NEW MEXICO
LEGISLATIVE
FINANCE
COMMITTEE

Senate Memorial 5 Task Force

September 27, 2024

Upcoming Meetings

Meeting	Focus Topic
May 24	Welcome and overview of systems
June 21	Prevention and early Intervention
July 25	Workforce
August 16	Access to services: resource families and children's behavioral health
September 27	Compliance and oversight Develop preliminary recommendations
October 18	Juvenile Justice
November 15	Final task force recommendations

Agenda

1. Organizational items: schedule through November and moving to recommendations
2. Overview of Oversight and Accountability
3. Task Force Discussion
4. Recommendation Framework

Public Comment

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Task Force Organization and Upcoming Meetings

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October 25 October 31	***Options to add time, based on Doodle Poll. Mornings looked best***
November 15	Final task force recommendations

Oversight and Accountability Mechanisms in New Mexico

Oversight of Child Welfare Systems

Federal Oversight Mechanisms

- States are required under the Child Abuse Prevention and Treatment Act (CAPTA) to establish **citizen review panels** (also known as foster care or substitute care review boards).
- States must also establish **child fatality review panels** to review, learn from or prevent child fatalities.
- The federal Administration of Children and Families provides comprehensive oversight of state child welfare agencies, but the scope is limited and driven by federal reporting (data lags 2 years).

NM Oversight Mechanisms

Substitute Care Advisory Council (SCAC) is housed within RLD but scope is limited and reporting has been inconsistent (FY23 report reviewed 242 case review for the period 2022-2022, following no annual reports).

New Mexico **Child Fatality Review** is housed within DOH and releases, non-identified, aggregate data and descriptive risk information in an annual report. Historically, reporting has been inconsistent with gaps in publication years. Reports for last two years are published online.

New Mexico Examples: SCAC

- The Substitute Care Advisory Council is created in New Mexico Statute to **provide a permanent system of independent and objective monitoring of children and youth in the custody of CYFD**.
- The Council is administratively attached to the Regulation and Licensing Department.

- SCAC **is comprised of 9 members** and is required to produce an annual report. (6 current filled)

- Statute requires an annual report, though SCAC has **not always published annual reports or had sufficient members.**

- The most recent report, published in 2023, reviewed **242 cases between July 2020 and December 2022**.

- Administrative code requires SCAC **establish priority criteria for case review each year** and shall include consideration of importance for sibling placements, frequency or severity of abuse or neglect, behavioral health status of the household, among other criteria.

FY24 Priority Case Review Criteria

- Placements in institutional or congregate care settings
- Number of children in placement
- Youth aged 13-18
- Sibling groups
- 3 or more 48-hour holds
- Requested by an interested party
- Follow-up on previous case reviews

2023 SCAC Report Recommendations

- CYFD should establish an MOU with the Council to include procedures for sharing information and responding to reports.
- The Council should develop a written plan that identifies the goals and objectives of the Council.
- CYFD should conduct internal reviews in cases of repeat maltreatment.
- Children and youth should be informed of their rights in a developmentally appropriate manner.
- CYFD should comply with existing policies and procedures related to youth services.
- Sibling groups should not split because an adoption resource has been identified for some but not all children.
- Sibling visitation should be evaluated every 90 days.
- Written discharge plans should include wrap around services.

New Mexico Child Fatality Review

- The New Mexico Child Fatality Review was established in 1998 to **examine the factors that contribute to the death of children in New Mexico.**
- Statute requires **all non-natural child resident deaths** are subject to review.
- The review panel is **comprised of a panel of experts in child safety, public health, education, juvenile and criminal justice** and is housed at DOH. (Includes SCAC representative).
- Statute requires the release of an **annual report that includes non-identified, aggregate data** and descriptive risk.
- Historically, reporting has been inconsistent.
- The most recent report was published in 2023.

2023 Annual Report

- 84 unique child fatalities reviewed.
- Report determined 80% could have been prevented.

