MCEDV.
The Maine Coalition
to End Domestic Violence

101 Western Ave.
P.O. Box 5188
Augusta, ME 04332-5188
207.430.8334

October 16, 2024

Senator Craig Hickman, Chair
Representative Jessica Fay, Chair
Government Oversight Committee
82 State House Station
Augusta, ME 04333-0082

RE: OPEGA Case File Review: Safety Decision and Actions Taken in the Case of Sylus Melvin

Honorable members of the Government Oversight Committee:

The Maine Coalition to End Domestic Violence (MCEDV) serves and supports a membership which includes Maine's eight regional domestic violence resource centers as well as two culturally specific service providers. Together, these programs provided services to more than 12,000 survivors of domestic abuse and violence and their children across the State of Maine last year. Our programs provide a broad range of services, to include: a 24/7 helpline; 13 of the state's emergency shelters; support and advocacy for survivors in civil and criminal court proceedings; certified domestic violence intervention programs for those who use abuse and violence; and individualized support in creating and implementing plans for safety. Additionally, each of Maine's domestic violence resource centers employs a full-time domestic violence child protective services liaison, who works both with survivor parents who are navigating the child welfare system response as well as with OCFS staff to help the system better understand and respond to families experiencing domestic abuse and violence. Last year, this program served more than 700 survivor parents across the state.

Through review of this one case, the Government Oversight Committee may look to make policy and practice recommendations for future action. To that end, MCEDV submits these comments not only to address some of the questions that were raised by Committee members during OPEGA's recent report on its case review of OCFS' work with the family of Sylus Melvin, but also to expand on some of the issues that were both present in this case

that we see as themes and patterns showing up more broadly in our work with survivors, and in how community systems respond to them.

Deficiencies in the Family Court Order

In the parental rights and responsibilities order as described in OPEGA's report, MCEDV observes two deficiencies that are commonplace in Maine's family court's response to families with a history of domestic abuse and violence: (1) a discomfort with ordering something other than shared parental rights and responsibilities as between the parents, despite a clear history where one parent has failed to demonstrate actions or intentions to parent the common child and/or has used the existence of child to further perpetrate abuse; and (2) a lack of specificity in how parent-child contact will happen between the child and the parent who has used abuse, placing an unreasonable burden on the vulnerable parent and setting them up for future, ongoing abuse.

MCEDV appreciates that OPEGA's report prominently notes the incongruence reflected in the parental rights and responsibilities order for this family between the child welfare system's expectations around supervised visits (in response to concerns about Mr. Melvin's behavior that included a history of domestic violence, repeated violations of court orders, and unaddressed mental health and substance use concerns) and the burden placed on Ms. Newbert by the resulting family court order to be fully responsible for the scope and type of Mr. Melvin's future contact with their child. She had the burden to, and was expected to, say "no" without any sort of supportive framework to do so. This is a common deficiency with family court orders in cases involving domestic abuse and violence, regardless of the level of child welfare case involvement. The child welfare response, whether it's limited to an assessment/investigation or involves a PC filing, frequently identifies the survivor parent has been abused and that the abusive person continues to pose a risk to both the survivor parent and the child. However, the family court process too often assumes that separation of the parents is an absolute cure to the domestic abuse and violence and thus sets up a scenario where the survivor parent must act as a gatekeeper and facilitator of the abusive parent's contact with the child. Without sufficient structure and support, this provides a court sanctioned opportunity for ongoing coercion, manipulation and abuse.

Maine's family court statutes set out three different types of parental rights structures regarding how parents will make decisions about the wellbeing of their child in Title 19-A, section 1501. These are: (1) sole parental rights, where one parent has exclusive decision making authority with respect to the child's welfare; (2) shared parental rights, where most or all aspects of a child's welfare are the joint responsibility and right of both parents, with the expectation that they will confer and make joint decisions; and (3) allocated decision making, where some aspects of a child's welfare may be exclusively the right and responsibility of one of the parents. In some domestic violence cases, the court will

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award shared parental rights, expecting the parties to try to co-parent, but will recognize the history of domestic violence by ensuring that the survivor parent retains the ability to make a final decision if the parties cannot agree. In practice, this approach often works to reduce the extent to which an abusive parent can misuse their decision-making authority to further perpetrate abuse post-separation. It is a worthy approach for many domestic violence cases, most specifically in cases where both parents are having significant contact with the child; it is a good tool for the family courts to have. However, it should not be used as a means to avoid ordering sole parental rights when sole parental rights are really the appropriate structure; it is too often used in just this way.

At the time of the entry of the PR&R order, Mr. Melvin was in jail and was going to be in jail for at least several more months. Part of the reason that he was in jail was his refusal to follow court orders and/or the safety boundaries that Ms. Newbert had put up, including violation of a civil protection order she had obtained. Its stretches credulity to conclude that all of the parties to the entry of this family court order could be confident that Mr. Melvin would be rehabilitated to such an extent upon his immediate exit from jail that he could participate as a functioning co-parent with Ms. Newbert. The family court's practice of setting out a requirement in a PR&R order that a survivor parent must try to co-parent under such circumstances is setting that family up for failure.

