OPEGA INFORMATION BRIEF

INFORMATION BRIEF

Oversight of Maine's Child Protective Services

January 2022

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

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Table of Contents

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Structure of this Report

This Information Brief reports on the first of three components that will comprise OPEGA's review of child protective services (CPS) in Maine. This Brief presents facts and background information to describe state and federal oversight of child protective services. It begins with an overview of the scope of work, the five topics examined, and the entities that make up the CPS oversight landscape. It then presents key lessons and observations from the research. Following the introduction, the Brief includes four major sections that address: federal regulatory oversight; state advisory oversight; best practices in child protective services oversight; and other state approaches. Finally, four appendices to the brief present: the research methods used; tables of detailed information referenced in the main report; and a summary of recent reports, recommendations from the advisory oversight entities, and a listing of related bills before the second regular session of the 130th Legislature.

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 – Initial Investigation and Assessment, 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 Information Brief on oversight of child protective services.

A. Scope of Work

The GOC directed OPEGA to narrow the scope of this component of the CPS review to produce an Information Brief rather than a full evaluation. In an Information Brief, OPEGA researches, synthesizes and presents relevant facts, background, and contextual information to the Legislature to build knowledge and understanding of a topic. This is distinctly different from, and more limited than, a full evaluation, in which OPEGA evaluates the performance and outcomes of an agency or

program through extensive data collection and analysis to deliver findings, conclusions and recommendations to the Legislature.

In limiting this first component of the CPS review to an Information Brief, the GOC ensured the Legislature would receive some information to work with early in the Second Regular Session of the 130th Legislature, while the full evaluation components of the CPS review are underway. In preparing this Information Brief, the GOC directed OPEGA to consider the following five topics:

1. ***Current oversight structure*** of DHHS/OCFS and child protective services broadly;
2. ***Roles and responsibilities*** of the entities involved in child protective services oversight, including Child Welfare Ombudsman and oversight panels required by law;
3. ***Information sharing*** between entities, including barriers or gaps;
4. ***Best practices and models*** of oversight of child protective services; and
5. ***Effectiveness*** of the structure of child protective services oversight.

Given the breadth and complexity of the overall child welfare system and oversight of that system, the GOC provided some direction to OPEGA on framing "oversight of child protective services" within the context of this assignment. Based on the GOC's guidance supplemented by initial research by OPEGA, the focused scope of this work addresses:

- **Child protective services** administered and delivered by the DHHS/OCFS;
- **Oversight** in the form of review and monitoring of these child protective services by state-level entities, in an advisory role, and by the federal government, in a regulatory role.[1]

OPEGA's research for this Information Brief was conducted between August and December 2021 and included in-depth interviews with state and federal agencies and review of documentation including relevant laws, regulations and other materials.[2]

B. Oversight Landscape

In this Information Brief, OPEGA addresses a defined set of state and federal elements within the overall landscape of child protective services oversight. Specifically, we address oversight of the child protective services delivered by Maine DHHS/OCFS as follows:

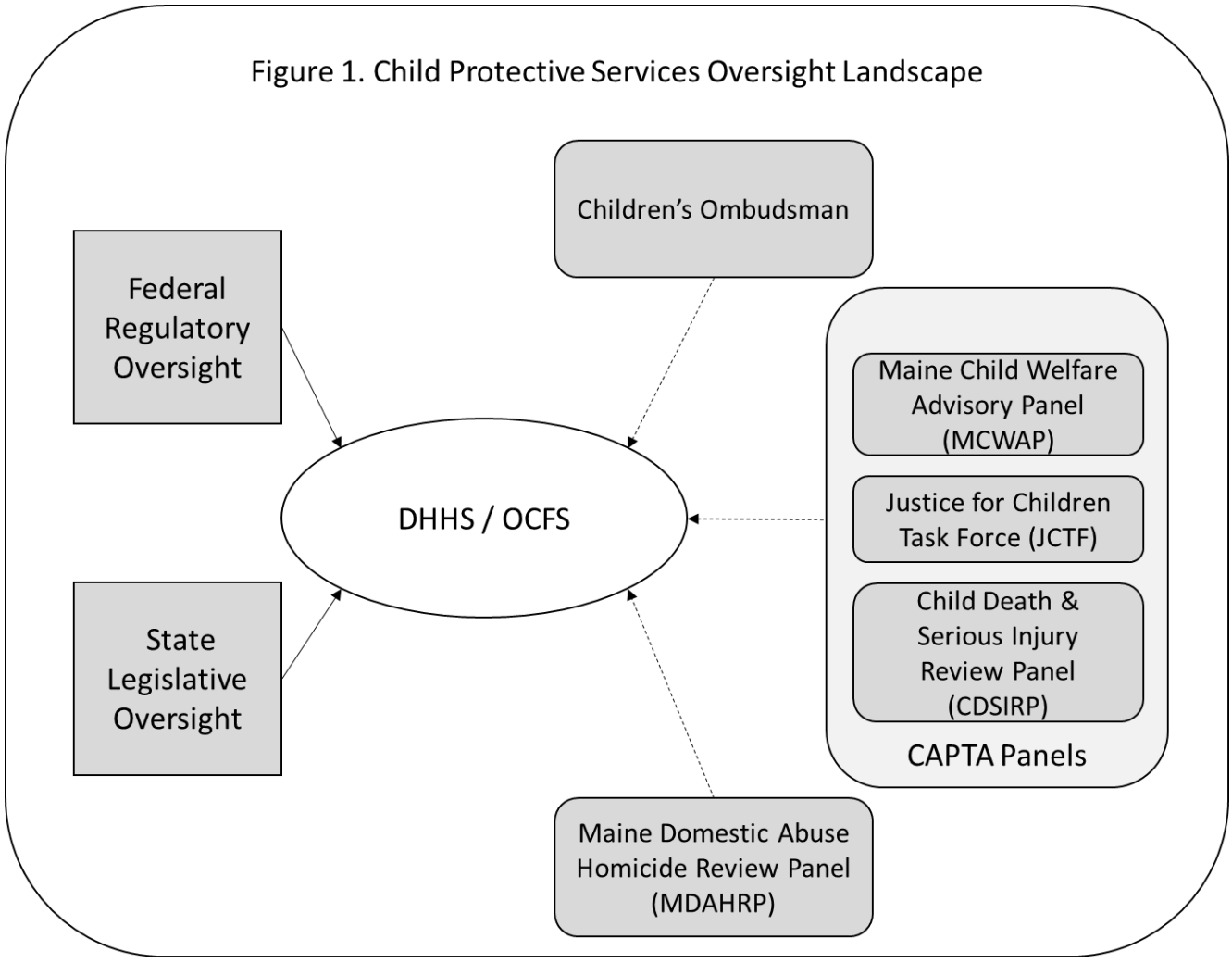
- **Federal regulatory oversight** provided by the U.S. DHHS Administration for Children and Families, which has regulatory authority over Maine DHHS/OCFS; and
- **State advisory oversight** provided by five entities that each have roles in reviewing and monitoring DHHS/OCFS from varying perspectives but do not have regulatory authority.
    - Children's Ombudsman; and
    - Four volunteer panels:
        - Maine Child Welfare Advisory Panel;
        - Justice for Children Task Force;

[1] While not addressed in this targeted scope, other forms of oversight include: joint standing committees of the Legislature, the additional DHHS/OCFS internal quality assurance unit activities, and a number of provider associations, such as the Maine Child Welfare Advocacy Network and the group Adoptive and Foster Families of Maine that provide advisory input to DHHS/OCFS.
[2] Additional information on methods is provided in Appendix A.

- Child Death and Serious Injury Review Panel; and
- Maine Domestic Abuse Homicide Review Panel.

Three of the four state advisory oversight panels have been designated as the citizen review panels that allow Maine to comply with the federal government's Child Abuse Prevention and Treatment Act (CAPTA). The oversight landscape is illustrated in Figure 1. In addition to the specific state and federal elements of child protective services oversight that are addressed in this Information Brief, this figure also notes the oversight role of the State Legislature which is carried out through lawmaking, including the state budget, and oversight by legislative committees. At the time of this report, there are eight bills before the 2nd Regular Session of the 130th Maine Legislature relating to oversight of Child Protective Services and related matters. A list of these bills is provided in Appendix D for reference.

Figure 1. Child Protective Services Oversight Landscape



C. Lessons and Observations

1. ***Current structure of oversight*** of DHHS/OCFS and child protective services broadly:
   - Child protective services as administered by DHHS/OCFS are subject to in-depth regulatory oversight by the federal government as well as advisory oversight from a network of state-level entities.
   - Federal oversight is comprehensive and outcomes-oriented with financial penalties for nonconformity.
   - State-level advisory oversight engages all three branches of government and both public and private sector stakeholders.

2. ***Roles and responsibilities*** of the entities involved in child protective services oversight:
   - The roles and responsibilities of the different entities address both macro-level oversight of the system and micro-level review and oversight of specific CPS cases, including cases of death and serious injury.
   - The four state-level panels and the Ombudsman have distinct missions, but there is a degree of overlap as well as nuanced differences in the scope of their activities.

3. ***Information sharing*** between entities, including barriers or gaps:
   - Information is routinely and regularly shared among the state-oversight entities and DHHS/OCFS. This routine information sharing among the panels is often the result of individual panel members and DHHS/OCFS staff being members of more than one oversight entity.
   - Work is currently being done by several of the state oversight entities to formalize and institutionalize information sharing practices to ensure continuity in information sharing over time.

4. ***Best practices and models*** of oversight of child protective services:
   - The state-oversight entities, including the four panels and the Ombudsman, are structured in a manner, and are practicing in a manner, that generally conform to published best practices for entities overseeing child protective services.
   - Several of the entities have recently made or are in the process of implementing changes to improve alignment with published best practices.