Prevention recommendations:

- Recurring appropriations for the NM Child Fatality Review
- Pass legislation that requires birthing hospitals and facilities provide safe sleep education
- Improve access to behavioral health services
- CYFD, ECECD, DOH, and PED should require suicide gatekeeper training

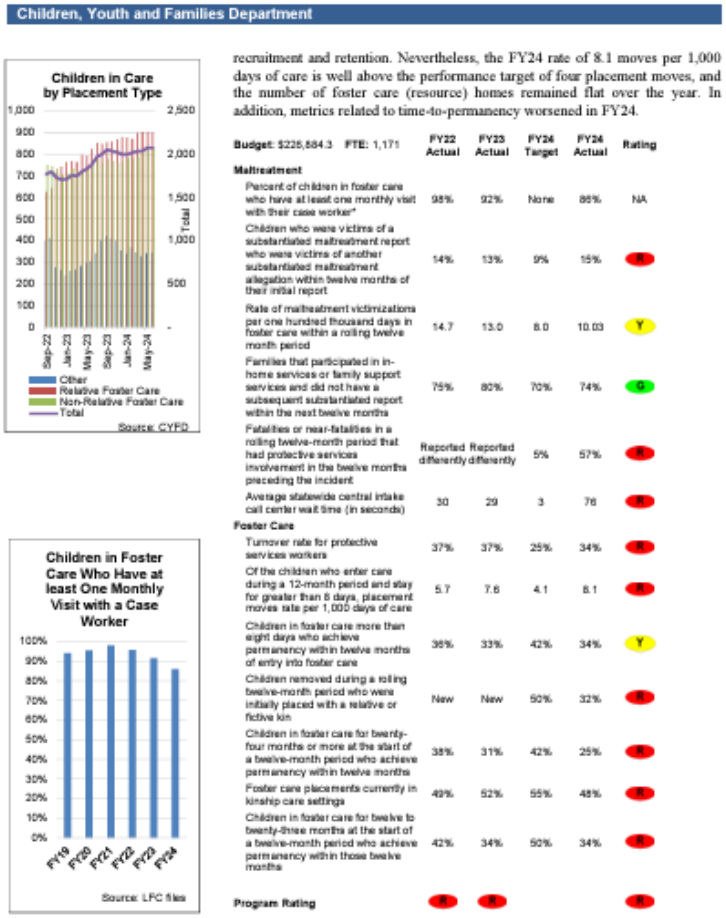
Internal Agency Oversight Mechanisms

A variety of internal oversight and review mechanisms exist within state agencies but have limitations for system oversight and improvement or public accountability.

Agency	Description	Limitations
CYFD inspector general	Reviews internal issues within CYFD	Does not publish a work plan, public report, and presents a conflict of interest if intended for system oversight
CYFD Office of Children's Rights	Youth focused advocacy	Unclear results. Remained unstaffed for several years.
CYFD Constituent Services	Position historically focused on constituent services and complaints	Ad hoc basis with no public reporting
District Court-Children's Court Improvement Commission	Cases reviews and internal recommendations for improvement	Scope specific to court proceedings. Generally does not include public reporting

Accountability in Government Act: Agency Report Cards

- The **Accountability in Government Act** (AGA) is a New Mexico Statute to provide government with the framework to provide responsive, cost-effective government services.
- Uses the state **budget process to establish performance measures and evaluate the performance** of state government.
- State agencies must **establish performance measures and report quarterly** to LFC and DFA.
- **Limitations:** driven by budgeting process and performance measurement. Does not include case review, in-depth program evaluation, or focus on recommendations for system improvement. LFC program evaluations are in-depth but ad hoc.



Children, Youth and Families Department

Children in Care by Placement Type

Children in Foster Care Who Have at least One Monthly Visit with a Case Worker

recruitment and retention. Nevertheless, the FY24 rate of 8.1 moves per 1,000 days of care is well above the performance target of four placement moves, and the number of foster care (resource) homes remained flat over the year. In addition, metrics related to time-to-permanency worsened in FY24.