We also note that this would not have been a PR&R order that was "negotiated" solely by Ms. Newbert and Mr. Melvin. The parental rights and responsibilities order was entered at a time when the following professionals were deeply involved with this family as a result of the PC case: an appointed guardian ad litem; an attorney for each parent as a result of the jeopardy petition; an assistant attorney general representing OCFS; OCFS staff; and at least one District Court judge. Despite the involvement of all of these professionals, the parent-child contact order entered, just like the shared decision-making order, was also similarly likely to set the family up for failure, given its lack of specificity. A PR&R order lacking specificity around how and when a perpetrator of domestic abuse and violence will have parent-child visitation sets up the custodial parent to: (1) need to assess appropriateness for any visitation to occur; (2) to try and figure out what that should look like; and (3) to have to do both of those things under the umbrella of a history of a clear, demonstrated history of coercive, controlling behavior towards them by the other parent. In this case, unspecified supervised visitation was ordered at Ms. Newbert's discretion.

Presumably, it was the preference that this be professionally supervised contact. However, it is not uncommon knowledge amongst civil court professionals that supervised visitation services are functionally non-existent, particularly in rural Maine, and have been for years.[1] Where and when they do exist, they are not free services. All involved in this case would have been aware of these deficiencies. The PR&R order functionally ignores this problem. Additionally, the lack of specificity as to how the supervised visitation would take place is also contrary to Maine's parental rights and responsibilities statute that sets out the conditions a court must establish when ordering supervised visitation in a family court order. Pursuant to Title 19-A, section 1653(c)(f), if the court is not ordering professionally supervised visitation, but is instead relying on family or household members, the court is supposed to establish supervised visitation in such a way that, at a minimum: (1) minimizes the circumstances when the family of the parent who has committed abuse would be supervising the visits; (2) ensures the parent-child contact does not damage the relationship with the parent who is the primary residential parent; (3) ensures the safety and well-being of the child; and (4) requires that the supervision be provided by a person who is physically and mentally capable of supervising a visit and who does not have a criminal history or a history of abuse and neglect. None of this structure was apparently provided for in the PR&R order in this case.

Again, Mr. Melvin was in jail at the time this PR&R order was entered, and no one could know what state he would be in upon release. Yet, the burden of engaging in that assessment and responding to it was placed upon an individual who was acknowledged to be a victim of his crimes. In our experience, and regardless of whether a protection from abuse order is in place or not, it is best practice to build in much greater specificity into PR&R orders when there are concerns about the safety of parent-child contact. Such specificity in a case like this would ideally include setting out pre-conditions for contact, such as requiring the visiting parent to provide evidence of compliance with any substance use treatment or participation in mental health support services or enrollment and sustained attendance in a certified domestic violence intervention program. The court order could also have provided no rights of parent-child contact and directed Mr. Melvin to file a motion to modify the order after his release.

Whether any of these conditions may have made a meaningful impact on the trajectory of this particular family can't be determined, but the practice of issuing a cursory PR&R order to resolve an intensely complicated family dynamic is not unique to this case.

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[1] MCEDV notes that there are two types of supervised visitation services. The first is supervised visitation services that are contracted by the Office of Child and Family Services when a family is involved in a child welfare case where the child has been removed from the parents' custody and the parents are having supervised visitation as part of the reunification process. This supervised visitation is arranged by and paid for by OCFS. The second type of supervised visitation services are those that families use when a child is in the custody of a parent and the other parent is visiting, pursuant to a family court or protection from abuse order, because of some type of recognized risk to the child. It is this second type of visitation services that is contemplated by the parental rights and responsibilities order.

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The family court's discomfort with naming the ongoing, post-separation impact of domestic abuse and violence, its risk to the wellbeing of children, and providing a truly protective framework for adult survivors of domestic violence and their children to rely on in the long-term is an ongoing challenge that we regularly hear about from survivors working with our programs.[2]

MCEDV would also like to highlight and appreciate that the Maine Judicial Branch has collaborated and partnered with over the last few years to support increased education and understanding of Maine's judicial officers on these issues. Under the current Chief Justice's leadership, in 2023, judicial officers joined family court professionals from across the state for a full day training from the Battered Womens Justice Project on the SAFeR Model, a best practice approach for screening, accounting for and responding to domestic abuse and violence in family court cases. Just last month, substantially all judicial officers participated in training about domestic violence risk assessment tools being used in Maine, research results on the implementation of the Ontario Domestic Assault Risk Assessment, and factors Maine's domestic abuse homicide review panel have consistently highlighted as indicators of higher risk of lethal violence. MCEDV has also partnered with the Maine Judicial Branch in the last few years to provide the required 6 hours of initial training for guardians ad litem and CASA volunteers – training that is up from only 1 hour and 45 minutes that were required prior to 2022.