5. ***Effectiveness*** of the structure of child protective services oversight. Without the benefit of a full evaluation, we cannot draw evaluative conclusions about effectiveness. However, based on the limited research for the Information Brief, we can say:
   - The oversight structure includes many opportunities for DHHS/OCFS to obtain multiple points of view and draw on the expertise of several professional disciplines engaged in child protection across the private sector and multiple levels and branches of government.

The oversight structure at the state-level is not significantly different than many other states. It is structured as a collaborative network of entities that provide advice and recommendations to DHHS/OCFS.

II. Federal Regulatory Oversight

U.S. Department of Health and Human Services (U.S. DHHS) conducts regular and ongoing oversight of state child welfare agencies, including OCFS, to ensure conformity with federal requirements and promote continuous improvement in child welfare. This oversight role is authorized by Federal law and regulations and administered by the Children's Bureau, within the U.S. DHHS' Administration for Children & Families (ACF). Key elements of the oversight conducted by the Children's Bureau include:

- Child and Family Services Review (CFSR) and associated Program Improvement Plan (PIP) and financial penalties
- Child and Family Services Plan (CSFP) and associated Annual Progress and Services Report (APSR)

A. Review of Services and Program Improvement

The Child and Family Services Review (CFSR) is central to federal oversight of state child welfare. The CFSR is used by the Children's Bureau: to ensure conformity with federal child welfare requirements; to determine what is happening to children and families as they are engaged in child welfare services; and to assist states in enhancing their capacity to help children and families achieve positive outcomes. The Children's Bureau conducts CFSRs with states on a rotating schedule (referred to as "rounds"). The third round of the CFSR was completed for Maine in 2017.

What the CFSR Evaluates. Through the CFSR, state performance is assessed across two areas: (1) child and family outcomes and (2) underlying systemic factors that influence child and family outcomes. Each of these areas includes specific items that are measured and assessed. The child and family outcomes and systemic factors evaluated in the CFSR are listed below. A full listing, which includes the measured items associated with each of these outcomes and systemic factors, can be found in Tables B.1 & B.2 in Appendix B.

Child and family outcomes evaluated in the CFSR:

- Safety 1: Children are, first and foremost, protected from abuse and neglect.
- Safety 2: Children are safely maintained in their homes whenever possible and appropriate.
- Permanency 1: Children have permanency and stability in their living situations.
- Permanency 2: The continuity of family relationships and connections is preserved for children.
- Well-Being 1: Families have enhanced capacity to provide for their children's needs.
- Well-Being 2: Children receive appropriate services to meet their educational needs.
- Well-Being 3: Children receive adequate services to meet their physical and mental health needs.

Systemic factors assessed in the CFSR:

- Statewide information system
- Case review system
- Quality assurance system
- Staff and provider training
- Service array and resource development
- Agency responsiveness to the community
- Foster and adoptive parent licensing, recruitment and retention

Components of the CFSR Process. The CFSR process incorporates three components – case reviews, stakeholder interviews and a statewide assessment – to complete the review of a state's performance against federal standards.

- **Case Reviews.** OCFS conducts case reviews[3] on a sample of 40 foster care cases and 25 in-home services cases, selected according to a methodology established by the Children's Bureau. Each individual case review includes examination and documentation of information from the case file relevant to specific items and outcomes. For each case, interviews are also conducted with children, parents, foster parents, caseworkers, and other professionals. These case reviews are conducted by experienced OCFS quality assurance staff, in teams of two, using the Children's Bureau CFSR Onsite Review Instrument and Instructions (OSRI). The OSRI contains definitions, instructions, and questions that reviewers must populate using information collected from the review of case file documentation or case-related interviews.
- **Stakeholder Interviews.** Staff from the Children's Bureau conduct interviews with a range of stakeholders in the state, including: child welfare agency senior management, program managers, supervisors and caseworkers; attorneys and judges; parents, foster parents, and children; and tribal representatives.
- **Statewide Assessment.** OCFS conducts the statewide assessment of performance in meeting federal standards. OCFS staff and stakeholders review the state's performance in each of the seven outcome areas and seven systemic factors. This work, along with the case review results, stakeholder interviews, and the state's current data indicators related to safety, permanency and well-being outcomes, form the basis of the statewide assessment.

CFSR Final Report and Conformity with Standards. The Children's Bureau prepares and issues the CFSR Final Report which documents whether the child and family outcomes and systemic factors are in substantial conformity with federal standards and whether specific items are rated as strengths or areas needing improvement. 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. These high standards also reflect the Bureau's interest in ensuring states have incentives to dedicate ongoing attention to improving outcomes and performance.

[3] States may conduct their own case reviews for the CFSR provided they meet certain criteria. These include using the Children's Bureau CFSR Onsite Review Instrument and Instructions (OSRI) and agreeing to secondary oversight by the federal government of a percentage of sampled cases to ensure accurate application of the OSRI and quality of case ratings. Maine is one of two New England states currently conducting its own case reviews.

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 state PIP is standard practice – in fact, no state has achieved substantial conformity with all seven outcome areas and systemic factors in round three of the CFSR. The state PIP must specify the state agency's goals, strategies and key activities designed to improve performance, and the plan must be approved by the Children's Bureau. Upon approval, the state has a two-year PIP implementation period followed by an evaluation period. During these periods, state progress is monitored through case reviews and any progress is measured against specific PIP goals. These goals are negotiated with the Children's Bureau and are based upon the state's actual CFSR results, rather than the CFSR's federal performance standards. These PIP goals are lower, more attainable than the CFSR standards, but still promote improvement.

Financial Penalties. The federal government assesses financial penalties against states for non-conformity identified through the CFSR process. Although penalties are determined based on the CFSR results, the assessment of the financial penalties is suspended throughout the PIP implementation and evaluation periods. During this time, no funds are withheld as long as the State is actively engaging in and adhering to the provisions of the PIP. If a state successfully achieves its PIP goals, the financial penalty is rescinded, meaning that no funds are actually withheld at any point. If the state fails to make required improvements under the PIP, however; the financial penalty is imposed.

B. Child and Family Services Plan and Annual Progress Reports

The Child and Family Services Plan (CFSP) is a federally required five-year strategic plan that sets forth a state's vision and the goals to be accomplished to strengthen the overall child welfare system. To receive federal funding under Title IV-B of the Social Security Act, states must submit the CFSP and Annual Progress and Services Report (APSR) to the federal government. The state plan and annual progress reports share many goals, action items, and review results as those captured in the CFSR and PIP.

The CFSP outlines the state's initiatives and activities to improve outcomes in the following areas: permanency for children; well-being of children and their families; and the nature, scope, and adequacy of existing child and family and related social services. The APSR provides an annual update on the progress made toward CFSP goals and objectives as well as planned activities for the upcoming fiscal year.

The state submits the CFSP and APSR first to the regional ACF office for initial review to ensure the reports include all information as outlined in the federal program instructions. The regional office provides feedback and questions, and once all requirements have been addressed, the report is submitted to the Children's Bureau for final review and approval.

C. Maine's Performance in Brief

Maine has completed three rounds of the CFSR process in 2003, 2009, and 2017. In the third round, Maine was found to be in substantial conformity with one of the seven outcomes and four of the

seven systemic factors and was required to develop and implement a PIP to address the remaining areas. Maine's results in the third round CFSR are shown in Table 1 along with the other New England states for context.

Table 1. New England States' 3rd Round CFSR Performance						
	ME	**CT**	**MA**	**NH**	**RI**	**VT**
Conformity with Child & Family Outcomes						
Safety 1: Children are, first and foremost, protected from abuse and neglect.	**No**	No	No	No	No	No
Safety 2: Children are safely maintained in their homes wherever possible and appropriate.	**No**	No	No	No	No	No
Permanency 1: Children have permanency and stability in their living situations.	**No**	No	No	No	No	No
Permanency 2: The continuity of family relationships and connections is preserved for children.	**No**	No	No	No	No	No
Well-being 1: Families have enhanced capacity to provide for their children's needs.	**No**	No	No	No	No	No
Well-being 2: Children receive appropriate services to meet their educational needs.	**YES**	No	No	No	No	No
Well-being 3: Children receive adequate services to meet their physical and mental health needs.	**No**	No	No	No	No	No
Conformity with Systemic Factors						
Statewide information system	**YES**	No	YES	No	YES	YES
Case review system	**No**	No	No	No	No	No
Quality assurance system	**YES**	YES	No	YES	No	No
Staff and provider training	**No**	No	No	No	No	No
Service array and resource development	**No**	No	No	No	No	No
Agency responsiveness to the community	**YES**	YES	YES	YES	YES	YES
Foster and adoptive parent licensing, recruitment, and retention	**YES**	No	No	No	No	No
Source: Child and Family Service Reviews 3rd Round https://www.cfsrportal.acf.hhs.gov/cfsr-reports						

The Children's Bureau approved Maine's required PIP in February 2020, following a series of delays attributed to three changes in OCFS leadership between 2017 and 2019. The two-year implementation period for this PIP ran from February 2020 through January 31, 2022. Due to the COVID-19 pandemic, OCFS applied for and has recently received an extension from the Children's Bureau to meet the goals of the current PIP. Under the extension, Maine has until January 31, 2024 to meet the PIP goals. OCFS reported to OPEGA that the program improvement plan activities, along with other improvement strategies, will enable the State to meet the goals of the PIP and, in doing so, the penalties will be waived by U.S. DHHS' Administration for Children and Families.

III. State Advisory Oversight

In this Information Brief, we describe five state entities, including four "panels" that have specific, but distinct, roles in reviewing and monitoring child protective services delivered by DHHS/OCFS. These are the:

- Maine Child Welfare Services Ombudsman;
- Maine Child Welfare Advisory Panel (MCWAP);
- Justice for Children Task Force (JCTF);[4]
- Child Death and Serious Injury Review Panel (CDSIRP); and
- Maine Domestic Abuse Homicide Review Panel (MDAHRP).

