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September 23, 2021

MEMORANDUM

TO: Patricia Lundstrom, Chair, Legislative Finance Committee

CC: Senator George Munoz, Vice-Chairman, Legislative Finance Committee
Representative Nathan P. Small, Member, Legislative Finance Committee
Representative Candie G. Sweester, Member, Legislative Finance Committee
Senator Gay G. Kernan, Member, Legislative Finance Committee
Representative Meredith A. Dixon, Designee, Legislative Finance Committee
Representative Phelps Anderson, Designee, Legislative Finance Committee
Representative Joy Garratt
Representative Marian Matthews
Senator Joseph Cervantes, Co-Chair, Courts, Corrections and Justice
Representative Gail Chasey, Co-Chair, Courts, Corrections and Justice

THRU: David Abbey, Director, Legislative Finance Committee

FROM: Jon Courtney, PhD, Deputy Director, Legislative Finance Committee
Eric Chenier, Principal Analyst, Legislative Finance Committee

RE: CYFD Child Welfare Member Concerns: Staffing, Safety, and Oversight

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During the Children, Youth and Families Department (CYFD) hearing on July 21 2021, a group of legislators consisting of LFC members and guests expressed concern with CYFD operations and oversight to LFC staff. Concerns included potentially incorrect statistics shared by the agency during their presentation regarding child maltreatment, a perceived lack of transparency around cases of injury or death for CYFD involved children, and a lack of oversight. LFC staff have collected information to provide an update on these issues using available data. Note that as a result of issues found during this committee services project the LFC Program Evaluation Unit has added a program evaluation of CYFD Protective Services Division to their work plan.

LFC staff found:

- **Staffing and leadership:** Key leadership positions at CYFD have high turnover or long periods of vacancy likely impacting performance;
- **Child safety and child deaths**: Child maltreatment death rates more than doubled in FY20 and New Mexico is significantly underperforming on child maltreatment and child safety metrics, contrary to public reporting from CYFD to LFC and LHHS; and
- **CYFD oversight:** Numerous oversight mechanisms for CYFD Protective Services are in place, but these efforts could be improved upon with care taken to avoid duplication.

Staffing and leadership. ***Key leadership, field, and administrative positions have high turnover or long-term vacancies.*** Research has identified turnover and leadership as being key to success in improving child welfare outcomes. According to Casey Family Programs, turnover rates below 10 percent to 12 percent are considered optimal or healthy[1]. Child welfare turnover rates tend to range from 20 percent to 40 percent nationally, with CYFD Protective Service fieldworker turnover rates ranging between 35 percent to 45 percent over the last several years with vacancy rates ranging from 15 percent to 20 percent. Issues with turnover and vacancies are not unique to fieldworker level positions. Lack of leadership and turnover was also cited by CYFD in their FY19 financial audit (FY19), where management responded to a significant deficiency finding by citing significant turnover in Administrative Services including "loss of leadership, guidance, and oversight."[2] Similarly, CYFD's FY20 audit cited ongoing "knowledge turnover" to be an issue.

For example,

- In the last four years CYFD has had four different cabinet secretaries;
- CYFD Protective Services has been without a permanent director since 2018;
- A deputy director has been performing in an "acting" director position for 3 years;
- Another 2 deputy director positions (of 5 total) are currently in "acting" roles;
- Most other deputy director positions have turned over in the last two years; and
- The first director of the Office of Children's Rights recently resigned.

Child safety and child deaths. ***Child maltreatment and child safety measures rank among the worst in the nation with maltreatment related fatalities doubling last year.*** The previous CYFD Secretary reported (to LFC and LHHS) child maltreatment rates are below national averages[3], however child maltreatment rates in NM are 6th highest in the nation[4] significantly above national averages (see Table 1). Child maltreatment victimization rates in New Mexico are almost twice the national average. The rate consists of unique substantiated victims of abuse or neglect of which New Mexico sees around 7 thousand each year. Comparing New Mexico outcomes to the most recent available data, New Mexico's child maltreatment victimization rates (per 1,000 children) are 16.9 per 1,000 children, almost double the national average (8.9 per

[1] https://caseyfamilypro-wpengine.netdna-ssl.com/media/HO_Turnover-Costs_and_Retention_Strategies.pdf
[2] https://reports.saonm.org/media/audits/690_NM_Children_Youth_and_Families_Department_FY2019_Final.pdf
[3] See first bullet of slide 18 of presentation to LFC: https://www.nmlegis.gov/handouts/ALFC%20072121%20Item%203%20CYFD%20Status%20Update%20LFC%202021(11.pdf
[4] https://cwoutcomes.acf.hhs.gov/cwodatasite/childrenReports/index