Budget: $226,884.3 FTE: 1,171

	FY22 Actual	FY23 Actual	FY24 Target	FY24 Actual	Rating
Maltreatment					
Percent of children in foster care who have at least one monthly visit with their case worker*	98%	92%	None	86%	NA
Children who were victims of a substantiated maltreatment report who were victims of another substantiated maltreatment allegation within twelve months of their initial report	14%	13%	9%	15%	R
Rate of maltreatment victimizations per one hundred thousand days in foster care within a rolling twelve month period	14.7	13.0	8.0	10.03	Y
Families that participated in in-home services or family support services and did not have a subsequent substantiated report within the next twelve months	75%	80%	70%	74%	G
Fatalities or near-fatalities in a rolling twelve-month period that had protective services involvement in the twelve months preceding the incident	Reported differently	Reported differently	5%	57%	R
Average statewide central intake call center wait time (in seconds)	30	29	3	76	R
Foster Care					
Turnover rate for protective services workers	37%	37%	25%	34%	R
Of the children who enter care during a 12-month period and stay for greater than 8 days, placement moves rate per 1,000 days of care	5.7	7.6	4.1	8.1	R
Children in foster care more than eight days who achieve permanency within twelve months of entry into foster care	36%	33%	42%	34%	Y
Children removed during a rolling twelve-month period who were initially placed with a relative or fictive kin	New	New	50%	32%	R
Children in foster care for twenty-four months or more at the start of a twelve-month period who achieve permanency within twelve months	38%	31%	42%	25%	R
Foster care placements currently in kinship care settings	49%	52%	55%	48%	R
Children in foster care for twelve to twenty-three months at the start of a twelve-month period who achieve permanency within those twelve months	42%	34%	50%	34%	R
Program Rating	R	R			R

LFC Recommendations to Strengthen Child Welfare System Oversight

Over time, LFC has identified short comings in existing system oversight mechanism and recommended strengthening system oversight and accountability.

- **Move SCAC** to be administratively attached to the Administrative Office of the Courts and **strengthen oversight and reporting functions** (Ex. Increased minimum number of reports, annual review of certain types of cases, strengthening CYFD feedback and response requirements.)

- Consolidate functions of existing oversight and any newly proposed oversight mechanisms to **avoid duplication of efforts and improve coordination**.

- **Strengthen Accountability in Government Act performance measures** (Ex. Multilevel response/ differential response measures)

LFC Risk Management Recommendations

2023 Risk Management Program Evaluation

- Under rule, New Mexico agencies are required to establish and implement procedures for the investigation, analysis, and evaluation of incidents and losses, but agencies are not required to document that they perform post-hoc reviews.

- Implement best practices from other states: **through statute, direct all agencies to appoint a loss prevention review** in the event of a death, serious injury, or other substantial loss.

CYFD Costs

- Since 2021, the state has paid $21.2 million for legal settlements on behalf of CYFD.
- CYFD's liability insurance will increase by $1.5M in FY26 to a total of $5.6M.

Oversight and Accountability Mechanisms in Other States

Citizen Review Boards in Other States

- Most states house the required Citizen Review Board functions in a **health and human services agency**, the **judicial branch**, or in a **stand-alone entity**.
- New Mexico is the **only state to house in a regulatory and licensing agency**.
- Several states **codify case review criteria** and **child welfare system response** and **data sharing** in statute. New Mexico does not. Some states also require more timely or frequent reporting.

Delaware	Idaho	Nebraska
Fulfills the citizen review board function through an accountability commission. The commission must report findings and recommendations quarterly.	Citizen review functions must review all cases brought under the child protective act open for six months and report quarterly.	Citizen review boards must review cases of all children in foster care for a period of more than 6 months.

Ombudsman and Office of the Child Advocate Functions

According to NCSL, **Children's Ombudsman and Child Advocacy Offices** are an increasingly common form of oversight in other states, and **33 states have established children's ombudsman or child advocate offices.**

Duties of these offices vary by state and typically include:

- Investigating complaints from citizens and families
- Recommending system-wide improvements to benefit children and families
- Monitoring placements, programs, and departments responsible for providing services to children.