Public Health Nursing – Screening for and Responding to Domestic Violence

Maine's public health nursing program, providing in-home support to families after the birth of a child, can be a vital post-partum support and opportunity for intervention when one parent has a history of engaging in abuse and violence against the other parent. In 2021, these nurses had no regular training on domestic abuse and violence and were using

[2] We note that it is also incredibly common for an abusive former partner to use the tether of children and family court orders to erode a victim's ability to make safety assessments and act accordingly. In many cases, if a survivor parent exercises the discretion to withhold parent-child contact due to safety concerns, the abusive former partner threatens, and often acts on that threat, to take the victim back to court, making claims of parental alienation and successfully limiting the protective parent's future ability to exercise discretion to keep the child safe.

outdated screening tools. Since that time, under new leadership, Maine's public health nursing program through the Maine Center for Disease Control has collaborated extensively with MCEDV and our member programs to improve the capacity of these health care professionals to better screen for and respond to domestic abuse and violence. The program's policy has been updated and expanded to require annual training in domestic abuse and violence for all public health nurses. Additionally, public health nurses are now using updated screening process and have Maine-specific handouts and tools to support their work with families experiencing domestic abuse and violence.

Office of Child and Family Services – Domestic Abuse and Violence Policy Update

Responding to domestic abuse and violence is a complicated and nuanced issue, made more so when children are involved. Since 2021, OCFS has updated their Domestic Abuse and Violence Policy. MCEDV and advocates from Maine's DVRCs consulted with OCFS throughout this process. MCEDV then partnered with OCFS to co-train the policy update for every OCFS district office. The updated policy introduces additional tools and considerations for OCFS staff to enhance their ability to respond to families where one parent is using abuse and violence against the other parent and the children. The policy focuses on child safety, domestic abuse offender accountability and providing support for the victim survivor. Tools within the policy include outlines for identifying high-risk behaviors that indicate lethality, an ODARA[3] fact sheet to assist in translating scores and risk of recidivism, and templates for trauma informed questions. The policy names best practices for interventions when domestic abuse is a factor, including OCFS making referrals to the DV-CPS advocate from their regional DVRC and continuing to utilize these advocates throughout the case; providing practical supports, including economic supports, to help the adult victim carry out their plan for safety; and for abusers, naming that the abusive actions should end and that they should enroll in a Certified Domestic Violence Intervention Program (CDVIP). The policy also specifies things that should not be part of a case plan, including putting the burden of the offender's success or failure on the victim.

MCEDV and the regional DVRCs continue to provide technical assistance for the implementation of the policy, both systemically and in individual situations. Additional resources to help caseworkers respond to nonfatal strangulation have also been a coordinated effort in the last two years, including ways to identify and respond the behaviors, injuries and risk of lethality associated with the tactic, which is often referred to as "practicing homicide."

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[3] The Ontario Domestic Assault Recidivism Assessment is an actuarial risk assessment that helps to identify risk of future assaults against intimate partners. In Maine, it is required to be used by law enforcement when responding to certain domestic violence calls, and, when available, can help inform decisions being made around safety and supports.

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Law Enforcement Training and Response

OPEGA was unable to resolve the conflicting accounts between Sylus' grandmother and the Milo Police Department officer who took her call in August 2021 as to the substance of that call, though both agree that she was expressing concerns about Mr. Melvin's level of risk to Ms. Newbert and the children. OPEGA concluded that the report from the officer (though not written until it was clear it would be needed as part of the homicide investigation) did not note anything had been reported that would have been immediately actionable by the police department. During OPEGA's report, Committee members had questions about whether or not law enforcement's practice would be to make some sort of referrals to community resources in response to concerns raised by Sylus' grandmother, even if immediate law enforcement response was not called for.

Advocates at Maine's domestic violence resource centers work with many local law enforcement agencies on a daily basis. Beyond the common practice of giving callers the contact information for their local domestic violence resource center and/or the 24hr helpline, which is a required practice under the Maine Criminal Justice Academy Board of Trustee's Minimum Standards for Mandatory Policy on Response on Domestic Abuse, Maine law also allows law enforcement agencies to proactively notify local DVRCs about calls they have received where domestic violence was flagged, together with contact information for the caller. Many, but not all, local law enforcement agencies forward information about these types of calls to their local DVRC on a regular basis. An advocate will then proactively call either the victim or the family member who had the concern, creating an entry point for them to begin accessing a wide range of community services and supports. This proactive information sharing is sometimes the first interaction one of our agencies might have with a victim or concerned family member. It is a practice that demonstrates to those who have reached out for help that there is no wrong door – that their community will work together to support them. It is unclear if this was a step taken by the Milo Police Department in response to the August call.

We note that, though law enforcement officers receive more training in domestic violence than almost any other professional, it is also not uncommon for law enforcement to experience a kind of 'frequent flyer fatigue' in practice when responding to a call involving a family that they have had an extensive history responding to. When police are called

frequently to respond to a particular family, and the victim "stays," there can be a tendency to let go of what is known to be a best practice response – to not ask the follow up question that might net the information that would necessitate dispatching an officer or making a call to CPS intake, or to not make the referral that may have also been made before. This is particularly prevalent in small communities where it is often the same one or two officers who are called upon to take the call. Maine's Domestic Abuse Homicide Review Panel has observed that repeated calls for service regarding the same couple or family indicate high risk and recommends that officers maintain vigilance in such cases.