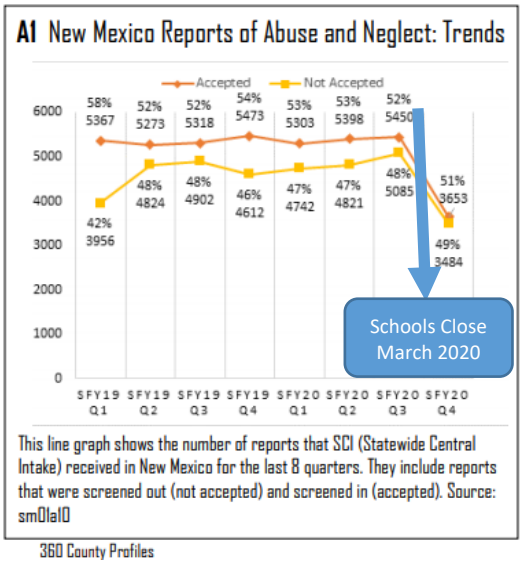
1,000). In 2019, New Mexico had the 6th highest child maltreatment rate in the nation. Although New Mexico's child maltreatment rate declined over the last two years, there is agreement among experts that child maltreatment rates likely declined nationwide during the pandemic in part due to decreased surveillance (school officials are the top source of child maltreatment reporting).

Table 1. Child Maltreatment Victimization Rate Per 1,000 Children

	2015	2016	2017	2018	2019	2020+	2021+
New Mexico	17.4	15.2	17.6	16.7	16.9*	15.1	14.3
United States	9.2	9.1	9.1	9.2	8.9	N/A	N/A

*NM had the 6th highest maltreatment rate in the nation in 2019.
+State fiscal years (Jul-June) whereas 2015-2019 are federal fiscal years (Oct-Sep)
Source: ACF and CYFD

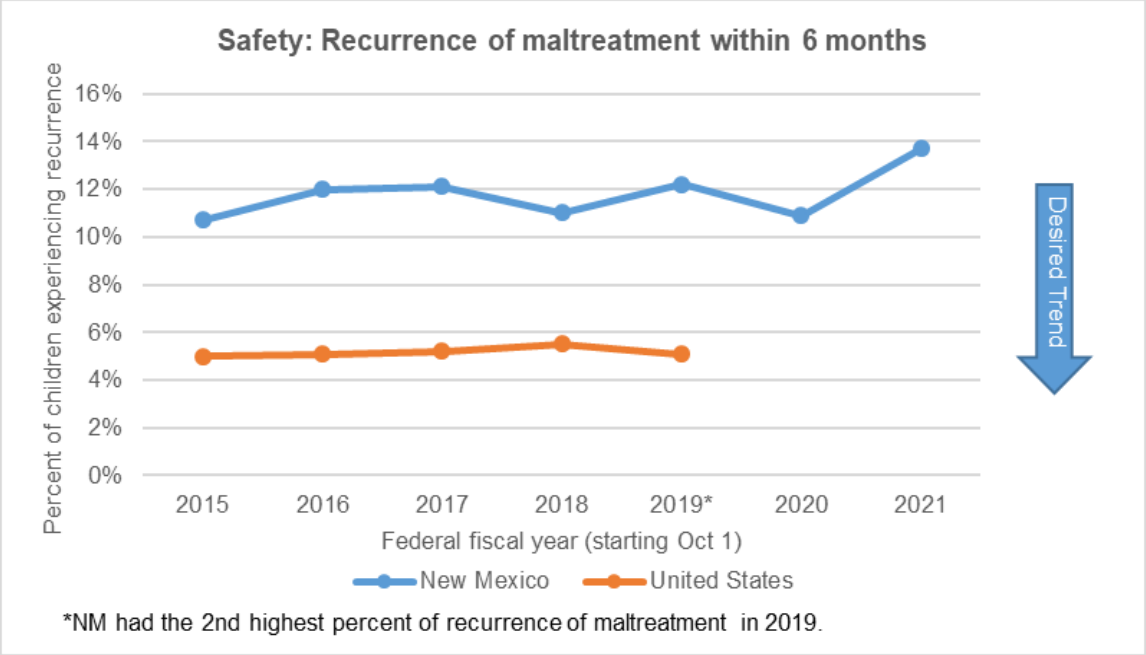
Reports of child abuse and neglect declined during the pandemic, impacted by school closures. FY21 saw the lowest number of reported maltreatment and substantiated abuse in the last eight years. The first quarter of the pandemic (SFY20 Q4) saw accepted reports of abuse and neglect decline by 24 percent and not accepted reports of abuse and neglect decline by 33 percent. Nationally, reports of child maltreatment dropped between 20 percent to 70 percent mostly attributable to less in-person surveilence from mandated reporters including teachers, social workers and physicians[5]. There has been some argument amongst child welfare experts as to whether the decline in reporting reflects a decline in child maltreatment, or simply reflective of reduced observation of maltreatment.