None of these entities has regulatory authority over DHHS/OCFS but each provides a form of oversight through formal and informal recommendations, advice, implementation of special projects and reporting – we refer to their role as "advisory oversight." Access to data, information sharing and relationships with DHHS/OCFS are integral to these entities' ability to provide advisory oversight.

Table 2. Advisory Oversight Entities

Oversight Entity	Federally-required	Overall Focus/Mission/Goal
Maine Children's Ombudsman		Provide ombudsman services regarding child welfare services provided by DHHS
Maine Child Welfare Advisory Panel	YES	Promote child safety and quality services for children, youth and families
Justice for Children Task Force	YES	Broad focus on safety, permanency, and well-being for children in the State of Maine child welfare system
Child Death and Serious Injury Review Panel	YES	Promote child health and well-being, improve child protective systems, and educate the public and professionals
Maine Domestic Abuse Homicide Review Panel		Improve the coordinated community response to protect people from domestic abuse

Three of these oversight entities – the Maine Child Welfare Advisory Panel, Justice for Children Task Force, and Child Death and Serious Injury Review Panel – are "citizen review panels" as specified and required under the federal Child Abuse Prevention and Treatment Act (CAPTA), or "CAPTA panels." The MCWAP and JCTF also meet requirements of funding under the federal Children's Justice Act.

According to CAPTA, the function of the designated citizen review panels for which the Act provides funding, is to examine the policies, procedures, and practices of state and local agencies and where appropriate, specific cases, in order to evaluate the extent to which the state and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with:

- A state's plan for CAPTA funds (coordinated with the CFSP to the extent possible);
- The federal child protection standards set forth in CAPTA; and
- Any other criteria that the panel considers important to ensure the protection of children, including:
    - a review of the extent to which the state and local child protective services system is coordinated with foster care and adoption programs established under title IV-E of the Social Security Act; and

[4] This is also referred to as a "panel" throughout this document for ease of reference.

- a review of child fatalities and near fatalities.

Chairs of the CAPTA panels interviewed by OPEGA noted that they attempt to perform these duties in a complementary and collaborative manner with DHHS/OCFS and have an advisory role in relation to the department. According to the 2020 report from the Maine Justice for Children Task Force[5], a goal of all three CAPTA panels is to conduct complementary work without duplication. There is naturally, however, some overlap in focus among the CAPTA panels, the Domestic Abuse Homicide Review Panel, and the Ombudsman's program. Also, while CAPTA panels throughout the United States were originally envisioned to have more of an oversight role, they have evolved into a more collaborative advisory role to promote better outcomes for children and their families.[6] The panel members OPEGA interviewed consistently noted that much of their work is accomplished through communication, interaction and information sharing with DHHS/OCFS, and that collaboration with OCFS is critical to fostering improvement.

A. Maine Children's Ombudsman

> "The Maine Child Welfare Services Ombudsman is an impartial office that specializes in assisting people with resolving concerns and complaints with Maine's Child Protective Services Department of the Department of Health and Human Services."[7]

The current children's ombudsman program in Maine was established by legislation in 2001. Pursuant to statute (22 MRSA §4087-A(2)), the program is "established as an independent program within the Executive Department to provide ombudsman services to the children and families of the State regarding child welfare services provided by the Department of Health and Human Services." The law requires that ombudsman services are delivered through a state contract with a nonprofit organization that the Executive Department determines to be free of potential conflicts of interest and best able to provide the services on a statewide basis.

Duties. The duties of the Ombudsman, as specified in statute, are to: consider and promote the best interests of the child involved, answer inquiries, and investigate, advise and work toward resolution of complaints of infringement of the rights of the child and family involved. The Ombudsman must be an attorney or a master's level social worker with experience in child development and advocacy. The Ombudsman program is currently funded for two staff positions to carry out its work. The Ombudsman reported that the limited staffing makes it challenging to meet the demands on the office. At the time of this report, there is proposed legislation before the 130th Legislature to increase staff resources. [8]

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[5] Maine Justice for Children Task Force 2020 Report to the Supreme Judicial Court. January 13, 2021.
[6] Jones, Blake (2016). CRP Tip Sheet #6: Communicating with External Groups, University of Kentucky School of Social Work under the auspices of the National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center (CANTASD).
[7] Maine Children's Ombudsman website: http://cwombudsman.org/
[8] LD 1755, An Act To Enhance the Child Welfare Ombudsman Program, Sponsored by Senator Glenn Curry
LD 1812, An Act To Strengthen the Child Welfare Services Ombudsman Program by Providing for Increased Staffing, Sponsored by Senator William Diamond
LD 1824, An Act To Improve the Maine Child Welfare Services Ombudsman Program by Providing Additional Resources, Sponsored by Representative Holly Stover

Operations. The Ombudsman reports that staff time and resources are divided fairly evenly between (1) answering inquiries – primarily responding to phone calls from the public – and (2) conducting investigations and related activities to respond to complaints. Time spent on the phone with individuals involves both listening to complaints with the child protective services system and also explaining state policies and procedures to callers who are new to the process. Some of these complaints result in the Ombudsman opening an individual case review to investigate. For context, a summary of case review activity of the Ombudsman since 2019 is provided in Table 3.

Table 3. Ombudsman Case Reviews 2019-2021*			
	2019	2020	2021
Case reviews opened	109	90	95
Case reviews closed	98	82	84
Closed cases with substantial issues**	37	38	42
* Cases are opened for review as the result of one or more complaints made to the Ombudsman. As they are drawn from complaints, they are not a representative, or random sample of OCFS cases. ** Cases with substantial issues are defined as cases where the Ombudsman found a deviation from best practices or adherence to policy that had a material effect on the safety and best interests of the children, or rights of the parents.			
Source: Maine Child Welfare Services Ombudsman Annual Reports 2019 - 2021			

Data access and information sharing. Pursuant to statute, the Ombudsman is provided access to files, records, and personnel of DHHS that are necessary for carrying out the Ombudsman's duties. DHHS and the Ombudsman have developed agreements for information sharing including an agreement that provides DHHS two weeks to respond to records requests and another agreement providing the Ombudsman access to the State's child welfare information system database (MACWIS[9]). The Ombudsman program is represented on the Maine Child Welfare Advisory Panel and the Justice for Children Task Force and provides and receives information through those groups.

Reports and recommendations. The Ombudsman provides recommendations to DHHS of two types: confidential and public. Based on findings of individual case reviews, the Ombudsman may confidentially recommend changes to DHHS to address specific issues raised by a complaint, or any other issues the Ombudsman notes in the course of the review. Confidential recommendations can also result from combinations of cases which share common issues. These confidential recommendations are reported to DHHS throughout the year. The Ombudsman also prepares periodic interim reports as well as an annual report, due January 1st, to the Governor, Legislature and DHHS that summarizes common themes and makes recommendations for DHHS/OCFS based on the prior year of Ombudsman case reviews. This public document includes only de-identified information.

B. Maine Child Welfare Advisory Panel

> "Formed in December 2015, The Maine Child Welfare Advisory Panel (MCWAP) is a multidisciplinary task force. It is comprised of private citizens and professionals from selected disciplines involved in handling child abuse and neglect. Meeting monthly, the panel ensures the state system is meeting the safety, permanency, and well-being of children and families through

[9] MACWIS is currently in the process of being replaced with a new DHHS/OCFS information system.

> assessment, research, advocacy, and greater citizen involvement. Its goal is to promote child safety and quality services for children, youth and families."[10]

MCWAP was formed in 2015 from the membership of two prior groups, the Child Welfare Steering Committee and Maine's Citizen Review Panel. This federally-required CAPTA panel reviews and provides advice regarding the delivery of child protective services.

Duties. The Maine Child Welfare Advisory Panel's mission is to "assure that the state system is meeting the safety, permanency, and well-being of children and families through assessment, research, case reviews, advocacy, and greater citizen involvement."[11] To meet federal requirements, the MCWAP performs a range of duties that include examining and evaluating policies, examining state investigative, administrative and judicial handling of child abuse and neglect cases, providing for public outreach and input, and making policy and training recommendations.[12]

Membership. The members of MCWAP are volunteers representing a wide range of public and private entities with an interest in the welfare of children. Several of the panel's members are OCFS staff who participate in a non-voting capacity, and the panel receives administrative support from a CAPTA coordinator employed by DHHS. Under the bylaws, panel membership includes, but is not limited to, representatives from the judicial system, health and mental health providers, law enforcement,[13] children and families and other service providers. Table B.3 of Appendix B includes a full list of membership as authorized by the panel's by-laws.

Operations. The MCWAP is required by CAPTA to meet quarterly but typically meets on a monthly basis for 10 months per year. Much of the panel's work is conducted through subcommittees. Current subcommittees include: family-centered policy and practice; coordination of care for children entering the system; and father engagement. MCWAP conducts surveys of service providers and families every three years to fulfill its Children's Justice Act requirement to evaluate state handling of cases of child abuse and neglect, and uses its website as its required mechanism for receiving input from the public. MCWAP members also have the opportunity to review and provide feedback to OCFS on child welfare policies prior to their implementation.

Data access and information sharing. MCWAP does not have access to confidential data but obtains information and aggregated data from DHHS/OCFS staff who serve on MCWAP as needed to conduct its work.

Reports and recommendations. MCWAP issues annual reports that describe the panel's activities and recommendations for the improvement of CPS. Under CAPTA, DHHS is required to provide a written response to MCWAP recommendations within 6 months; however, MCWAP does not have

[10] Maine Child Welfare Advisory Panel website: https://www.mecitizenreviewpanels.com/maine-child-welfare-advisory-panel/

[11] Maine Child Welfare Advisory Panel By-Laws, December 2018. (Note: The Panel voted to delete "case reviews" from the mission statement in 2021.)