For those needing help, calling law enforcement can be a big decision that has far reaching, often unpredictable implications. Very often, when victims or concerned others reach out for help, they can be testing the waters, to see how they are received and if they will be believed. Responses from law enforcement that are closed ended, for example, "We cannot do anything with what you are reporting," can feel like, "We can't help you." It is not uncommon for victims to then feel they need to engage in an abundance of proof-bringing to be believed and heard – for example that they will not be taken seriously if they do not have marks to prove an assault. For families who have already engaged with law enforcement, criminal legal systems, or the child welfare response, this prior experience may act as a further barrier to reaching out.

Assessing the Viability of a Protective Framework

We urge the Committee to be cautious around accepting the premise of any conclusion that there was truly a functional protective framework in either 2018 or in 2021. It is not clear that there was. All involved professionals recognized that Mr. Melvin was a threat to this child and, to some extent, a threat to Ms. Newbert, and yet left all the responsibility on her shoulders to be the guardrails around his behavior.

Sylus was killed by his father – a man who had a longstanding history of acting on his clear beliefs that he had a right to be violent with his partners and family and a man who had a long history of unaddressed mental health and substance use issues and who demonstrated an obvious disinterest to be a parent throughout his interactions with service providers. Too often, in reviewing domestic violence homicides, the conversation focuses on what the adult victim of domestic abuse and violence did and did not do. The common questions are "Why did she continue to stay?" and "Why didn't she just leave?"

We urge the Committee to not fall into that same pattern of transferring responsibility from the abusive parent to the adult victim, and focusing on the victim's choices rather than the question of why this man thought it was ok to act the way he did. It is important to identify the gaps and challenges in the responses of the multiple systems who engaged with this family over the course of several years that failed to hold Mr. Melvin accountable for his behavior. It is also important to examine whether the adult victim was

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provided with the systemic support she needed to sustain the safety of herself and her children, which should not be framed exclusively as a question of whether or not she kept Mr. Melvin away.

There are still questions that can be asked to support those inquiries, answers to which may help inform any recommendations for policy or practice change that might result from the Government Oversight Committee's child protective services case reviews, including:

- Was Mr. Melvin ever ordered to attend a certified domestic violence intervention program? OPEGA's report notes his history of domestic violence terrorizing and assault before his incarceration for PFA violations and felony domestic violence assaults in 2018. There is also a reference in OPEGA's report to a referral for a "level of care" assessment to determine if he was eligible for a Batterer's Intervention Program (since renamed) in 2018, but it is unclear if Mr. Melvin was ever referred for this intervention.
- Was Mr. Melvin on probation for any of his many interactions with the criminal justice system from 2018 through 2021? What interactions did probation have with this family and/or with child protective services and were there any opportunities for additional information sharing and collaborative intervention?
- Were the economic needs of Ms. Newbert and her children ever assessed and supported by the Department? We know that separation from an abusive person is not possible without the financial resources to maintain a safe and stable household independent of that other person. OPEGA's report notes a three and a half hour call from Ms. Newbert to the Office of Family Independence in mid-August 2021. The practical supports related to transportation, child care and home health were named in the report as not in fact truly accessible or sufficient to meeting the needs.

MCEDV and its member programs grieve the death of Sylus Melvin and all the children and adults killed through domestic violence homicide. There are no simple answers, and it is important to engage in the kind of deep inquiry that you have done to help all of us examine our policies, practices, and opportunities to understand our impacts – both intended and unintended - so that we can do better work for and with Maine's families to prevent such tragedies.

Thank you for the opportunity to offer some additional information and perspective in response to the OPEGA report. Please do not hesitate to let me know if MCEDV can be of any assistance to you as you continue your review and discussion.

Sincerely,

Andrea Mancuso
Public Policy Director
andrea@mcedv.org

Testimony of
Mark W. Moran, LCSW
Chair, Maine Child Death and Serious Injury Review Panel
Before the Government Oversight Committee
October 16, 2024

Senator Hickman, Representative Fay, and members of the Government Oversight Committee:

My name is Mark Moran. I am a Licensed Clinical Social Worker and the Chair of Maine's Child Death and Serious Injury Review Panel (CDSIRP)*. Thank you for the opportunity to join you again today to offer some additional thoughts after the last of four child fatality case reviews conducted and presented to the Committee by OPEGA. Over the course of several public hearings in front of both this Committee and the preceding GOC, I have attempted to take an educational approach with my testimony. I have tried to share some of the lessons I've learned and knowledge I've acquired over a nearly 25-year career in various aspects of child welfare work, and I will try to take the same approach today.

During Director Schleck's presentation of the Melvin case in September, committee members asked multiple questions or made multiple statements relating to the topic of substance use disorder (SUD) and medication for opioid use disorder (MOUD), reporting of substance exposed or substance affected newborns, and the notion of "addicted" babies. I will focus on each of these topics before offering two brief closing comments.