New Mexico has the 2nd highest percentage of children suffering from repeat maltreatment in the nation, a key child safety measure. State statute charges CYFD to take action to protect the safety of children in the home. The federal government's Department of Health and Human Services (HHS) Administration for children and Families (ACF) requires child welfare agencies to report on several metrics of child safety including reporting on some of the most vulnerable families in the system, those who have already had a substantiated case of maltreatment. Additionally, CYFD has at least one of these measures included as a performance measure reported to LFC on a quarterly basis. In 2019, New Mexico saw 12.2 percent of children who were the victims of a maltreatment allegation substantiated by CYFD, have another case of substantiated maltreatment within six months. This proportion of repeat maltreatment is among the highest in the nation, second only to the state of New York. Since that time, recurrence of maltreatment in New Mexico has increased to 14 percent. No state has reported a repeat maltreatment rate above 14 percent since at least 2015.

[5]https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a1.htm

A number of evidence-based programs and practices have been proven to reduce out of home placement and child maltreatment including family preservation services, Safe Care, Parent-Child Interaction Therapy (PCIT), and alternative response. Previous LFC studies have noted that CYFD provides fewer preventative and early intervention services per child than most other states. Although the legislature passed HB376 during the 2019 legislative session requiring CYFD to implement an alternative response system, the piloting of the system has been limited by the pandemic. Additionally, CYFD references families being less likely to access and engage in community services during the pandemic which may have led to deterioration of performance on this metric. In recent years the Legislature has appropriated additional resources for services and has provided a framework through differential response to increase preventative and early intervention services. However, progress or limitations have not been discussed in depth with legislative committees and CYFD should provide an update during their LFC budget hearing this fall. In the late 2000's CYFD's Protective Services data unit was deployed to meet with county office managers where performance was underperforming, digging into data to look for contributing factors including caseloads, such a continued practice could help to identify issues contributing to underperformance.



New Mexico child maltreatment death rates doubled in 2020, the only metric on child death CYFD is currently required to report. The requirement to report child maltreatment related deaths comes from the ACF. These deaths include both fatalities that were investigated by CYFD and those unknown to CYFD and identified as homicides by the state Office of the Medical Investigator (OMI). From 2015 to 2019 the child maltreatment death rate for New Mexico hovered around the national average. However, in 2020, the death rate jumped to almost double that. CYFD indicates that differences in fatalities from year to year are susceptible to fluctuation due to overall low numbers of fatalities each year. Additionally, delays in investigation and determination from CYFD or OMI can also impact frequencies on a year to year basis. However, there is recent literature suggesting the pandemic corresponds with

increased risk for child maltreatment[6], and increased occurrence of severe child injuries resulting from maltreatment such as abusive head trauma[7]. Data from New Mexico shows a dramatic increase in the child fatality rate during the pandemic. In 2019, New Mexico reported 11 maltreatment related fatalities whereas in 2020 the number of child maltreatment related fatalities more than doubled to 23, a 110 percent increase. However, those 2020 data will be publically released by ACF until January 2022.

Table 2. Child Fatality Rate Per 1,000 Children						
	2015	2016	2017	2018	2019	2020
New Mexico	2.8	2.2	3.3	2.5	2.3	**4.8**
United States	2.2	2.3	2.3	2.4	2.5	N/A