[12] 2020–2024 Child and Family Services Plan. Office of Child and Family Services, State of Maine. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/documents/Maine%20OCFS%202020-2024%20CFSP%20-%20%20091219.docx

[13] The panel does not currently include a member from law enforcement but is continuing its recruitment efforts.

any authority to require OCFS implementation of its recommendations. MCWAP reported to OPEGA that in the past, obtaining feedback from DHHS/OCFS on the implementation of recommendations has been based on informal updates provided by the Department to the panel. The panel recently voted to establish a formal process for DHHS/OCFS to provide annual updates and comments on the Department's progress on MCWAP recommendations from the prior year.

Evolving to citizen-led Model. Recently, the MCWAP co-chair position has evolved from being held by a non-voting co-chair from DHHS/OCFS, and a citizen co-chair who directs the meetings, to having two citizen co-chairs not affiliated with DHHS/OCFS. MCWAP is continuing to update its by-laws to reflect these changes. The panel has also built up its executive committee to include more representation of non-OCFS members. The 2020 annual report, published in early 2021, was written completely by citizen-members of the panel and this has been used by DHHS/OCFS to satisfy the federal CAPTA requirement for an annual report on the CAPTA panels' activities. Interviews with DHHS/OCFS management indicate that this shift to a more citizen-led MCWAP has been made with support of DHHS/OCFS.

C. Justice for Children Task Force

> "The Maine Justice for Children Task Force ("the Task Force") is a collaborative, multidisciplinary task force. The Maine Judicial Branch convened it to improve safety, permanency, and well-being for children in the State of Maine child welfare system. Task Force membership consists of representatives from the legislative, judicial, executive branches, and other participants, including advocates for children, parents, and individuals involved in the child welfare system."[14]

The Maine Justice for Children Task Force is convened by, and operates as, a standing committee of the Maine Judicial Branch. The mission of this group is "to improve safety, permanency, and well-being for children in the State of Maine child welfare system."[15] The JCTF serves to meet federal requirements under both CAPTA and grant funding from the Children's Bureau to develop and implement recommendations to improve the court's role in achieving permanency for children.[16]

Duties. The JCTF charter outlines specific duties the task force will fulfill. These duties include, but are not limited to:

- Identifying strengths and systemic barriers to the safety, permanency, and well-being of children in the State of Maine child welfare system, and solutions to barriers;
- Identifying training needs of stakeholders in child protective proceedings and adopting a training curriculum;
- Monitoring implementation of the Court Improvement Programs;
- Encouraging participation in Child and Family Services Reviews (CFSRs);
- Sponsoring local meetings with stakeholders for training and collaboration;

[14] Maine Justice for Children Task Force website: https://www.mecitizenreviewpanels.com/maine-justice-for-children-task-force/
[15] Maine Justice for Children Task Force 2020 Report to the Supreme Judicial Court, January 2021.
[16] Under the Court Improvement Program (CIP), the highest court of each state and territory receives a grant from the Children's Bureau to complete a self-assessment and develop and implement recommendations to enhance the court's role in achieving stable, permanent homes for children in foster care.

- Providing feedback on statewide performance standards; and
- Developing and implementing programs to improve assessment and investigation of suspected child abuse and neglect cases.

Membership. The membership of the JCTF is set forth in the task force charter and includes representatives from the legislative, judicial, and executive branches and a spectrum of stakeholders including advocates for children, parents, foster parents, and other individuals involved in the child welfare system (See Table B.3 in Appendix B for a full list of membership categories). The JCTF is chaired by the Chief Justice of the Maine Supreme Judicial Court who also appoints members to the group.

As an entity under the Maine Judicial Branch, the JCTF has a distinct position separate from DHHS/OCFS in the Executive Branch. At the same time, as stated in the JCTF charter, "[i]t is anticipated that the work of the Task Force will regularly occur in conjunction and collaboration with the work of the Executive and Legislative Branches, along with appropriate child welfare entities." DHHS/OCFS staff who serve on the JCTF regularly present information on OCFS activities at task force meetings and actively work on the subcommittees and task force projects.

Operations. The JCTF meets at least quarterly and maintains a strategic plan, which is revisited at each meeting, to guide its work. Areas identified for focus in the strategic plan are then worked on by subcommittees that may meet more regularly as needed. The task force has one standing subcommittee on continuing education that meets year-round and supports the annual judicial branch child protective conference. This annual conference provides a significant training and continuing education opportunity for many individuals in Maine's child welfare community.[17] The task force also currently has two other subcommittees, one focused on parent curriculum and another on race and equity data.

Data access and information sharing. The JCTF, like MCWAP, does not have access to confidential data and instead, receives presentations of child welfare statistical data from DHHS/OCFS members at task force meetings. Members interviewed by OPEGA noted that this data is used in specific projects as well as to analyze child welfare trends in the State.

Reporting and recommendations. The JCTF charter requires the submission of an annual report to be presented to the Supreme Judicial Court on January 15 or as otherwise requested.[18] The annual report details the activities of the panel for the prior year, including activities of its subcommittees and how they relate to the task force's strategic plan.

As an entity of the Judiciary, the JCTF does not make formal recommendations to DHHS/OCFS. The task force does, however, offer feedback to DHHS/OCFS on policies and practices.

[17] The 3-day virtual session in 2020 averaged 205 participants at each session. 3,563 hours of CLE credits were reported along with 208 hours of ethics credits, 74 hours of self-study CLE credits, and 1900 guardian ad litem credits. Maine Justice for Children Task Force 2020 Report to the Supreme Judicial Court. https://www.mecitizenreviewpanels.com/wp-content/uploads/2021/02/Maine-Justice-for-Children-Task-Force-2020-Annual-Report-1.pdf

[18] Reports are available on the JCTF website: https://www.mecitizenreviewpanels.com/maine-justice-for-children-task-force/

D. Child Death and Serious Injury Review Panel

> "The Child Death and Serious Injury Review Panel's mission is to promote child health and well-being, improve child protective systems, and educate the public and professionals who work with children to prevent child deaths and serious injuries. The Panel accomplishes this mission through collaborative, multidisciplinary, comprehensive case reviews, from which recommendations to state and local governments and public and private entities are developed."[19]

The CDSIRP is a multidisciplinary panel of professionals established in state law (22 MRSA §4004) to review child deaths and serious injuries to children and recommend methods of improving the child protection system, including modifications of statutes, rules, policies and procedures. The CDSIRP's goal is to help reduce the number of preventable child fatalities and serious injuries in the State; through comprehensive case reviews, summarizing findings, and making recommendations for system-level changes to increase protection, safety, and care for Maine's children.[20]

Membership. Required membership of the CDSIRP is specified in statute (see 22 MRSA §4004(1)(E)). Membership is narrower than the other CAPTA panels due to the CDSIRP's specific focus on child deaths and serious injuries. The membership of the panel includes the Chief Medical Examiner[21] and other medical professionals including pediatricians, public health nurses, and forensic and community mental health clinicians. The panel also includes district attorneys, Assistant Attorneys General, law enforcement officers and DHHS/OCFS agency staff. (See Table B.3 in Appendix B for a full list of membership categories.) Beyond the required membership, the Chair indicated that the panel seeks to include other professionals with relevant perspectives, such as representatives from the Maine Coalition to End Domestic Violence, the Department of Corrections, the Maine CDC, and the Judicial Branch.

Operations. The panel meets monthly, generally for 10 months out of the year, to conduct case reviews, evaluate sentinel events and patterns of injury and/or death, and analyze the effectiveness of state programs and systems that provide for child protection, safety, and care. For cases involving prosecution, the CDSIRP initiates a case review only after adjudication is complete. The CDSIRP conducts three different levels of case reviews:

- Level 1 – Periodic Summary Review: Involves a review of summaries of all child deaths and serious injuries that are reported to OCFS to identify the types of cases, injuries, and deaths being reported, themes warranting further review and potential recommendations.
- Level 2 – Cluster Review: Involves specific review of a cluster of cases (2-4) around a theme, for example, unsafe sleep practices – to seek to identify recommendations.

[19] Child Death and Serious Injury Review Panel website: https://www.mecitizenreviewpanels.com/child-death-and-serious-injury-review-panel/
[20] 2020–2024 Child and Family Services Plan. Office of Child and Family Services, State of Maine. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/documents/Maine%20OCFS%202020-2024%20CFSP%20-%20%20091219.docx
[21] In practice the Chief Medical Examiner position on the panel has been filled by a representative or designee of the Examiner.

- Level 3 – Individual Case Review: Involves review of OCFS records and other related records (law enforcement, mental health, medical, or educational) and interviews with selected professionals involved in the case – for example the OCFS caseworker and supervisor, law enforcement, school personnel, or a child's pediatrician.

Additionally, sometimes the CDSIRP will jointly review cases with MDAHRP (described below). At the time of this report, the CDSIRP panel is nearing completion of by-laws designed to more consistently and clearly detail the group's practices and relationships with other entities.

Data access and information sharing. The CDSIRP's authorities and restrictions associated with information, subpoena power, and confidentiality are provided within the framework of statute granting these authorities and restrictions to DHHS. The panel is provided confidential data from DHHS and panel members from DHHS/OCFS can answer further questions with their access to the OCFS database system, MACWIS[22].

Reports and recommendations. Under the CAPTA requirements, the State is required to report annually to the federal government on the activities of the CDSIRP. This has been achieved historically through either a report submitted by the CDSIRP or, in years that the CDSIRP has not submitted a report, DHHS/OCFS has summarized the panel's activities for the purposes of federal reporting. At the time of this report, the CDSIRP is preparing a report on the last five years of activity. The chair has indicated that the panel plans to issue annual reports starting in spring of 2022 to coincide with the required report to the federal government. The panel has not routinely produced reports containing recommendations in the past; rather, the chair indicated that most of the panel's suggestions are implemented through ongoing communication and collaboration with OCFS or other parties in a position to make change. OCFS management does attend each CDSIRP case review and this involvement can inform modifications to OCFS policy and the content of DHHS-proposed legislation. Currently, the CDSIRP sends its reports to DHHS who may pass them on to the Legislature. In their on-going work to create by-laws, the panel is considering a broader distribution of their reports going forward.