SUD- what some might call "addiction"- is a chronic, treatable, medical disease that is characterized by physical, behavioral, and cognitive impairments and involves complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. It includes functional, potentially long-lasting changes of the brain's neurochemical processes involved in reward, stress, and self-control. Symptoms of SUD can be grouped into four categories: 1) drug effects (tolerance- need for larger amounts of the substance to achieve the same effect and withdrawal- symptoms that arise from the absence of the substance); 2) impaired control (cravings or strong urges to use the substance or repeated efforts to cut down or otherwise control use of the substance); 3) social problems (neglecting ones social, occupational or recreational responsibilities due to seeking, using or recovering from the substance); and 4) dangerous use (substance is used in unsafe settings and/or is used despite knowledge of negative consequences). SUD is similar to other chronic diseases because 1) it has both biological and behavioral components, both of which must be addressed during treatment; 2) recovery from it -which means abstinence and restored functioning- often requires repeated episodes of treatment; 3) relapses can occur during or after treatment and are an opportunity for treatment adjustment rather than an indicator of a person's commitment to treatment and recovery; and 4) participation in support programs during and after treatment can be helpful in sustaining long term recovery.

Different substances work in different ways but generally impact the areas of the brain involved in the reward pathway. The reward pathway is activated by any positive or pleasurable experience- most fundamentally by the things that allow us to survive as a species: eating, drinking, and procreating. Endorphins, our naturally occurring internal opioids, are released in the brain, connect to opioid receptors, and trigger a release of dopamine, which makes us feel good. Opioids from outside the body

also work by connecting to opioid receptors, though they trigger a bigger dopamine response and other neurochemical changes. Over time, with repeated use of outside opioids, the brain's natural ability to produce opioids decreases. Cessation or removal of the outside opioid then leaves the person with an impaired natural system, which drives adverse physical and psychological experiences.

During Director Schleck's presentation to the committee and in the ensuing discussion, the terms buprenorphine, Suboxone, and Subutex were asked about. Buprenorphine is one medication used to treat Opioid Use Disorder. When paired with a small amount of naloxone, buprenorphine is sold under the brand name Suboxone. When produced as the single substance without the naloxone, buprenorphine has previously been sold under the brand name Subutex. Buprenorphine works similarly, though not identically, to methadone, by occupying the opioid receptors and stabilizing the amount of dopamine released in the brain, allowing a person to function normally so they can return to being productive members of society and/or address other co-occurring problems. These medications may be prescribed for anyone with an OUD, including pregnant and breastfeeding women. Having access to MOUD during pregnancy has multiple benefits for the mother and the fetus, including reducing the instability of the intrauterine environment associated with the intoxication and withdrawal cycle of continued illicit opioid use, reducing the risk of fatal and non-fatal maternal overdose, reducing the risk of pregnancy loss, reducing the frequency of additional risk taking behaviors that increase the spread or acquisition of infectious diseases, and reducing the risk of premature delivery. While I have never heard anyone argue in favor of a substance exposed pregnancy over a non-substance exposed pregnancy, there is broad agreement among the major medical organizations that a pregnant woman with active OUD receiving needed MOUD is much preferred over a pregnant woman with OUD continuing to use illicitly or attempting to manage her sobriety without appropriate treatment.

In both the Maddox Williams' and Sylus Melvin reviews, the topic of reporting substance exposed or affected newborns was raised. For the past 20 years, federal law has required states to establish protocols for notification to Child Protective Services (CPS) of infants born affected by substance abuse or having withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder. The general intent of the law is to identify babies who are at risk of consequences from their prenatal exposure and connect them and their families, via a Plan of Safe Care or the evolving name "Family Care Plan," with appropriate resources to attempt to mitigate those potential consequences. Federal law explicitly states this requirement is not to be construed as establishing a definition of child abuse or neglect that includes prenatal substance exposure or as requiring criminal prosecution for substance use in pregnancy. To be compliant with federal requirements, Maine has enacted its own laws on the subject, specifically 22 MRS §4004-B, which lists what the Department shall do, and §4011-B, which requires healthcare providers to notify the Department of such cases. Both healthcare providers and child welfare professionals will draw a distinction between "notifying" and "reporting." While I have offered that argument myself to many families over the years, from the perspective of a family who is going to be the subject of a notification or report, this is a distinction without a difference. Notifications must be made in the same manner as reports of abuse or neglect.

Unfortunately, some of the language of these Maine laws is, in part, unclear, and this lack of clarity results in inconsistent interpretation and application of the law among healthcare professionals. Specifically, I am concerned about the lack of definition of "substance" or "substance use" and

"affected." What constitutes a substance and what substances does the system really care about? Certainly, drugs like illicit fentanyl, cocaine, and methamphetamine are easy to be concerned about. What about nicotine? Caffeine? Antidepressants? Marijuana? Are those "substances" for the purpose of these laws? Is a pregnant person who has a cup of coffee after taking their morning Prozac dose a substance user, thus making their baby substance exposed or substance affected? What does it mean to be substance affected? Again, it is easy to consider a baby with obvious, recognizable withdrawal symptoms who was born to a person with active OUD to be substance affected, and the statute does specifically include withdrawal symptoms that require medical monitoring or care beyond standard newborn care, regardless of whether the precipitating exposure was to legal or illegal substances. What about the infant who is statistically at increased risk of Sudden Infant Death Syndrome (SIDS) as a function of nicotine exposure during pregnancy? What about the infant whose mother smoked marijuana or used edibles during pregnancy, yet the infant was born at full term, appropriately sized, in no obvious distress, and apparently healthy? I have long advocated for OCFS to propose a statutory change to define "affected" in this context. The absence of such a definition leaves individual healthcare providers or individual institutions to create and operationalize their own definition, resulting in inconsistent reporting across the state. As a specific example, some hospitals submit notifications of infants exposed to marijuana in utero while others do not.

