

DHHS Office of Child and Family Services

Protocol For Assisting Children At Risk

INTRODUCTION/PURPOSE

The Office of Child and Family Services (OCFS) is committed to working collaboratively to best meet the needs of children in Maine. We recognize that there are times when the duties and responsibilities of the various divisions of OCFS will overlap. This protocol is specifically designed to assist the Children's Behavioral Health Service (CBHS) Division and the Child Welfare Service (CWS) Division in planning for such times.

****Please note that this protocol does not negate mandatory reporting of suspected child abuse or neglect by anyone involved with the child and/or family.**

This protocol MUST be used if either of the two following situations is occurring:

1. All of the following must apply:
 - Abuse and/or neglect is suspected or there is an open case with Child Welfare or the child is in state's custody **and**
 - A child is having significant behaviors related to his/her mental health and/or behaviors related to family system challenges **and**
 - Current providers are unable to move forward in addressing the present concerns after documented attempts to engage the family in moving past the barriers.

Examples – 1.) A child open to Child Welfare who also has significant behaviors that have been unable to be decreased even after planning sessions and attempts to decrease these behaviors with the current providers. 2.) A community case manager involved with a child having significant behaviors and there is concern that family system challenges are so severe that child's behaviors will not resolve unless family system changes are made, and there have already been attempts by current providers to address family concerns without success. 3.) A child's family is refusing/unable to participate in treatment with their child.

2. A child is in Intensive Temporary Residential Treatment (ITRT) **and**:
 - Barriers to discharge exist that stem from safety concerns within the family or there is disagreement around discharge criteria **and**
 - Documented attempts have been made to move past the barriers and have been unsuccessful **and**
 - There is clear documentation that the family has been made aware that if the child can't come home it is their responsibility to find a safe alternative for their child and the family has not done this, or if safety issues exist in the home the caregivers have decided to return the child to **and**

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- At least **one** of the following must **also** apply:
 - i. History of prior CWS involvement resulting in the removal of a child.
 - ii. Caregiver's own need(s) is primary barrier to reunification, including homelessness or inadequate housing, caregiver mental health symptoms, medical illness of caregiver and other identified unmet needs.
 - iii. There is documented concern for the safety of the caregiver, other children in the home and/or members of the community should the child return home.
 - iv. There is documented concern for the safety of the child should (s)he return home.
 - v. The family's progress is not commensurate with the child's progress.
 - vi. Caregiver is participating but openly expresses that the child can not return to their home.

Examples- 1.) A child's family is unable/unwilling to participate in treatment with their child. 2.) A child's family is not following treatment recommendations in a manner that is detrimental to the child's progress as determined by the child's treatment team. 3.) A discharge date is set by the facility or by APS Healthcare and the parents are unable/unwilling to take the child home. 4.) Caregiver is openly expressing a desire not to take the child home once treatment is completed.

Guidelines to follow when implementing this protocol:

- Releases of information may need to be signed by the legal guardian(s) if protected information will be shared.
- Meetings should be scheduled when and where it is most convenient to the family, whenever possible.
- We recognize that this process may be very threatening to families. If the decision is made to have a joint meeting with the family, it is suggested that the individual responsible for approaching this with the family bear that in mind. The following wording is suggested: "We have been working together and things are not moving forward as much as we would all hope. Every member of this team wants what is best for this child. Right now, I think we should include another division of OCFS (CWS or CBHS) to see if we can come up with some other ideas and some other resources to help us in this. We hope that you as her/his parents will be involved and help lead this team, but we feel it is important enough that we will meet together regardless."

**If this is a situation where child welfare is not open, it is important to stress to the family that when child welfare comes to a meeting they will be there as another resource and not as an open case.

