

Child Welfare Briefing
Christine Alberi, Child Welfare Ombudsman
Health and Human Services Committee
September 20, 2023

Good morning, Senator Baldacci, Representative Meyer, and members of the Health and Human Services Committee. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine. I have a brief update for you today.

As part of our statute, 22 MRSA §4087-A, we report annually to the Governor, Legislature, Department of Health and Human Services, and the public. We are starting work on our annual report right now, and our fiscal year ends on September 30. I look forward to presenting that report to this committee in January, but I do not have any further detail to add at this point.

I am pleased to report that our organization has grown since I was last before you in May. I was able to start two new employees in June which brings us up to four employees. Our new employees are Kathryn Brice and Craig Smith, and they both bring invaluable experience and dedication to child welfare to our office.

On Monday all of the New England Offices of the Child Advocate and the Maine Ombudsman's office met for the first time since before the pandemic. Each state aside from Maine has an Office of the Child Advocate that has a broader mandate than ours: in addition to child welfare, they may investigate children's behavioral health, residential treatment, juvenile justice, and other areas of state government that affect the welfare of children. It was very helpful to get together and share our knowledge and experiences gained through carrying out our unique and often challenging role in state government. Unfortunately, all of the other New England states appear to be experiencing many of the same challenges that Maine is. The shortage of services for children with mental health and behavioral issues was a consistent theme, as well as the related fact that there are workforce issues for all areas of child welfare.

As you know, the Office of Child and Family Services (OCFS) has been working with Collaborative Safety LLC to implement the Maine Safety Science model. Safety science is a method of reviewing critical incidents where instead of focusing on *what* went wrong, focuses on *why* something went wrong. The findings of the reviews identify systemic issues that prevent staff from performing casework the way that they want to and are expected to.

Cases sent for a full review by a safety science mapping are selected by a team that includes key OCFS employees, the Ombudsman, and Dr. Amanda Brownell, one of the state's child abuse pediatricians. 13 full mappings were completed during 2022 and 171 technical reviews were completed. The results of these reviews were just released in the first annual report.

The key findings of the report include barriers in staff knowledge, training, and experience; decisions around safety planning vs. court petitions; time frames; vacancies, turnover, and increased workload putting pressure on staff; training around structured decision-making tools; and challenges with use of the new child welfare database, Katahdin.

The findings in the first annual safety science report are consistent with issues identified both by internal quality assurance reporting by OCFS and the Ombudsman, but there is a key difference which makes safety science findings extremely valuable. In an Ombudsman report, we might identify that an investigation was not completed thoroughly, but we cannot identify exactly why that happened. Safety science might give us the other part of the story: that all of the investigation activities were not completed because of the pressure to complete investigations on time, which influenced the staff decision to close the investigation without interviewing collaterals or fully considering the family's history. This targeted identification of issues gives all systems the ability to work together to solve a specific systemic issue that has now been identified.

Safety science is an ongoing process within OCFS, and implementation of the recommendations that are supported by the safety science reviews is the next key step. We still have a great deal of work to do, but this report reflects the hard work of the safety science analysts and all of the staff that participated in the difficult case reviews that led to these findings.

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

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