During the Committee's discussion of the Melvin report, I also heard the term "addicted" used in reference to babies, and I have rarely in my career turned down an opportunity to explain to individuals or groups why this is an inappropriate and inaccurate descriptor for a baby. I offer three specific arguments in support of my position.

First, earlier in my testimony I outlined the symptoms of SUD or addiction. I submit that babies are not capable of the vast majority of those symptoms. They cannot use a substance despite knowledge of negative consequences. They cannot use in larger amounts or for longer periods of time than they intended. They cannot neglect their social, occupational, or recreational activities because they are getting, using, or recovering from a substance. They cannot have repeated efforts to cut down or control their substance use. They can, however, become habituated to a substance to which they have been exposed repeatedly in utero. They can be physiologically dependent on the substance such that they have withdrawal when the substance is no longer available. It would be accurate, therefore, to characterize such a baby as substance dependent, but absent the behavioral and cognitive aspects of SUD or addiction, it is simply incorrect to refer to a baby as addicted.

Second- I believe that labeling equals limiting. In the 1980s there was an epidemic of so-called "crack babies" being born, typically to low income, black women in urban settings. Many highly regarded professionals opined that those babies would grow up to be delayed, damaged, deficient, and delinquent, and would be drains on society. What we know now, 40 years later, is that the opinions of those highly regarded and highly educated people did not come to fruition. I don't know how many, if any, of those babies went on to achieve great academic success and make major contributions to society, but I would ask how many of them could have? If they were not labeled in a pejorative, stigmatizing way, such that their expected achievement bar was set low, what might they have achieved? Where might they be and what might they be doing if they were supported and encouraged and pushed to achieve the maximum of which they were capable? I worry that we run the same risk

with this generation of opioid exposed children. By using clinically incorrect and stigmatizing language, we potentially limit them in ways we may not realize.

Third- language imparts meaning. If I asked you all to come up with a mental picture of addiction, you would likely conjure up images of intravenous drug use, impoverished people spending their pennies on another bottle of alcohol, people snorting powdered drugs through a straw, or other similar imagery. All of the opinion, emotion, and implicit or explicit bias that many people have about the humans in such imagery is attached to the words we use to describe them. Are we really going to use the same words that carry the same meaning- whether intended or not- for a newborn baby? Words matter- even more so when coming from people in positions of power and authority. Words have their own power. They can reinforce stereotypes and perpetuate stigma, or they can offer someone hope and enhance their resilience. We are all responsible for choosing the words we use wisely.

In closing, I wanted to offer a couple of brief thoughts on comments made by Senators Timberlake and Keim.

After more than one of the OPEGA case reviews, I heard Sen. Timberlake make comments like "there is obvious failure here," and "somewhere there's fault." These reviews, and others like them conducted in other venues, have highlighted some opportunities to improve the child protection system and I expect there will continue to be additional opportunities for improvement in the future. Those of us who do this work will continue our efforts to identify those opportunities, and I have every reason to expect that Director Johnson and Associate Director Haynes will be a partner in those efforts. But to partially quote and paraphrase OPEGA's writing, there is a misconception that adverse outcomes must be the fault of caseworker error or flawed processes. Adverse outcomes occur for complex reasons and can occur despite quality staff and processes in place.

I very much appreciate Sen. Timberlake's obvious passion for this topic, and I acknowledge that accepting this reality, as articulated by OPEGA, is difficult and unsatisfying. But having been involved in various elements of this work for nearly 25 years, I must say I agree with OPEGA's comment on this point. This does not mean the efforts of the GOC and OPEGA have been in vain. On the contrary, they have helped highlight deficiencies, sparked change, and kept our children's welfare at the forefront of our public policy discussions, and for that I am grateful.

Finally, during one of my prior appearances in front of this committee, Sen. Keim asked me a semi-rhetorical question: How can we increase children's safety without decreasing parental rights? This question has stuck with me for the past several months, and I want to offer the following answer. Kids are made safer when families are made stronger. In a recent presentation from the Department and Maine Children's Trust, I was reminded of the five protective factors included in a strengthening families approach: Parental resilience, concrete supports, social connections, knowledge of parenting and child development, and social-emotional competency of children. For those of you who will return to the next legislature, or hope to, I'd like to challenge you to keep this concept front of mind as you face difficult choices about which bills to vote for, which initiatives to fund, and where you can have the most impact. Kids are made safer when families are made stronger, and this responsibility falls to all of us, not just OCFS.

I will leave you with that and say thank you once again for the opportunity to speak to you today, and for your continued partnership and support in this work. I'm happy to try to answer whatever questions you may have.