The United States Ombudsman Association establishes the following best practices:

1) Ombudsman office should be **independent** (free from outside control or influence)
2) **Impartial** (receive and review each complaint in an objective manner)
3) **Confidential** (have the privilege and discretion to keep confidential or release information related to the complaint)
4) Maintain a **credible review process**

Ombudsman and Office of Child Advocates

State Examples: Children's Ombudsman and Child Advocacy Offices

Illinois' Office of the Inspector General is located within the Department of Children and Families. It independently conducts investigations into any employee, foster parent, service provider or contractor of the Department.

Montana's Office of Child and Family Ombudsman is part of the Department of Justice and works in consultation with the child welfare department and county attorneys to strengthen children and family services.

Ohio's Youth and Family Ombudsman Office is under the Department of Job and Family Services. The office consists of a Youth Ombudsman, a Family Ombudsman and at least two regional ombudsmen. The office investigates and resolves concerns made by or on behalf of children and families involved with public children's services agencies.

Minnesota's Office of Ombudsperson for Families is an independent state agency. The ombudsperson monitors agency compliance with laws regarding child protection and placement as to the impact on children of color. The office also provides cultural diversity training to state and local courts and receives and investigates complaints.

Child Welfare Commissions and Councils

According to NCSL, since 2012 at least **8 states have created state commissions** related to child welfare.

Commissions are typically **long-term bodies** that work to address broad issues. Some commissions have served **temporary oversight functions** and sunset.

Commissions generally require **membership by appointment**.

In some states, commissions primarily serve an **oversight or advisory function**, while in a few states the commission directly oversees the leadership of the child welfare agency (ex. Oklahoma temporarily).

Child Welfare Commissions and Councils

State Examples: Child Welfare Commissions and Councils

Texas's Policy Council for Children and Families studies and makes recommendations to improve long-term services and supports, including community-based supports, for children with special health care needs, as well as children with disabilities and their families receiving protective services from the state.

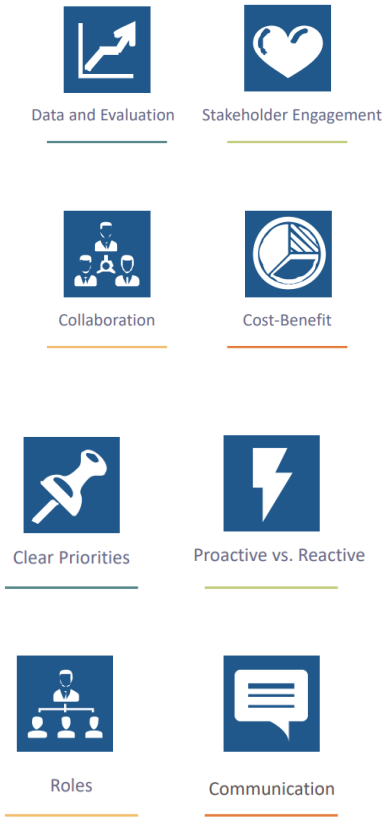
Nebraska created a committee within the State Children's Commission in 2019 as a high-level leadership body to monitor and evaluate the child welfare and juvenile justice systems.

In 2021, **Nevada** required the Juvenile Justice Oversight Commission to establish a 5-year strategic plan to establish policies and procedures for the Division of Child and Family Services of the Department of Health and Human Services. The plan must outline the use of evidence-based services to children subject to the jurisdiction of the juvenile court.

Oregon established the Governor's Child Foster Care Advisory Commission in 2016 to advise the Governor and Director of Human Services regarding foster care system in the state.

Task Force Discussion

Task Force Break Out Group Discussion



1. What should the key goals of child welfare system oversight and accountability? (identify top 3)
2. What are needs and gaps related to those top 3 goals in New Mexico?
3. What recommendations could the task force consider?

Drafting Recommendations

Framework for Child Welfare System Improvement

1. Implement **evidence-based prevention** and **early intervention programs** to support families and divert formal system involvement
2. Recruit, retain, support and develop a **professional** social work **workforce**
3. Expand **access to behavioral health and other community-based services** for children and adults, particularly **evidence-based** approaches
4. Strengthen **oversight** and **accountability** mechanisms

Task force discussions have tended to align with these themes

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