Source: ACF HHS Child Maltreatment Reports and CYFD ACF Submissions

CYFD oversight. ***Child welfare and child death oversight mechanisms have shortcomings and could be improved upon.*** There are both internal and external oversight mechanisms for protective services with additional oversight mechanisms existing at the federal level (see Table 3 for a summary of oversight mechanisms). Internally, CYFD has an agency wide Inspector General, a newly established Office of Children's Rights, and a Quality Assurance Unit within protective services. The CYFD Inspector General has a wide scope over the entire agency including staff misconduct. The CYFD Inspector General does not publish their work plan publically, has a vacancy rate of 33 percent (6 of 9 positons filled), and possesses an inherent conflict of interest as they work for the leader (Cabinet Secretary) of the agency for which they are responsible for oversight. The legislature has a proposed mechanism to address these types of conflict of interest situations and improve oversight (e.g. 2014 SB13, State Inspectors General Act), but these bills have not been successful. Constituent services positons respond to complaints from the pubic including CYFD involved families, but work is done on an ad hoc basis with no reporting to the public. The Office of Children's Rights is focused on youth advocacy issues but CYFD recently dismissed their first director. Although CYFD involved youth are more at-risk than those in the general population, younger children make up a larger proportion of protective services cases, and younger children tend to be more vulnerable. The Quality Assurance Unit conducts case reviews based on federal best practices reviewing county office operations, but the Unit only reviews one county each month and have been conducting reviews remotely due to the pandemic. Note that CYFD Protective Services reports having developed a protocol system to report "serious injuries" or near fatalities to the Secretary, Chief of Staff, and Executive Management, but no public reporting of these data exist.

There are numerous oversight mechanisms external to CYFD but there are either inadequate or provide dated information to the public. External to CYFD at the state level, a number of oversight mechanisms exist. CYFD participates in existing child fatality review panels including the Child Fatality Review Board (CFRB) and the Maternal Mortality Review (MMR). However, reports to the public from these panels have been lacking with the CFRB not having released a report since 2015. Note that the CFRB indicates they are working on reporting for 2018 and 2019 which should be available later in 2021. The Substitute Care Advisory Council (SCAC)

[6] https://www.sciencedirect.com/science/article/pii/S2665910720300384
[7] https://adc.bmj.com/content/archdischild/106/3/e14.full.pdf

was put into place by the state Act of the same name (Chapter 32, Article 8 NMSA 1978), and fulfills a federal requirement from the Child Abuse Prevention & Treatment Act (CAPTA) asking states to establish volunteer citizen panels to review child welfare policies, and practices[8]. The SCAC is currently placed within the Regulation and Licensing Department (RLD) overseeing review boards, yet the FY20 SCAC annual report identifies this placement as a liability due to a perceived lack of ability to pursue a statutory charge of independence and autonomy preferring to be administratively attached to the Office of the State Auditor. Given the deep involvement of the judiciary in child welfare issues, the Administrative Office of the Courts (AOC) would likely be a good administrative partner for the SCAC. Additionally, housing such a function in the judiciary rather than the executive could improve independence of function. There may be additional issues with SCAC following statute law calls for establishment of training requirements, criteria for designation of cases, and procedures for board review of cases in rule. Administrative rule on these issues tends to shift the responsibility to the council instead of defining in rule. Regarding operations, FY20 SCAC reviews are limited to youth and limited in number (FY20=100 children reviews) such that reviews are likely not statistically representative of children involved in the child welfare system[9]. Additionally, the FY20 SCAC annual report cites a number of issues they feel need to be addressed to improve performance, notes that previous recommendations from SCAC to CYFD have not been addressed, calls for a number of additions to law including mandating CYFD to provide a formal response, and a recommendation that the CYFD Cabinet Secretary be included on the Council (which would create a conflict of interest as previously identified for the CYFD Inspector General). Note that there is a federal mandate for a formal response from CYFD within 6 months of the SCAC report, however this year (FY20) the response came 10 months after. Court Appointed Special Advocates also have access to case files with volunteers assisting children in court but this role is based in advocacy rather than oversight.

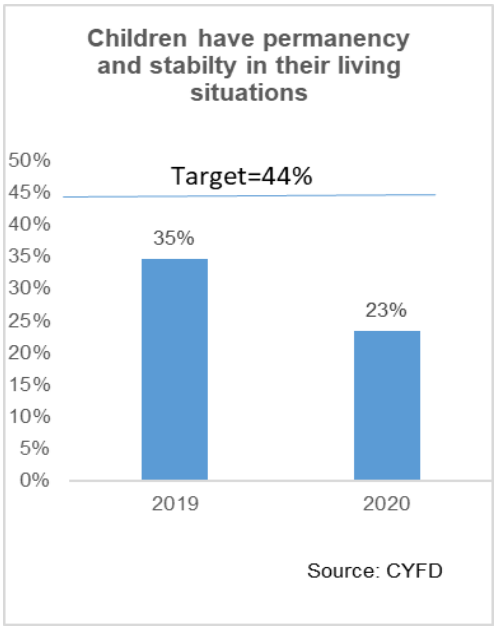
District courts also have a 6-month case review mechanism but those reviews are not summative and no public reports are created. There are additional court review mechanisms aimed at quality improvement (e.g. Children's Court Improvement Commission (CCIC) and Court Improvement Project), however these mechanisms do not necessarily fill a compliance or performance oversight mechanism. CCIC reviews often concentrate on removing barriers to permanency in select judicial districts. Other state level oversight mechanisms including the Office of the State Auditor, the Office of the Attorney General, and the Legislative Finance Committee offers some additional oversight, although regular oversight tends to be fiscal in nature, and performance oversight is limited with the exceptions of ad hoc investigations or evaluations. Statute limits LFC oversight to non-confidential information and therefore LFC has no ability to conduct case reviews (LFC has previously requested case specific data and to participate in ride alongs but this has been denied by previous administrations). There have also been proposals and legislation (e.g. HB213 2020 regular session) to create on ombuds office for CYFD which is a practice a number of other states employ to strengthen oversight. According to NCSL, these offices exist to investigate complaints, recommend improvements, protect the interests and rights of families and children, and monitor programs which may include facility inspections. Twenty-two states have established such an office with another five states