**Testimony offered on behalf of the CDSIRP does not necessarily reflect the official opinion of any state, public, or private entity whose employee is a member of the Panel. The testimony offered today does not necessarily reflect the official opinion of the CDSIRP unless otherwise stated.*

Melissa Hackett, Policy Associate for the Maine Children's Alliance
and Coordinator for the Maine Child Welfare Action Network
Testimony to the Government Oversight Committee
Sylus Melvin Report
October 16, 2024

To begin, we would like to again thank the OPEGA team for their thorough work. The details of this case, as with the three others already considered, are traumatic and difficult to process. As it has been for us all to bear witness to them.

We appreciated and support the considerations presented by OPEGA as a result of their investigation. Similarly, we appreciated the response from OCFS/DHHS, and their outline of actions already taken and those underway to make improvements where opportunities were noted in the report.

This is an incredibly difficult case, with multiple stressors on each of the parents, over many years and, including the stress of a new child, mental health and substance use issues for both parents, domestic violence in the home, in combination with the fragility of an infant. It is heartbreaking. It is also hard to acknowledge how many people were involved with this family; yet the risk to the child/children was not recognized, known, or alleviated.

Something else that feels necessary to name is the complication presented by conflicting reports of information related to the case and incidents that occurred before, during, and after the death of Sylus Melvin. Whatever the challenges with corroborating or reconciling those facts, it feels important to acknowledge that any time a child dies, there is understandable desire from many parties to look for someone to blame. Ultimately, the person deemed responsible for the death of Sylus Melvin – his father – is being held accountable for his actions by our criminal justice system.

There are a few details that I continue to struggle with in this case. First, the significant issue of the PR&R assigning the mother sole responsibility and discretion for visitation between her abuser and their child. If this is happening with any consistency in the family courts, we should consider how to strengthen practice to ensure victims of domestic violence have more safeguards and supports in place when facilitating visitation between the abuser and their children (particularly if there are modifications made to safety measures that were in place at the time of the PR&R). Second, the issue of the police officer who received the call from the grandmother. I was surprised that this did not result in a mandated report to the CPS hotline or other outreach to someone working locally in child protection. It is critical that law enforcement, as well as other partners like Public Health Nurses, Home Visitors, and behavioral health providers, have relationships with each other and work together around families they are involved with. While some work has

been undertaken, as noted by the OCFS response, there is more to be done to ensure those collaborative partnerships are in place and being utilized effectively to ensure child safety.

As it relates to substance exposed newborns – a common theme across the cases reviewed - and access to treatment for expectant and new birthing parents, we would share with the committee that 29 states, the District of Columbia, and Guam include substance use disorder treatment provisions in statute or regulation specific to pregnant individuals.[i] These provisions typically include a requirement that treatment programs provide priority access to treatment for pregnant and/or postpartum individuals. Maine is not on that list of states and could consider how we might prioritize treatment prenatally and postpartum to ensure care for substance use is being provided and with the goal of alleviating child safety risks related to that. Similarly, we should consider how access to mental health support might be prioritized for expectant and new parents.

Substance use, mental health disorders, and child abuse and neglect are three of the most highly stigmatized conditions in society. Stigma and shame associated with substance use and mental disorders as well as child welfare involvement 1) result in a reduced chance that the individual will seek treatment; 2) influence the kinds of treatment people are willing to accept; and 3) affect treatment retention as well as the individual's ability to maintain a recovery-oriented lifestyle.[ii] Our efforts must also include an intention and focus on reducing the stigma and fear parents and caregivers face in seeking help and sustaining support.

Additionally, we strongly encourage consideration of efforts to prevent domestic and intimate partner violence (DV/IPV). We should be setting intention around developing and bolstering efforts to prevent the conditions for DV/IPV to occur, and to intervene to mitigate harm in ways that reduce judgment and fear and provide meaningful support to survivors and their children.

National Data on Domestic and Intimate Partner Violence[iii]

- 1 in 4 women and 1 in 10 men have experienced contact sexual violence, physical violence or stalking by an intimate partner and reported an IPV-related impact (ie, being fearful, concerned for safety, needed medical care, needed help form law enforcement, missed work or school, etc.) during their lifetime.
- Each year, 1 in 15 children live in homes where one of the parents (or a parent's partner) abuses the other adult. 90% of these children are eyewitnesses to the violence.
- 1 in 3 (31%) children who witnessed intimate partner violence reported being physically abused themselves. Of those children who did not witness intimate partner violence, only 4.8% reported physical abuse.

- Nearly 1.5 million high school students nationwide experience physical abuse from a dating partner in a single year.

Maine Data

- 7.9% of Maine high schoolers who had a dating relationship in the preceding year report that someone they were dating or going out with physically hurt them on purpose at least once.
- Advocates from the MCEDV network worked with 14,199 people statewide in 2022. 12,193 of those were directly experiencing abuse and violence. 42% of adults served had at least one child in their home.
- In 2022, domestic violence assaults comprised 30% of the total assaults reported to law enforcement. Nationally, only 56% of all nonfatal domestic violence crimes are reported to the police.

