Testimony of Christine Alberi, Child Welfare Ombudsman
Government Oversight Committee
Health and Human Service Committee
Joint Session
Ombudsman Annual Report Update
November 10, 2021

Good afternoon, Senator Libby, Representative McDonald, Senator Claxton, Representative Meyer, and members of the Government Oversight Committee and Health and Human Services Committee. Thank you for having me present 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. The statute also directs the Ombudsman to issue an annual report by January 1 of each year to the Governor, Legislature, and Department.

The statistics, findings, and recommendations in the annual report are based on case-specific reviews completed throughout the fiscal year. 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. Those reports are further distilled into two interim reports that are sent to the Department, detailing issues and trends.

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, it is important to note that 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. Although the Ombudsman has reviewed the cases involving the deaths of Jaden Harding, Hailey Goding, and Maddox Williams, these cases were not included in this annual report.

- 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. Learning and reform will be an ongoing process and will take time.

As we are all very aware, this spring and summer, and continuing on into the fall have been marked by continued reports in the news of deaths and serious injuries of young children.

In July of 2021 during a three-day period, I participated in the Casey Family Services and Collaborative Safety, LLC review of the deaths of Jaden, Hailey, and Maddox, who all had previous or current child welfare involvement. Casey Family Services has engaged with the organization, Collaborative Safety, LLC, to implement a new case review process informed by "safety science" within child welfare systems across the country. This is an entirely new way of thinking about how to solve problems in child welfare and improve the system. This model has had success in many other states where it has been previously implemented.

One of the most important parts of the safety science review process is that there can be no learning or solving problems without listening to caseworkers and understanding their experiences and what system issues are limiting their ability to do their jobs in the way that they wish they could.

During the Collaborative Safety review, I was able to learn from people that I as the Ombudsman rarely get to interact with: caseworkers and supervisors. The caseworkers and supervisors were present, along with child welfare directors, police, ARP representatives, and others who had roles the same as those who had been directly involved in the cases.

But the review process had started before we gathered in July. A Collaborative Safety employee had interviewed the staff directly involved in the cases to try to understand why each individual made the decisions that they did during the case. From the start, this was not a punitive process. Collaborative Safety gave those caseworkers, who had experienced the death of a child, the chance to explain what happened.

The stories of those caseworkers were then told to the larger group during the reviews, and other caseworkers in the room were able to say things like, "I totally understand, this sort of thing happens all the time when we have to respond after hours, and it is because of x, y, and z." The directors of child welfare are then able to hear those explanations, and in my experience this summer, were extremely receptive to caseworker and supervisor experiences.

The subsequent report from Collaborative Safety, LLC, has raised many questions for the legislature and the public, and I am happy that you will have an opportunity to hear from them today. It is important to understand that this report is only scratching the surface of realizing meaningful change within child welfare.

For example, take one of the key findings in the Collaborative Safety Report: difficulty engaging caregivers strongly affects the ability of child welfare to support safety for children. This finding came right from the reports of caseworkers either who were directly involved in the cases reviewed or doing similar work in the field. This finding is not the end of the process. I asked Collaborative Safety the question that is probably on everyone's mind: but now that we know this difficulty engaging parents is a serious issue, how do we fix this problem and make it so that

caseworkers can more effectively engage difficult families? The reason that the Collaborative Safety report does not give a specific recommendation for this, is that they, and people like the Ombudsman, and the directors of the Office of Child and Family Services do not know the answer. The answer to this type of answer has to come from the caseworkers themselves.

The entire Collaborative Safety model requires that caseworkers need to be involved in solving the problems of child welfare from start to finish. Caseworkers can be engaged by asking a caseworker to answer specific questions about her investigation that missed a form of child abuse or neglect, or having caseworkers sit on policy work groups from the beginning or finding caseworkers who are extremely good at engaging reluctant parents and asking what has contributed to their success. Caseworker involvement at all levels provides constructive ways to make incremental, but crucial and sustainable changes to child welfare practice.

Using Collaborative Safety to analyze and improve child welfare issues is a new idea. I am still learning about the process and the science and methodology behind it. I am very hopeful that this process, implemented in Maine in an as yet unknown manner, will be a way to bring Maine's child welfare system slowly but surely to a place where we can fully support the safety of children.

Child Welfare is an incredibly complex system, and we continue to have deep seated problems. The problems that we have did not appear overnight and we will not solve them overnight. We need to do something different than what we have been doing, and I am hopeful outside knowledge and expertise will be a step in the right direction.