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- A trauma-informed approach MUST be utilized throughout this process. Key points to this approach that need to be remembered are 1.) Meetings/plans need to be family driven; 2.) Meetings and plans need to be youth guided; 3.) All aspects of the process need to be culturally and linguistically appropriate; 4.) Physical and emotional safety are ensured throughout the process; 5.) Youth and Family Empowerment, Choice and Control are emphasized throughout the process; 6.) All providers involved need to be supported in being trauma competent; 7.) Trustworthiness needs to be maintained throughout the process. **Please contact the Thrive Initiative with any questions pertaining to the trauma-informed approach (207)782-5783.
- A CPS referral may be appropriate during this protocol process and should be made when specified in the outlined steps of this protocol. Maine State Statute states that this would be appropriate at these times most likely related to:
Title 22, Chapter 1071
§ 4002 Definitions:
 1. Abuse or neglect. "Abuse or neglect." "Abuse or neglect" means a threat to a child' health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these.
 - 1-A. Abandonment. "Abandonment" means any conduct on the part of the parent showing an intent to forego parental duties or relinquish parental claims. The intent may be evidenced by:
 - A. Failure, for a period of at least 6 months, to communicate meaningfully with the child;
 - B. Failure, for a period of at least 6 months, to maintain regular visitation with the child;
 - C. Failure to participate in any plan or program designed to reunite the parent with the child;
 - D. Deserting the child without affording means of identifying the child and his parent or custodian;
 - E. Failure to respond to notice of child protective proceedings; or
 - F. Any other conduct indicating an intent to forego parental duties or relinquish parental claims.
- If at anytime during this outlined process, there is disagreement between the two divisions (Child Welfare and Children's Behavioral Health) that cannot be resolved, the Program Administrator from Child Welfare, the Team Leader from Children's Behavioral Health Services, and the OCFS Medical Director will be asked to assist. If it can not be resolved at this point, OCFS Central Office will be requested to intervene. This needs to take place in a timely manner so that the needs of the child are met as soon as possible.

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- The respective divisions will properly document when this protocol is used (please see further in this document how to do this).
- This protocol will move forward, even if there is disagreement (by APS, caregiver, CBHS, CW, treatment provider) as to whether or not a child meets level of care for treatment, when there appears to be barriers to permanency planning for a child.

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PROTOCOL

Criteria I

All of the following must apply:

- Abuse and/or neglect is suspected or there is an open case with Child Welfare or the child is in state's custody **and**
- Significant behaviors occurring related to his/her mental health and/or behaviors related to family system challenges **and**
- Current providers are unable to move forward in addressing the present concerns after documented attempts to engage the family in moving past the barriers.

Examples – 1.) A child open to Child Welfare who also has significant behaviors that have been unable to be decreased even after planning sessions and attempts to decrease with the current providers. 2.) A community case manager involved with a child having significant behaviors and there is concern that family system challenges are so severe that child's behaviors will not resolve unless family system changes are made, and there have already been attempts by current providers to address family concerns without success. 3.) A child's family is refusing to participate in treatment with their child.

Process if child may meet above Criteria I

- 1.) The CWS caseworker or CBHS community case manager will contact the Mental Health Program Coordinator (MHPC) who will discuss the situation and they will determine together if more intensive collaboration is warranted. The MHPC may decide to have a meeting with the family team prior to initiating a combined process (i.e. meeting/planning with Child Welfare and Children's Behavioral Health Services together).
- 2.) If the MHPC determines that more intensive collaboration between CWS and CBHS is warranted, a meeting will be convened. CWS will be represented by a supervisor or higher level. CBHS will be represented by the MHPC, Utilization Review (UR) specialist and/or Team Leader.
- 3.) If it is determined that a meeting with both Child Welfare and Children's Behavioral Health is appropriate:
 - A. The initiating division will convene a meeting within 2 weeks of determining that this meeting needs to take place. The purpose of this meeting is to explore the strengths and challenges of the child and family with the intent of creating a plan to address the current barriers. At the conclusion of this

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meeting a plan will be developed outlining actions steps that will be implemented to best meet the needs of the child. Team members will include the family, representatives from CBHS and CWS, community providers involved with the family, and natural supports the family has identified.

B. Prior to the scheduled meeting, the lead division will contact the other division to have a conversation regarding the current status of the case and identify what information is necessary so that the other division is able to be an active participant in the meeting. Information that may be important to discuss:

- Identifying Information (name, DOB, address, current provider)
- History of OCFS involvement (if any)
- Current strengths and challenges, family history, diagnosis
- Current and past treatments (psychological, medical and hospital)
- School information and psychological testing
- Current Living Situation (legal guardian/caretaker)
- Past and Present history of violence, risk assessment
- Documentation of Lack of Family Involvement
- Documentation of efforts to support parental involvement and efforts to reduce any barriers to involvement.

The lead division will also request documentation from providers of family participation in treatment as well as attempts to engage the family in treatment prior to the scheduled meeting.