Prevention efforts should reduce the occurrence of intimate partner violence by promoting healthy, respectful relationships. Healthy relationships can be promoted by addressing risk and protective factors at the individual, relationship, community, and societal levels. CDC developed the Intimate Partner Violence Prevention Resource for Action to help states and communities take advantage of the best available evidence to prevent intimate partner violence.[iv]

It outlines the following strategies and activities:

- Teach safe and healthy relationship skills
    - Social-emotional learning programs for youth
    - Healthy relationship programs for couples
- Engage influential adults and peers
    - Men and boys as allies in prevention
    - Bystander empowerment and education
    - Family-based programs
- Disrupt the developmental pathways toward partner violence
    - Early childhood home visitation
    - Preschool enrichment with family engagement
    - Parenting skill and family relationship programs
    - Treatment for at-risk children, youth and families
- Create protective environments
    - Improve school climate and safety
    - Improve organizational policies and workplace climate
    - Modify the physical and social environments of neighborhoods

- Strengthen economic supports for families
    - Strengthen household financial security
    - Strengthen work-family supports
- Support survivors to increase safety and lessen harms
    - Victim-centered services
    - Housing programs
    - First responder and civil legal protections
    - Patient-centered approaches
    - Treatment and support for survivors of intimate partner violence, including teen dating violence

Last year's budget included the establishment of an Office of Violence Prevention at the Maine Center for Disease Control and Prevention, to coordinate and promote efforts to reduce violence, including through the creation of a central hub to bring together data about violence-related injuries and deaths that is currently kept separate (such as in police reports, medical examiner files, and emergency department files) to inform public health and prevention measures to reduce suicides and homicides in Maine. This office, in coordination with work happening at OCFS, should be an area of focus and resource in the coming years.

The prevalence of DV/IPV in families with children is likely much higher than is known given the current data we have to understand the depth and breadth of the issue. We must start talking to young people much sooner about healthy relationships, and support them in processing their own experiences when they have experienced DV/IPV in their homes or in their own relationships.

This case serves as a painful reminder that even with many people involved with a family, external interventions are not a guarantee of a child's safety. As we continue to consider how to bolster interventions we know to generally be effective to reduce the likelihood of child abuse and neglect, we must also continue to consider the community's responsibility and role in the private lives of families. Building informal social connections and supports for families is an important and effective means of ensuring that when parents are experiencing challenges, they have people to go to for help that they already trust and have relationships with. We must continue to explore and invest in opportunities to support children and their families much earlier, and much better, to prevent tragedies like this.

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[i] https://legislativeanalysis.org/wp-content/uploads/2024/06/Substance-Use-During-Pregnancy-and-Child-Abuse-50-State-Summary.pdf

[ii] https://ncsacw.acf.hhs.gov/files/disrupting-stigma-brief.pdf

[iii] https://www.mcedv.org/learn-about-abuse/statistics/

[iv] https://www.cdc.gov/intimate-partner-violence/prevention/index.html

Christine Alberi, Child Welfare Ombudsman
Public Hearing
OPEGA Report on Child Protective Services Case File Review for Sylus Melvin
October 16, 2023

Good afternoon, Senator Hickman, Representative Fay, and members of the Government Oversight Committee. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine.

I wanted to start by saying that I very much appreciate the challenging work that OPEGA has done to review the death of Sylus Melvin, as well as the deaths of Maddox Williams, Hailey Goding, and Jaden Harding. These are not easy cases to review, either emotionally or intellectually. The Ombudsman's office has also reviewed these four cases, but as with the previous cases, I am unable to share our findings with you due to confidentiality law.

The Child Welfare Ombudsman was created by statute, 22 M.R.S.A. §4087-A. Disclosure of information held by our office, or case-specific reports maintained by our office can only be disclosed as allowed or required under 22 M.R.S.A. 4008, subsections 2 and 3. This is the same part of the statute that does not allow the Department to share records with the public or legislature.

In addition to OPEGA and the Ombudsman's office, the Serious Injury and Death Review Panel is also able to review deaths of (and serious injuries to) children, but the Panel's information is also generally confidential. The Serious Injury and Death Review Panel also must wait to review suspicious child deaths so that the Attorney General's office can investigate and prosecute homicides.

The Commissioner is required to release information publicly when child abuse or neglect results in a child fatality or near fatality, unless the disclosure of child protective information would jeopardize a criminal investigation or proceeding.

The combined effect of all of this is that while information on child protective investigations can be released under some circumstances, that information is limited and not often timely. Confidentiality rules are important to maintain, especially when it would be easy to identify children and other family members involved in these cases, and highly sensitive information could follow individuals forever on the internet. Surviving siblings deserve privacy in the midst of already horrific circumstances.

It is worth noting, however, that confidentiality rules vary widely throughout the states and various child advocacy organizations. For example, the Connecticut Office of the Child Advocate Released a report last year on the death of a ten-month-old baby due to a fentanyl overdose. The baby died on June 28, 2023, and the Connecticut OCA publicly released their report on February 20, 2024, eight months later. The baby's mother was arrested and charged with manslaughter, but the criminal charges were still pending when the Office of the Child Advocate Report was released.

It is important that laws and oversight structure maintain the correct balance between system improvements and accountability, and privacy for the children and families involved. It would be worth looking at our system as a whole to see whether any changes could, or should, be made.

Thank you again for having me here today, and I am happy to answer any questions.

Christine Alberi
Child Welfare Ombudsman
ombudsman@cwombudsman.org
207-215-9591