Child Welfare Briefing
Christine Alberi, Child Welfare Ombudsman
Health and Human Services Committee
Quarterly Briefing
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Good afternoon, Senator Baldacci, Representative Meyer, and members of the Health and Human Services Committee. My name is Christine Alberi, and I am the Child Welfare Ombudsman. I am here today to provide a quarterly update.

The Ombudsman's office has spent some time recently looking into the history of child welfare in Maine over the past 25 years to try to understand why systemic issues in child welfare ebb and flow in such a frustrating way. In 2001, Logan Marr, a child in state custody, died at the hands of her foster parent, who was also a child welfare caseworker. At the time there were over 3000 children in state custody. This outsized number of children in state custody was due to another horrific child death at the hands of the mother's boyfriend in 1984, which caused the conventional wisdom to become: when in doubt, remove the child. Additionally in 2001, very few children were placed in kinship homes. As we have seen, highly publicized child deaths can create a spotlight on child welfare practice, and this is just what happened in 2001. Logan's death also began a series of intensive and successful child welfare reforms.

In May 2004 the Office of Child and Family Services was created which included a single system of care for Children's Behavioral Health. A new director was appointed and with several years of previous study of issues, with the help of outside consultants, and support from state government, child welfare reform started to take effect. Between 2004 and 2009 kinship placements increased from 16% to 38.9%. By 2008 the number of children in state custody dropped to less than 2000. As we all remember, in 2008 there was also a national economic crash which squeezed state budgets. Nevertheless, by 2011, Maine Child Welfare was held up as a national model by the Annie E. Casey Foundation, and Harvard's Kennedy School of Government named Maine as a finalist for the Innovations in American Government Award in 2009 due to the child welfare reforms. Child welfare professionals and legislators from Virginia, Louisiana, Maryland, and Indiana had visited Maine to observe Maine's system.

I share this to say that despite all of the problems we have now, there is no reason we cannot get back to a place where we can again be a national model. That having been said, things are more complicated now. The opioid crisis caught most state's child welfare systems unprepared. Frontline staff will report that cases are far more complicated now than they were 15 years ago, as is the risk to staff in the field. Our challenges are very different than they were in 2001.

As you know, I have been a proponent of the use of safety science to improve child welfare practice and culture. While case specific ombudsman reviews and internal federal reviews at the Department are able to determine what went wrong in any given case, safety science reviews are able to determine why decisions were made. For example, the ombudsman's office might issue a report that finds that a court petition was not filed quickly enough given the information that staff

had at the time. But the ombudsman's office is not able to determine why this decision was made. A safety science review of the same case might find that staff believed erroneously that the court would not grant a PPO without safety planning or further reasonable efforts to prevent removal. Or a review might find that staff lacked experience and training in understanding the legal standards necessary in drafting court orders. These are both systemic issues with different solutions and safety science helps to narrow the focus of system improvements to the most consequential problems. As importantly, safety science has some convincing data on successful reduction of turnover and as well as culture change once fully implemented.

Safety science was first used in Maine in 2021 to review several highly publicized child deaths that had occurred that spring and summer. It is a reasonable question to ask at this point, if we started using safety science in 2021 and 2022, why have we continued to see a decline in child welfare practice? Last week I was invited to attend a statewide supervisors meeting that turned out to be a restart of the implementation of safety science and the start of what will hopefully be an integration of the model fully throughout all levels of OCFS, which has not happened before. Although safety science staff within the Department have been working diligently to review cases, the results of those reviews have up until this point not been widely shared, and so any knowledge and understanding has not been passed along. I am cautiously optimistic that this has now changed and that all staff will now be able to benefit from this process.

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

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Annie E. Casey Report on Maine's Child Welfare Reforms:

https://assets.aecf.org/m/resourcedoc/AECF-FixingABrokenSystem-2009.pdf