Testimony of Christine Alberi, Child Welfare Ombudsman
Health and Human Services Committee
Child Welfare Services Briefing
January 25, 2022

Good morning Senator Claxton, Representative Meyer, and members of the Health and Human Services Committee. Thank you for having me here today.

Maine's Child Welfare Ombudsman program is an independent non-profit authorized by 22 M.R.S.A. § 4087-A to provide information and referrals to individuals requesting assistance with child welfare and to perform case-specific reviews of child welfare involvement. Under the statute the Ombudsman also has a duty to analyze and provide opinions and recommendations to agencies, the Governor, and the Legislature on child welfare programs, rules, policies, and laws.

The Ombudsman's opinions and recommendations are based on our case-specific reports. We receive a complaint from an individual who calls the Ombudsman and then the complaint is referred to the Department. Then we review all of the information relevant to the determination of the complaint, including a response from the Department. A report is drafted, we receive feedback on the report, come to an agreement about the contents of the report, and then finalize the report.

Unfortunately, case specific reviews by the Ombudsman for fiscal year 2021 show a downward trend in child welfare practice. While the causes of this are complex and not well understood, the amount of stress that Covid-19 has had on child welfare at all levels cannot be understated.

Out of the 84 cases closed this year, 42 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practices or adherence to policy or both that had a material effect on the safety and best interests of the children, or rights of the parents. Out of these 42 cases, 22 involved investigations and 14 involved reunification. The remaining six cases had varying issues.

- As has been consistent over several years of Ombudsman reviews, practice issues continue to appear most prominently during two phases: 1) initial safety investigations of reports when the safety of children is not accurately determined and 2) once children are in state custody, during ongoing assessment of parents' progress in reunification. Issues with assessments of children's safety at the beginning and end of child welfare cases are concerning as these are the times when the risk to children can be at its highest.

The reasons why these practice issues continue are only beginning to be understood. The reviews of the three child deaths completed in July of 2021 shed light onto some of the problems that caseworkers face in the field that contribute to missed opportunities in child welfare practice. Learning and reform will be an ongoing process and will take time.

The Ombudsman recommends that:

- Frontline staff have their voices heard and their experiences and opinions considered in child welfare reforms, from the start to the finish of all processes. Collaboration and

transparency with stakeholders is also an important part of any child welfare reform process.

- Maine should strongly consider the implementation of Safety Science in child welfare.
- Although outside of the scope of the Child Welfare Ombudsman's review practice, prevention services are crucial to reducing risk for children and preventing entry of children into state custody. The fact that services and resources for families are minimally discussed in this report should not discount their importance.

Training for staff and supervisors should be aligned with national best practices and supervisor training and support should be prioritized.

I am happy to answer any questions about the report, and elaborate further on our findings, but there were two other topics I wanted to comment on today. The Office of Child and Family Services responded to our report separately this year, and in that response OCFS included the following paragraph:

> "A source of disagreement for a number of reports relates to the Ombudsman's finding or recommendation that involves bringing children into State care or keeping them in care for a longer period of time. While OCFS recognizes the perception that children are safer when removed, the evidence overwhelmingly shows that removing a child from their home has the potential to inflict harm or trauma. In addition, there is little research to support the belief that, in general, children who enter state custody are safer than they would be if they had remained in the home with efforts undertaken to address safety concerns. There are numerous scholarly articles regarding the potential harm of removal." (P. 3 of the Department's Response to the Maine Child Welfare Ombudsman's 2021 Report)

I wanted to highlight this, because this often goes to the heart of discussions about child welfare. Removing children from their families is inherently traumatic. These removals should be prevented and avoided whenever possible. Often, after a tragedy, or series of tragedies involving children, the rate of removals of children increases. This is not the outcome that anyone wants. The decision made about whether or not to remove a child should never be based on outside factors, but based on a sound investigation. We need to know the facts about what is going on for that particular child, in that particular home, in that particular moment. Is this child safe right now? Will this child be safe tomorrow? Is there anything we can do to prevent removal? This is how decisions about removal should be made.

It is not clear that the Ombudsman and OCFS are actually in disagreement about this. There are, unfortunately, circumstances where children must be removed to ensure their safety. The eventual goal of all of us should be to safely lower the number of children in foster care. These numbers have increased over the past year, and since 2018 in general. Reducing the number of children in state custody safely can be done in a number of ways, most importantly by preventing children from entering foster care in the first place, and more importantly, preventing that call to the child abuse hotline from ever being made. Prevention services for families are crucial, and a I said above, improvements to these should not be lost in the discussions of improving how child welfare functions after the call to the child abuse hotline is made.

Finally, I wanted to talk about the presentation of the OPEGA information brief to the joint committees last week. The thorough briefing clearly detailed the child welfare oversight organizations in Maine. I agree with OPEGA that the Office of Child and Family Services' Quality Assurance department, that performs internal reviews for federal reporting purpose, has a thorough and objective process. They have strict guidelines as to how to review cases, and as you heard, review the same number of cases every year. I use those reviews as a check on my own work, as I am able to be more flexible in what I review. As noted in the information briefing, the cases the Ombudsman reviews are also complaint driven. The Ombudsman's office pays close attention to the reports of all of the organizations detailed in the information brief. I would be happy to discuss this further, but it should be noted that the oversight entities currently appear to align and agree in their findings and recommendations.

Thank you, and I am happy to answer any questions.