*** Written information shall be made available to all parties prior to the meeting, whenever possible.

C. The meeting shall be organized in the following manner:

- The lead division will identify the purpose of the meeting and the agenda (this must include all possible outcomes of this meeting such as “the intention is that a plan will be developed and a follow up meeting will occur,” “the caregiver finds safe alternatives without the assistance of this team but in a timely manner,” or “no plan is created and a CPS report will be made”).
- Introductions will include explanations of each team member’s role
- The family story will be told by the family with input from others at the table as appropriate.
- Summary of past and present services, highlighting successes, strengths and challenges.
- Barrier Identification
- A concrete plan will be created to overcome barriers and will include action steps, who will be the lead in getting each action step completed, and target dates that each step will be completed by.
- A follow up meeting will be scheduled before the conclusion of the initial meeting and all other subsequent meetings. Follow up meetings will be utilized to monitor progress on the action steps.

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- The meeting is clearly documented and all parties receive written notes of the meeting within 1 week of the meeting (it should be documented simply that this process is occurring in the APS Healthcare Care Connection computer system as well).

4.) In the event that no plan can be created at this initial meeting or that the caregiver refuses to have a joint meeting, a Child Protective Services (CPS) report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

5.) If 3 months has passed since the initial meeting and it is determined that progress is not being made a CPS report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is disagreement at this point between the CBHS participant and CW participant about progress made or not made, the District Program Administrator, Team Leader and OCFS Medical Director will be asked to review the case and determine next steps.

If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

6.) If a CPS report is made and Child Welfare opens a case, a CPS assessment will occur as mandated in current practice/law. Once the CPS assessment is completed, all parties involved in this process will be notified of the outcome. If the child goes into state's custody, all parties involved will continue to be involved as needed in future planning for this child until it is agreed otherwise.

If the child does not go into state's custody, the team will continue to meet (including child welfare) for planning purposes and the meeting format decided for use in this protocol should continue to be used. The District Program Administrator, Team Leader and OCFS Medical Director must be made aware of this situation so that they can be part of determining next steps.

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Criteria II

A child is in Intensive Temporary Residential Treatment (ITRT) **and**:

- Barriers to discharge exist that stem from parental refusal to take the child home or there are concerns for the parent's ability to meet the needs of the child **and**
- Documented attempts have been made to move past the barriers and have been unsuccessful **and**
- There is clear documentation that the family has been made aware that if the child can't come home it is their responsibility to find a safe alternative for their child and the family has not done this, or if safety issues exist in the home the parents have decided to return the child to **and**
- At least **one** of the following must also apply:
 - a. History of prior CWS involvement resulting in the removal of a child.
 - b. Caregiver's own need(s) is primary barrier to reunification, including homelessness or inadequate housing, caregiver mental health symptoms, medical illness of caregiver and other identified unmet needs.
 - c. There is documented concern for the safety of the caregiver, other children in the home and/or members of the community should the child return home.
 - d. There is documented concern for the safety of the child should (s)he return home.
 - e. The family's progress is not commensurate with the child's progress.
 - f. Caregiver is participating but openly expressed that the child can not return to their home.

Examples- 1.) A child's family is unable/unwilling to participate in treatment with their child.
2.) A child's family is not following treatment recommendations in a manner that is detrimental to the child's progress as determined by the child's treatment team. 3.) A discharge date is set by the facility or by APS Healthcare and the parents are unable/unwilling to take the child home. 4.) Caregiver is openly expressing a desire not to take the child home once treatment is completed.

Process if child may meet above Criteria II

1.)The community case manager, CWS caseworker and/or ITRT provider will contact the CBHS MHPC or UR Specialist to discuss the situation and determine together if more intensive collaboration is warranted. The

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MHPC/UR Specialist may decide to have a meeting with the family team prior to initiating a combined process (i.e. meeting/planning with Child Welfare and Children's Behavioral Health Services together).