E. Maine Domestic Abuse Homicide Review Panel

> The mission of the Maine Domestic Abuse Homicide Review Panel is to engage in collaborative, multidisciplinary case review of domestic abuse related homicides for the purpose of developing recommendations for state and local government and other public and private entities to improve the coordinated community response that will protect people from domestic abuse.[23]

By law effective October 1, 1997, the Maine Domestic Abuse Homicide Review Panel (MDAHRP) was established under the Maine Commission on Domestic and Sexual Abuse "to review the deaths of persons who are killed by family or household members" (see 19-A MRSA §4013(4)). A subset of the deaths reviewed by MDAHRP involve children or child welfare cases. While the MDAHRP is another volunteer citizen review panel, it is not a CAPTA panel and therefore not subject to CAPTA requirements.

[22] MACWIS is currently in the process of being replaced with a new DHHS/OCFS information system.
[23] The 8th Report of the Maine Domestic Abuse Homicide Review Panel—January 2010

Duties. As specified in statute, the MDAHRP is required: to collect and compile data related to domestic and sexual abuse following adjudication of the court case; and to recommend to state and local agencies methods of improving the system for protecting persons from domestic and sexual abuse. This includes recommending modifications to state laws, as well as state and local rules, policies, and procedures.

Membership. Membership of the Panel is established in state statute and is multidisciplinary, including representatives from the fields of medicine, law enforcement, mental health, health and human services, corrections, public safety, and law, as well as domestic violence and family crisis service providers. By statute, the panel's membership includes the Commissioner of Health and Human Services, the Commissioner of Corrections, the Commissioner of Public Safety, the Chief Medical Examiner, two Assistant Attorneys General and one judge appointed by the Chief Justice. In practice, some of the seats for high-level government officials are filled by department designees of those officials with relevant expertise. (See Table B.3 in Appendix B for a full list of membership categories.) For about the past 20 years, an Assistant Attorney General (who is also the Criminal Division Chief) has chaired the panel.

Operations. The panel operates out of the Office of the Attorney General, although this is not required by statute. The panel is supported by one, part-time, staff person. The MDAHRP meets monthly, generally for 10 months out of the year. At the meetings, the members review domestic abuse-related homicides cases that have been adjudicated to see what changes they could recommend that might have prevented the death. When the case under review includes the death of a child, the panel sometimes reviews cases in collaboration with the Child Death and Serious Injury Review Panel (CDSIRP) discussed above.

Data access and information sharing. The MDAHRP has access to the confidential information from the Attorney General's case files of a homicide after the case has been adjudicated. These case files may also include any confidential information from DHHS/OCFS, when such information has been provided to the Attorney General under court order.[24]

Reports and recommendations. MDAHRP's parent body, the Maine Commission on Domestic and Sexual Abuse, is required to submit a report on the panel's activities, conclusions and recommendations to the Legislature's Judiciary Committee by January 30th biennially (even numbered years). The biennial report includes recommendations, including specific recommended changes to practice by DHHS/OCFS as well as other parts of the broader system such as health care providers, Judicial Branch personnel and even the media.

IV. Best Practices

For this Information Brief, OPEGA conducted limited research on best practices related to CPS oversight. We did not identify best practices that apply generally to state systems of oversight of child

[24] 22 M.R.S.A. §4008(3)(B). This is known as a "Clifford Order".

protective services. However, OPEGA gathered available information on best practices that may be relevant to the work of the specific advisory oversight entities addressed in this Information Brief.

A. Ombudsman Offices

For best practices for ombudsman programs, OPEGA reviewed a National Conference of State Legislatures (NCSL) report on Children's Ombudsman Offices and Offices of Child Advocates.[25] The best practices cited in that report are from the United States Ombudsman Association (USOA). USOA standards include that an Ombudsman should:

(1) **Be independent** – free from outside control or influence;
(2) **Be impartial** – receive and review each complaint in an objective and fair manner, free from bias, and treat all parties without favor or prejudice;
(3) **Control confidentiality** – have the privilege and discretion to keep confidential or release any information related to a complaint or investigation[26]; and
(4) **Create a credible review process of complaints** – perform his or her responsibilities in a manner that engenders respect and confidence and be accessible to all potential complainants.

As shown in Table 4, elements of the Maine Children's Ombudsman program's design promote independence and impartiality. Its access to and uses of confidential information are specified in state statute. The program's statute also includes elements to help the credibility of its review process.

Table 4. Best Practices for Ombudsman Offices Overseeing Child Protection Services

Best Practice	Maine's practice
Independence	The ombudsman program is established in 22 MRSA §4087-A as an independent program within the Executive Branch. The Ombudsman operates by an annual contract with a non-profit organization. The Department of Administrative and Financial Services (DAFS) manages the contract rather than DHHS.
Impartiality	Pursuant to statute, the program must be operated by contract with an organization that the Executive Branch determines to be free of potential conflicts of interest. Statute restricts state-level partisan activities of the incumbent ombudsman by specifying: "The ombudsman may not be actively involved in state-level political party activities or publicly endorse, solicit funds for or make contributions to political parties on the state level or candidates for statewide elective office."
Confidentiality	Information held by, or records or case-specific reports maintained by, the program are confidential (22 MRSA §4087-A). Disclosure may be made as allowed or required in accordance with the provisions of §4008 which reflects a description regarding the information that can be disclosed, and limitations under which it might be made public.
Creation of a Credible Review Process for Complaints	Creating a credible review process entails providing personnel and systems that (a) engender respect and confidence and (b) are accessible to all potential complainants. • Staff qualifications: Statute prescribes that the program be staffed "by an attorney or a master's level social worker who must have experience in child development and advocacy, and support staff as determined to be necessary." • Accessibility to complainants: The Ombudsman employs a website to provide general information to the public and provides numerous options to make a

[25] Children's Ombudsman Offices | Office of the Child Advocate. National Conference of State Legislatures. https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx
[26] In the original USOA document, it is made clear that an ombudsman's discretion to release confidential information continues to be constrained by law.

Table 4. Best Practices for Ombudsman Offices Overseeing Child Protection Services	
Best Practice	**Maine's practice**
	complaint, including online forms, telephone, and email access. The Ombudsman states that the office spends about half of their time in communications with the public. The Ombudsman has also noted that resources often limit the ability to mediate between the Department and the individual complainant.

In Maine, the ombudsman program appears to have many of the elements that help to ensure its independence, impartiality, control of confidential information, and requirements that help ensure a credible review process. As noted on page 10, the duties of the Ombudsman program are extensive, and in interviews with OPEGA, the Ombudsman stated that they lack resources to be able to mediate individual complaints with the Department. Instead, the Ombudsman reviews specific cases and makes recommendations to the Department that may address a complainant's problem. The complainant's case may prompt an improvement, but it may occur in a time period that does not aid the initial caller.

B. Advisory Oversight Panels

The MCWAP, JCTF and CDSIRP, are examples of CAPTA citizen review panels (CRPs) which are featured in most U.S. states. Currently, 48 states plus D.C. and Puerto Rico receive a CAPTA grant and as a result are required to have citizen review panels.[27] Because of their ubiquity, much work is being conducted to provide information to states to help structure and improve the performance of these entities.

Based on interviews of stakeholders and public documents, OPEGA observes that the CAPTA panels in Maine are employing many of the best practices for structuring the citizen review panels as well as performing the panels' work. Table 5 is a comparison of Maine's CAPTA panel practices to published best practice guides.[28] While the Maine Domestic Abuse Homicide Review Panel (MDAHRP) is not a CAPTA panel, it is included here as it performs similar oversight activities in the State.

Table 5. Best Practices for Citizen Review Panels Overseeing Child Protection Services	
Best Practice	**Maine's practice**
CRPs should be given access to information	All of the CAPTA panels are provided information needed to perform their tasks. MCWAP and the JCTF include DHHS/OCFS personnel on their panels and they provide updates on the department's activities at each meeting. Panels receive statistical information from the department to examine data trends. MDAHRP obtains its confidential data from the case files of the Attorney General and CDSIRP receives confidential case information from DHHS/OCFS. CDSIRP includes panel members who have access to the department's case record database. The

[27] Children's Bureau, an Office of the Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/cb/grant-funding/child-abuse-prevention-and-treatment-act-capta-state-grants

[28] Jones, Blake (2015 & 2016). Tip sheets for CRPs 1-7. University of Kentucky School of Social Work under the auspices of the National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center (CANTASD). CANTASD is funded by the U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Child Abuse and Neglect.

