office of Child and Family Services,Youth Leadership Advisory Council (YLAT)

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