- 2.) If the MHPC or Utilization Review Specialist determines that more intensive collaboration between CWS and CBHS is warranted, a meeting will be convened. CWS will be represented by a supervisor or higher level. CBHS will be represented by the MHPC, UR specialist and/or Team Leader.
- 3.) If it is determined that a meeting with both Child Welfare and Children's Behavioral Health is appropriate:
 - a. The initiating division will convene a meeting within 2 weeks of determining that this meeting needs to take place. The purpose of this meeting is to explore the strengths and challenges of the child and family with the intent of creating a plan to address the current barriers. At the conclusion of this meeting a plan will be developed outlining actions steps that will be implemented to best meet the needs of the child. Team members will include the family, representatives from CBHS and CWS, community providers involved with the family, and natural supports the family has identified.
 - b. Prior to the scheduled meeting, the lead division will contact the other division to have a conversation regarding the current status of the case and identify what information is necessary so that the other division is able to be an active participant in the meeting.

Information that may be important to discuss:

 - Identifying Information (name, DOB, address, current provider)
 - History of OCFS involvement (if any)
 - Current strengths and challenges, family history, diagnosis
 - Current and past treatments (psychological, medical and hospital)
 - School information and psychological testing
 - Current Living Situation (legal guardian/caretaker)
 - Past and Present history of violence, risk assessment
 - Documentation of Lack of Family Involvement
 - Documentation of efforts to support parental involvement and efforts to reduce any barriers to involvement.

The lead division will also request documentation from providers of family participation in treatment as well as attempts to engage the family in treatment prior to the scheduled meeting.

*** Written information shall be made available to all parties prior to the meeting, whenever possible.

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- c. The meeting shall be organized in the following manner:
- The lead division will identify the purpose of the meeting and the agenda (this must include all possible outcomes of this meeting such as “the intention is that a plan will be developed and a follow up meeting will occur,” “the caregiver finds safe alternatives without the assistance of this team but in a timely manner,” or “no plan is created and a CPS report will be made”).
 - Introductions will include explanations of each team member’s role
 - The family story will be told by the family with input from others at the table as appropriate.
 - Summary of past and present services, highlighting successes, strengths and challenges.
 - Barrier Identification
 - A concrete plan will be created to overcome barriers and will include action steps, who will be the lead in getting each action step completed, and target dates that each step will be completed by.
 - A follow up meeting will be scheduled before the conclusion of the initial meeting and all other subsequent meetings. Follow up meetings will be utilized to monitor progress on the action steps.
 - The meeting is clearly documented and all parties receive written notes of the meeting within 1 week of the meeting (it should be documented simply that this process is occurring in the APS Healthcare Care Connection computer system as well).

4.)In the event that no plan can be created at this initial meeting or that the caregiver refuses to have a joint meeting, a Child Protective Services (CPS) report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

5.)If 3 months has passed since the initial meeting and it is determined that progress is not being made a CPS report will be made. This will be done within the district with the Child Welfare participant entering the report into MACWIS with the CBHS participant assisting. No CPS reports will go through central intake if they are generated through this process.

If there is disagreement at this point between the CBHS participant and CW participant about progress made or not made, the District Program Administrator, Team Leader and OCFS Medical Director will be asked to review the case and determine next steps.

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If there is already an open case with Child Welfare, the Child Welfare caseworker and supervisor will take the lead in determining next steps with consultation from CBHS.

6.) If a CPS report is made and Child Welfare opens a case, a CPS assessment will occur as mandated in current practice/law. Once the CPS assessment is completed, all parties involved in this process will be notified of the outcome. If the child goes into state's custody, all parties involved will continue to be involved as needed in future planning for this child until it is agreed otherwise.

If the child does not go into state's custody, the team will continue to meet (including child welfare) for planning purposes and the meeting format decided for use in this protocol should continue to be used. The District Program Administrator, Team Leader and OCFS Medical Director must be made aware of this situation so that they can be part of determining next steps.

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DOCUMENTATION OF THIS PROCESS

- Each division will keep documentation of their participation in their division's respective formats as required by their individual division.
- Each district will be required to have a district log that keeps track of all OCFS protocols that have taken place. The lead division in each case will be responsible for making sure that the correct information is entered into the district log in a timely manner (See attached documentation format for district logs).

ONGOING MONITORING/EVALAUTION

- The district logs from all 8 districts will be reviewed at a minimum of every 6 months by the OCFS Protocol for Assisting Children at Risk Review Team. It will be determined at these reviews what steps need to be taken to ensure that the protocol is being used appropriately and that it is effective in meeting the needs of children. These reviews may also include talking with key players within the districts to assess the protocols' effectiveness. Further training of staff and/or editing the protocol may or may not need to happen as a result of these reviews.