Table 5. Best Practices for Citizen Review Panels Overseeing Child Protection Services	
Best Practice	**Maine's practice**
	timeliness of receiving information only after adjudication is a concern to some panel members.
CRPs should be consulted early in the policy development process	DHHS/OCFS has a structured policy development system which includes numerous stages in a policy's development. Members of CRPs and the Ombudsman are invited to participate in the policy development focus groups at the same time as the general population of departmental case workers. The policies are not final at this stage, however; it is one of the last levels of review and much of the policy is already structured.
CRPs should be given feedback about their recommendations.	DHHS/OCFS is required by CAPTA to respond to recommendations from CAPTA panels in writing within six months. These responses are usually written within the annual reports, describing intended actions to address the issue. Some panels are working to formalize requesting and receiving progress updates on recommendations.
CRPs should be provided staff and other logistical support.	DHHS currently provides a CAPTA Panel Coordinator for staff support to MCWAP and the CDSIRP. The Attorney General's Office provides a person to support MDAHRP – and the Judiciary, through the Court Improvement Program, provides staff support for the JCTF. Additionally, the CAPTA panels have developed a linked website with the support of the DHHS. Staff turnover was mentioned as an issue for at least two of the panels: the CDSIRP reported that 10 different individuals have filled the staff support role since 2008; and over the 20-year history of the MDAHRP, the longest tenure in the staff support role has been four years.
CRPs should be connected to the child welfare agency, but not controlled by it.	CRPs in Maine vary in their independence from the department but are all moving toward more independence. MDAHRP is statutorily quite independent and the JCTF's independence comes from its position as primarily an entity of the judiciary. MCWAP's recent history has been moving toward being more citizen-led, and the CDSIRP is creating by-laws to regulate its relationship with DHHS.
CRPs should formalize the relationship with the child welfare agency.	The trend to formalization is a continuing effort. Proponents of formalization interviewed by OPEGA believe institutionalizing processes helps to maintain CRP effectiveness over time, but does not replace the need for the collaboration between all the groups involved.
Members of CRPs should have diverse backgrounds.	Statute, by-laws and charters dictate the diverse types of occupations and stakeholders that must be represented but remain silent on additional members. MCWAP by-laws note as a CAPTA requirement that "MCWAP will be composed of volunteer members who are broadly representative of the community." OPEGA was informed of the concern for gender diversity of the MDAHRP which was estimated to be overwhelmingly female.
CRPs should ensure membership expectations and duration of service are clear.	Member attendance was stated to occasionally be an issue in our interviews of panel members. These are volunteer positions held by professionals with multiple responsibilities living in communities across the State. At times, panels have had an issue obtaining a quorum for voting. Several interviewees have stated that attendance has improved significantly with the advent of video-meetings.
CRPs should produce an annual report.	The MDAHRP is required by state statute to produce a biennial report. DHHS must submit a report on the activities of the CAPTA panels to the federal government to comply with CAPTA. The JCTF submits an annual report to the Supreme Judicial Court that has been used as one of these reports. In the past, the reports for MCWAP and the CDSIRP have at times been written by DHHS, but MCWAP has produced a completely citizen-led report since its 2020 report and the CDSIRP is completing a 5-year lookback and plans to submit annual reports starting the spring of 2022.
CRPs should connect with other groups of advocates and stakeholders.	Along with the recent improved coordination of the CAPTA panels, the panels continue to reach out to other stakeholders in Maine's child welfare system. The MDAHRP and CDSIRP have coordinated on certain homicide reviews in order to gain more perspectives as well as to more efficiently use the time of people they interview. MCWAP and JCTF continually hear from service providers, parents' groups, adoptive families' groups and others. JCTF partners with the judicial branch, DHHS, the Department of Corrections, the Department of Public Safety, and the Department of Education. The varied membership of the CRPs results in natural connections with other stakeholders.

As can be seen from the above examples, the citizen review panels overseeing child protection services in Maine are evolving in a direction that conform with the accepted best practices. Recent movements toward formalizing relationships, taking responsibility for reporting, and potentially formalizing updates of the Department's implementation of recommendations are increasing the independence and oversight potential of the CRPs.

V. Other State Approaches

A. Children's Ombudsman/Advocate

According to the NCSL, approximately 23 states, including Maine, have established a Children's Ombudsman or Office of the Child Advocate with duties and purposes specifically related to children's services. Another five states have a statewide Ombudsman program that addresses the concerns of all governmental agencies, including children's services. Nine states have related Ombudsman services, program-specific services, or county-run programs.[29]

OPEGA reviewed information regarding the structure and duties of child welfare ombudsman and child advocate offices in the New England states. All New England states, except Vermont, have either an office of the child ombudsman or an office of the child advocate.[30]

In all New England states, the ombudsman or children's advocate is described as an independent entity. The location of advocates and ombudsman offices within state government varies, but the offices are typically independent agencies or part of the executive branch. Maine is the only New England state that contracts the position.[31] Where qualifications are stated, ombudsman and child advocates in New England are typically required to be attorneys. The duties of these positions in New England are generally similar to those in Maine. Some offices include more services such as providing training to attorneys and guardians ad litem. Rhode Island's Child Advocate can also litigate against the state on behalf of a child. Many of the offices have subpoena power. Maine's ombudsman program does not have subpoena power, but does have statutorily guaranteed access to DHHS files, records and personnel. Table B.4 in Appendix B compares Children's Ombudsman and Advocate Offices for each of the New England states.

B. Overall approach to CPS Oversight

To complete this Information Brief, OPEGA also performed limited research to identify ways in which other states' approach CPS oversight. CAPTA panels are ubiquitous across the nation.

[29] Children's Ombudsman Offices | Office of the Child Advocate. National Conference of State Legislatures. https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx

[30] Vermont does not currently have an ombudsman or child advocate, but there is a bill before the Legislature to create an Office of the Child Advocate.

[31] According to NCSL data (see footnote 28), Maine is unique in the U.S. in contracting its ombudsman services.

Currently, 48 states, D.C. and Puerto Rico receive CAPTA funding.[32] Along with this form of citizen review, states employ other mechanisms for oversight of child protective services. Forms of oversight in some other states include full legislative committees and joint committees dedicated only to child welfare issues. Other state bodies of oversight OPEGA noted are independent advocates, standing commissions, legislative panels, and oversight boards. Alternate approaches that we identified are summarized in Table 6, below.

Table 6. Summary of Some Alternate Approaches to CPS Oversight in Other States

State	Entity	Description
Arizona	Joint Legislative Oversight Committee on the Department of Child Safety	Legislative committee established to review the implementation of policy and procedures, and program effectiveness of the department responsible for child safety. (This Committee is still authorized, but appears inactive.)
Kentucky	Child Welfare Oversight and Advisory Committee	Legislative committee that reviews, analyzes, and provides oversight on child welfare, including but not limited to foster care, adoption, and child abuse, neglect, and dependency.
Utah	Child Welfare Legislative Oversight Panel	Legislative panel established to oversee child protective services.
Vermont	Joint Legislative Child Protection Oversight Committee	Joint legislative committee established to oversee child protective services.
Nebraska	Office of Inspector General of Nebraska Child Welfare	Office that provides independent review of the actions of individuals and agencies responsible for the care and protection of children in the Nebraska Child Welfare and Juvenile Probation systems. The OIG is a subdivision of the Office of Public Counsel (Ombudsman's Office).
New Hampshire	Child Advocate Office	Office that provides independent and impartial oversight of the NH child welfare and juvenile justice systems to promote effective reforms that meet the best interests of children. Complaints about CPS must first be exhausted by all other avenues, including the DHHS Ombudsman, before coming to them.
Indiana	Commission on Improving the Status of Children in Indiana	Statewide commission including members from all three branches of government. It includes a number of committees and task forces, including a Child Health & Safety Task Force and a Child Services Oversight Committee.
Washington State	Department of Children, Youth & Families (DCYF) Oversight Board	Board established to monitor, and ensure, that DCYF achieves its stated outcomes, and to ensure that the Department complies with administrative acts, relevant statutes, rules, and policies pertaining to early learning, juvenile rehabilitation, juvenile justice, and children and family services.

[32] Children's Bureau, an Office of the Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/cb/grant-funding/child-abuse-prevention-and-treatment-act-capta-state-grants

VI. Conclusion

For this Information Brief, OPEGA reviewed five aspects of child protective services oversight in Maine: current oversight structure, roles and responsibilities, information sharing, best practices and models, and effectiveness of the oversight structure. The review focused on child protective services administered and delivered by the DHHS/OCFS, and examined the review and monitoring of those services conducted by the U.S. Department of Health and Human Services Administration for Children and Families in a regulatory role and five state-level entities in an advisory role. This Brief offers ten lessons and observations from the research along with detailed descriptions and a series of tables presenting contextual information.

OPEGA's review of child protective services will include two evaluation reports to be delivered to the Government Oversight Committee later this year. Protecting Child Safety – Initial Investigation and Assessment is slated for March 2022 and Protecting Child Safety – Reunification and Permanency is scheduled for completion in September 2022.

VII. 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 Information Brief to the Government Oversight Committee. OPEGA also thanks the Maine Children's Ombudsman and the representatives of the Maine Child Welfare Advisory Panel (MCWAP); the Justice for Children Task Force (JCTF); the Child Death and Serious Injury Review Panel (CDSIRP); and the Maine Domestic Abuse Homicide Review Panel (MDAHRP). Their assistance and review made this Information Brief possible.

Appendix A. Information Brief Methods

In light of the fact that this project was an Information Brief, and not an evaluation, OPEGA's work for this product did not include the evaluation of performance or outcomes, audit testing, data analysis, or other evaluative work. Instead, OPEGA's work included gathering, synthesizing and presenting descriptive, contextual information to build knowledge and understanding of the topic by the GOC and the Legislature.

Data sources included:

- Relevant state and federal statutes;
- Materials and testimony submitted to the GOC to date related to oversight of CPS;
- Legislator requests for review of CPS submitted to the GOC;
- Materials available on the websites of the entities included in this review and the website of DHHS/OCFS;
- Reports published by the state oversight entities (Ombudsman and citizen review panels);
- Report by the Casey Family Services in October 2021
- Federal Child and Family Services Review (CFSR) reports for each of the New England states;
- DHHS/OCFS's 2020-2024 Child and Family Services Plan (CFSP);
- DHHS/OCFS's FFY 2022 Annual Progress & Service Report (APSR);
- Published research and information on best practices for oversight of CPS generally or for citizen review panels and offices of ombudsman specifically;
- Interviews with the management of DHHS/OCFS;
- Interviews with the chairs of each of the five state advisory entities, or their designees;
- Interviews with U.S. DHHS, Administration for Children and Families, Children's Bureau representatives;
- Interviews with DHHS/OCFS Quality Assurance Program Manager; and
- Published information on alternate structures, or entities, that other states are currently using in their oversight of child protective services.

Appendix B. Tables

Table B.1. Child and Family Outcomes and Measured Items in the Child and Family Services Review (CFSR)
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.
Item 01: Timeliness of Initiating Investigations of Reports of Child Maltreatment.
Safety Outcome 1: Children are safely maintained in their homes whenever possible and appropriate.
Item 02: Services to Family to Protect Children in the Home and Prevent Removal or Re-Entry into Foster Care.
Item 03: Risk and Safety Assessment and Management.
Permanency Outcome 1: Children have permanency and stability in their living situations.
Item 04: Stability of Foster Care Placement
Item 05: Permanency Goal for Child
Item 06: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.
Item 07: Placement with Siblings
Item 08: Visiting with Parents and Siblings in Foster Care
Item 09: Preserving Connections
Item 10: Relative Placement
Item 11: Relationship of Child in Care with Parents
Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.
Item 12: Needs and Services of Child, Parents, and Foster Parents Item 12a: Needs Assessment and Services to Children Item 12b: Needs Assessment and Services to Parents
Item 13: Child and Family Involvement in Case Planning
Item 14: Caseworker Visits with Child
Item 15: Caseworker Visits with Parents
Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.
Item 16: Educational Needs of the Child
Wellbeing Outcome 3: Children receive adequate services to meet their physical and mental health needs.
Item 17: Physical Health of the Child
Item 18: Mental/Behavioral Health of the Child
Source: Child and Family Service Reviews: Maine Final Report 2017

Table B.2. Seven Systemic Factors and Measured Items that Affect Outcomes for Children and Families Assessed in the CFSR
Statewide Information System
Item 19: Statewide Information System has certain required functionality.
Case Review System
Item 20: Written Case Plan for each Child.
Item 21: Timely Periodic Review for Child.
Item 22: Timely Permanency Hearing for Children.
Item 23: Termination of Parental Rights occurs in accordance with required provisions.
Item 24: Foster Parents, Pre-adoptive Parents, and Relative Caregivers are notified of any review or hearing held with respect to the child.
Quality Assurance System
Item 25: Quality Assurance System includes certain characteristics
Staff and Provider Training
Item 26: Initial Staff Training
Item 27: Ongoing Staff Training
Item 28: Foster and Adoptive Parent Training
Service Array and Resource Development
Item 29: Array of Services
Item 30: Individualizing Services
Agency Responsiveness to the Community
Item 31: State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR
Item 32: Coordination of CFSP Services with Other Federal Programs
Foster and Adoptive Parent Licensing, Recruitment, and Retention
Item 33: Standards Applied Equally
Item 34: Requirements for Criminal Background Checks
Item 35: Diligent Recruitment of Foster and Adoptive Homes
Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements
Source: Child and Family Service Reviews: Maine Final Report 2017

Table B.3. Membership of Maine's Child Welfare Citizen Review Panels	
Oversight Entity	**Membership either required by statute, charter or by-laws**
Maine Child Welfare Advisory Panel	Chair: Until recently the panel was co-chaired by a citizen chair and a non-voting chair representing the State's child protective service agency. The panel is moving toward two citizen co-chairs. Required members: • Individuals representing law enforcement (currently recruiting for this category) • Judges & attorneys involved in criminal or civil court proceedings related to child abuse and neglect • Child advocates: attorneys for children, Court-appointed special advocates • Health and mental health professionals • Individuals representing child protective services agencies • Individuals experienced in working with children with disabilities • Parents who have been involved with the child welfare system • Representatives of parents' groups • Representatives from at least one of the following: foster, adoptive, or kinship families • Youth survivors of child abuse or neglect who are over 18 years of age • Tribal representatives • Individuals representing early childhood development and school systems • Individuals representing substance use treatment and recovery • Individuals representing domestic violence services • Individuals representing sexual assault services • Legislators • Clergy • Individuals experienced in working with homeless children and youth
Justice for Children Task Force	Chair: The chair is the Chief Justice of the Maine Supreme Judicial Court Required members: • Child advocates: attorneys for children, guardians ad litem, court-appointed special advocates • Parents or their advocates: representatives from parents' groups, parents' lawyers or advocates • Judges & attorneys involved in criminal or civil court proceedings related to child abuse and neglect • Individuals representing law enforcement • Health and mental health professionals • Individuals representing child protective services agencies • Individuals experienced in working with children with disabilities • Tribal representatives • Adults who were victims of child abuse or neglect • Individuals experienced in working with homeless children and youth • Other members appointed by the Chief Justice at her discretion
Child Death and Serious Injury Review	Chair: The chair is selected by the group from its membership. Required members: • Chief Medical Examiner • A pediatrician • A public health nurse • Forensic and community mental health clinicians • Law enforcement officers • Departmental child welfare staff • District attorneys

Table B.3. Membership of Maine's Child Welfare Citizen Review Panels	
Oversight Entity	**Membership either required by statute, charter or by-laws**
	• Criminal or civil assistant attorneys general
Maine Domestic Abuse Homicide Review Panel	Chair: The chair of the panel has been the same appointee by the Attorney General's Office for most of the life of the panel. Required members: • Chief Medical Examiner • A physician • A nurse • A law enforcement officer • The Commissioner of Health and Human Services • The Commissioner of Corrections • The Commissioner of Public Safety • A judge as assigned by the Chief Justice of the Supreme Judicial Court • A representative of the Maine Prosecutors Association • An Assistant Attorney General responsible for the prosecution of homicide cases • An Assistant Attorney General handling child protection cases • A victim – witness advocate • A mental health service provider • A facilitator of a certified domestic violence intervention program under §4014 • 3 persons designated by a statewide coalition for family crisis services

Table B.4. State Children's Ombudsman/Advocate Offices in New England				
State	**Office**	**Jurisdiction & Location Within Government**	**Appointment & Qualification**	**Duties & Powers of the Ombudsman / Child Advocate**
CONNECTICUT Conn. Gen. Stat. § 46a-13k	Connecticut Office of the Child Advocate	The Child Advocate shall act independently of any state department. The Office of the Child Advocate is located within the Office of Governmental Accountability.	The Child Advocate is appointed by the Governor with Approval by the General Assembly to serve a four-year term and may be reappointed.	The Child Advocate receives and investigates complaints; periodically reviews institutions; recommends policy changes; provides training to attorneys and guardians ad litem; has access to confidential information; issues subpoenas; maintains confidentiality; maintains a child fatality review panel; represents a child in court; produces annual and public reports.
MAINE Me. Rev. Stat. 22 MRSA § 4087-A	Maine Child Welfare Services Ombudsman	The Ombudsman is established as an independent program within the Executive Branch, and contracted to a non-profit organization to oversee the Office of Child and Family Services.	Contract to a nonprofit organization by the Governor. The Ombudsman may not be actively involved in state politics and must be an attorney or master's level social worker with experience in child development and advocacy.	The Ombudsman receives and investigates complaints; provides public outreach; has access to persons, files, and records, does not have the power to subpoena; maintains confidentiality; provides recommendations to the child welfare agency as well as annual and public reports.
MASSACHUSETTS Mass Gen. Laws ch. 18 § 1-13	Massachusetts Office of the Child Advocate	The Child Advocate is an independent office within the Executive Branch with the jurisdiction to oversee children served by the child welfare or juvenile justice systems.	The Child Advocate is appointed by the Governor and a nominating committee and serves a term coterminous with that of the governor.	The Child Advocate investigates critical incidents; receives and investigates complaints; reviews and makes recommendations for system-wide changes; educates the public; has access to facilities and records; has the power to subpoena;

Table B.4. State Children's Ombudsman/Advocate Offices in New England				
State	**Office**	**Jurisdiction & Location Within Government**	**Appointment & Qualification**	**Duties & Powers of the Ombudsman / Child Advocate**
				provides annual and public reports.
NEW HAMPSHIRE Section 170-G:18	New Hampshire Office of the Child Advocate	The Office of the Child Advocate shall be an independent agency, administratively attached to the department of administrative services pursuant to RSA 21-G:10	The office shall be under the supervision of an unclassified director of the office of the child advocate. The director shall possess a professional graduate degree in law, social work, public health, or a related field and be qualified by reason of education, experience, and expertise to perform the duties of the office.	The Office of the Child Advocate provides independent oversight of the division for children, youth, and families to assure that the best interests of children are being protected.
RHODE ISLAND R.I. Gen. Laws § 42-73-1 et seq.	Rhode Island Office of the Child Advocate	The Office of the Child Advocate (OCA) is an independent and autonomous state agency responsible for protecting the legal rights and interests of children in state care.	The Child Advocate is appointed by the Governor, with the advice and consent of the Senate. The Advocate shall have a term of five years. The Child Advocate shall be a member of the Rhode Island Bar for at least three years and must be qualified by training and experience to perform the duties of the office.	The Child Advocate provides an annual report to the Governor and Legislature; insures all children in the child welfare system are appraised of their rights; reviews procedures; reviews complaints; provides training; has access to confidential information; has the power to subpoena; commences civil action against the state on behalf of a child; maintains confidentiality.
VERMONT*	***Proposed –*** Office of the Child Advocate	***Proposed –*** The Office shall act independently of any State agency in the performance of its duties.	***Proposed*** – The Oversight Commission on Children, Youths, and Families established pursuant to section 3210 of this chapter shall recommend qualified applicants for the position of the Child, Youth, and Family Advocate to the Governor for consideration. Subject to confirmation by the Senate, the Governor shall appoint an Advocate from among those applicants	***Proposed*** – The Office of the Child Advocate shall: (1) collect and analyze data regarding the well-being of children in Vermont; (2) identify systemic shortcomings in Vermont's justice-involved youth and child welfare systems; and (3) make recommendations to the General Assembly regarding any

Table B.4. State Children's Ombudsman/Advocate Offices in New England				
State	**Office**	**Jurisdiction & Location Within Government**	**Appointment & Qualification**	**Duties & Powers of the Ombudsman / Child Advocate**
			recommended by the Oversight Commission for a term of four years.	necessary reforms to better serve Vermont children and youths.
(Primary Source: Children's Ombudsman Offices / Office of the Child Advocate. National Conference of State Legislatures. https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx)				
** Information on Vermont's proposed Office of the Child Advocate is taken from the Vermont Legislature's H-0265 which was passed by the Vermont House and was referred to the Committee on Health and Welfare of the Vermont Senate on 01/04/2022 as per Temporary Senate Rule 44A.*				

Appendix C. Recommendations from Oversight Entities

The Ombudsman and most of the state-level oversight panels make recommendations to improve the delivery of services by DHHS/OCFS, and often the broader child welfare system. These recommendations are often communicated in published reports, some of which are directly reported to the Legislature. However, some of these advisory oversight entities make confidential recommendations directly to OCFS that are not publicly accessible due to the confidential nature of the information on which they are based. Any recommendations made to DHHS/OCFS by these advisory entities are strictly advisory and the agency is not obligated to implement them.

Table C.1. Public Reports from Maine's Oversight Entities

Oversight Entity	Confidential case-specific recommend-ations to DHHS/OCFS?	Published (aggregate) recommend-ations	Published reports & frequency	Reports submitted to:
Maine Children's Ombudsman	Yes	Yes	Annual Reports	Governor, Legislature and DHHS.
Maine Child Welfare Advisory Panel	No	Yes	Annual Reports	Health and Human Services Committee through DHHS/OCFS
Justice for Children Task Force	No	No*	Annual Reports	Maine's Supreme Judicial Court
Child Death and Serious Injury Review	Yes	Yes	Periodic Reports	DHHS
Maine Domestic Abuse Homicide Review Panel	Yes	Yes	Biennial Reports	Judiciary Committee

*JCTF provides feedback to the Executive Branch, but not formal recommendations.

OPEGA reviewed the two most recent published reports of each of the five advisory entities for this Information Brief. We found that the recommendations reported publicly by the Ombudsman and the four panels vary widely in number, content and specificity. Some of these entities don't include anything termed "recommendations" while others include a large number of recommendations, including many not directly linked to DHHS/OCFS. Some recommendations outline very specific desired changes to processes or procedures, whereas others describe a general area of difficulty that needs to be addressed. For a summary list of published recommendations (or findings that appear to recommend an action) we reviewed, see Table C.2 (below).

None of the five entities have a formal process for tracking whether, and how, OCFS implements the recommendations made. OCFS management reports that they provide responses directly on recommendations made by the Ombudsman and the MCWAP, JCTF, and CDSIRP (the three CAPTA panels). The OCFS responses are often in writing but may also include additional discussion during meetings of the panels. The Maine Child Welfare Advisory Panel and Ombudsman's Office have historically printed an OCFS response to recommendations within their annual reports in the past. Going forward, the Ombudsman reported that they will discontinue that practice, citing that it has created timing issues and that keeping OCFS's response separate from the

Ombudsman's report should make it cleaner for both parties to communicate their sometimes-differing perspectives.

Table C.2. Summary of Recently Recommended Changes Specific to OCFS Child Protective Services	
Description of Recommended Change	**Data Year**
Ombudsman's Office (Source: Annual Reports)	
More staff training and support, particularly training of casework supervisors	2020
Recognize risk when evidence is clear, complete basic investigation practices, thoroughly investigate caregivers' histories, make and monitor safety plans, ensure children have legal protection	2020
Avoid arriving at the end of a case, or other crucial decision-making points, without enough information to make an informed decision	2020
Ensure consistently accurate determinations about the safety of children at the outset of child welfare involvement	2019
Ensure sufficient data is collected (particularly via contact with parents and collaterals), and used, to support key decisions	2019
Recognize truancy as a sign of risk to a child, as educational neglect rarely exists in isolation	2019
Maine Child Welfare Advisory Panel (Source: Annual Reports)	
Improve the Department's ability to effectively engage the fathers of children involved with OCFS	2020
Strengthen current training and professional development for caseworkers and supervisors in areas of communication and engagement with caregivers	2020
Continue exploring options to meet 24-hour response timelines, which may include more staff, different staff structures, and appropriate supervision and support	2019
Prioritize and implement the recommendations of the PCG and OPEGA assessments	2019
Continue to collaborate with Maine Courts to increase timeliness of court cases	2019
Create opportunities for relationship building between law enforcement, district staff, and forensic medical experts at the local level	2019
Increase the child welfare workforce knowledge base regarding children and adults with disabilities	2019
Justice for Children Task Force (Source: Annual Reports)	
Provided feedback to DHHS/OCFS to revise content and form of reunification plans to more clearly present a roadmap for parents to follow to regain custody of their children	2020 & 2019
Child Death and Serious Injury Review Panel (Source: 2014-2016 Report)	
Improve the health and wellbeing of substance exposed newborns	2014 -2016
Create a public education program regarding indicators, in children under six months, of abuse and neglect that should be reported; support strengthening mandated reporter laws	2014 -2016
Maine Domestic Abuse Homicide Review Panel (Source: Biennial Reports)	
Implement strategies to address training needs, caseload challenges, and adequate supervision for CPS staff to ensure that reports of suspected child abuse and neglect are thoroughly investigated, and appropriate and effective interventions can be implemented	2014 - 2019
Sustain the Child Protective Liaison collaboration between OCFS and Maine Coalition to End Domestic Violence	2014 -2019

Table C.2. Summary of Recently Recommended Changes Specific to OCFS Child Protective Services	
Description of Recommended Change	**Data Year**
Immediately identify a plan for the safest and appropriate placement and services for surviving children in cases when a child loses a parent(s) and/or sibling(s) to homicide or homicide-suicide, and especially if children have witnessed a homicide or discovered the body.	2014 - 2019
Develop and update training for all legally mandated reporters, as laws change and vigilance declines	2014 - 2019
Review OCFS intake processes and identify additional training for intake workers on identification and documentation of high-risk offenders who use specific tactics	2012 - 2016
Interview all household members during an investigation, and consider interviewing neighbors that may have had an opportunity to observe the family, to gather pertinent information to support safety planning and to document facts and circumstances that may not otherwise present themselves	2012 – 2016
Provide ongoing training regarding mandated reporting to all agencies providing direct care or other services to children, such as law enforcement, healthcare providers, domestic violence resources center staff, and other community services	2012 – 2016

Appendix D. Bills Before the 2nd Regular Session of the 130th Legislature Related to Child Protective Services Oversight

Table D.1. Bills Before the 2nd Regular Session of the 103th Legislature Related to Child Protective Services Oversight

LD #	Title	Sponsor	Committee	Summary
1755	An Act To Enhance the Child Welfare Ombudsman Program	Senator Curry	HHS	This bill makes numerous changes to the laws governing the ombudsman program that provides ombudsman services to the children and families of the State regarding child welfare services provided by the Department of Health and Human Services. For all changes, refer to full bill summary: http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0615&item=1&snum=130
1812	An Act To Strengthen the Child Welfare Services Ombudsman Program by Providing for Increased Staffing	Senator Diamond	HHS	This bill provides ongoing funding for two additional associate ombudsman positions and one administrative assistant position for the child welfare services ombudsman program in the Executive Department.
1824	An Act To Improve the Maine Child Welfare Services Ombudsman Program by Providing Additional Resources	Representative Stover	HHS	This bill is a concept draft. This bill, as emergency legislation, proposes to enact measures to provide additional resources to the office of the child welfare services ombudsman to enhance the capacity of that office to improve child welfare practices through both the review of individual cases and the provision of information on the rights and responsibilities of families, service providers and other participants in the child welfare system.
1825	An Act To Establish Limits on the Number of Hours Worked by and Workloads of Child Protective Services Caseworkers in the Department of Health and Human Services	Representative Madigan	HHS	This bill requires that the Department of Health and Human Services ensure that a caseworker in the Office of Child and Family Services does not work or drive more than a maximum number of hours in a certain period. It repeals Resolve 2019, c.34, which required DHHS to develop a standard case load recommendation and instead requires that DHHS establish a maximum workload for caseworkers. It requires DHHS to report to the HHS Committee and the child welfare ombudsman whenever a caseworker's workload exceeds the maximum workload. It also requires DHHS to report annually to the HHS Committee on the staffing, case load and workload assignments of caseworkers by county and district office.

Table D.1. Bills Before the 2nd Regular Session of the 103th Legislature Related to Child Protective Services Oversight				
LD #	**Title**	**Sponsor**	**Committee**	**Summary**
1834	An Act To Establish Ongoing Monitoring of Maine's Child Protective Services	Senator Diamond	HHS	This bill requires the Government Oversight Committee to create a system designed to monitor, on an ongoing basis, the DHHS, Office of Child and Family Services regarding the effectiveness of the office in protecting the safety of children in state care. The committee may create a working group that has the purposes of monitoring the policies and practices used by the office to maintain the safety of children in state care, reporting to the committee on a quarterly basis and providing an annual report to the committee and the Legislature.
1850	An Act To Ensure the Continuation of Services to Maine Children and Families through the Alternative Response Program	Representative Hymanson	HHS	This bill provides ongoing funding for the Department of Health and Human Services to continue the alternative response program services contract
1853	An Act To Support Improvements in Child Protective Services	Senator Claxton	HHS	This bill is a concept draft. This bill proposes to enact measures to support improvements in child protective services.
1857	An Act To Prioritize the Prosecution of Child Murder Cases	Senator Diamond	JUD	This bill requires the Attorney General to prioritize the investigation and prosecution of cases involving the murder of a child and to request the judicial branch to give priority in scheduling to those cases.