[8] CAPTA Section 106 (c)

[9] Note previous iterations of the SCAC (Citizens Review Board) reviewed over 3 thousand cases in some years: http://www.pacwrc.pitt.edu/Organizational%20Effectiveness/AdmnsHndbk/RsrcMtrls/CAPTA/NtnlDrctry.pdf

possessing a statewide ombuds office addressing all government agency concerns[10]. The Courts, Corrections and Justice Committee is examining a potential Ombudsman on their September agenda (September 28, 9am)[11].

The strongest and widest reaching oversight of CYFD is from the federal government, but this oversight prioritizes federal policy and does not provide the public with timely information. The most widespread oversight tends to come from the federal government in the form of the Administration for Children and Families tied to their Child and Family Services Review (CFSR)[12] and associated activities (IV-E funding audit). CFSR's contain three goals including compliance with federal child welfare requirements, examining the experiences of child welfare involved families, and assistance with helping states achieve positive outcomes. This includes performance on previously mentioned child safety measures. These outcomes metrics and CFSR priorities are included in much of the aforementioned Quality Assurance Unit activities. As a part of CFSR's, child welfare agencies develop a Program Improvement Plan (PIP) to address shortcomings in areas needing improvement within the child welfare system. CYFD Protective Services works to set targets in the areas of safety, permanency, and well-being. Targets are sometimes set to be more achievable than national standards or averages, which often reflect higher performance at the national level. CFSR PIP activities, metrics, and performance are reported annually in CYFD's Annual Progress and Service Plan (APSR)[13]. The APSR shows underperformance on metrics related to safety, permanency, and well-being although progress has been seen in some areas. However, the APSR shows that the permanency outcome "Children have permanency and stability in their living situations" has seen a lack of progress and is an area of concern.



[10] https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx
[11] https://www.nmlegis.gov/Agendas/CCJageSep27.21.pdf
[12] https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews
[13] https://cyfd.org/docs/NM_CYFD_FY2021_APSR_FINAL.pdf

The LFC Director asked for staff to provide next steps to address issues with performance and accountability.

Next steps.

Staffing and leadership. CYFD should identify a permanent protective services director or promote the acting director to permanent director if warranted. Furthermore, CYFD should follow previous LFC staffing recommendations implementing research-based hiring practices including using information garnered from exit surveys to identify issues impacting retention given continued high turnover and vacancy rates[14].

Child safety and child deaths. Numerous previous LFC reports have identified differential response as an effective evidence-based practice to reduce child maltreatment. CYFD should continue with the pilot of differential response and provide a plan for expansion as statutorily required by July 2022. CYFD should incorporate federal child maltreatment death reporting into public reporting documents when available to increase transparency. Furthermore, previous LFC reports have identified New Mexico Protective Services as having a lack of resources dedicated to evidence-based prevention and early intervention and the legislature has provided additional resources for such programming. CYFD should provide an update on those efforts to LFC during their fall budget hearing[15]. Child death review mechanisms should resume public reporting to identify common trends and potential strategies to better prevent this outcome.

Child welfare oversight. CYFD should submit timely feedback to the SCAC annual reports (within 6 months) to meet federal requirements. The SCAC should promulgate rule to come into compliance with statute (Chapter 32 [32], Article 8 NMSA 1978). The Legislature should consider moving the SCAC to be administratively attached to the Administrative Office of the Courts.

The legislature should also consider consolidating functions of existing and newly proposed oversight mechanism to avoid duplication of efforts and to pursue potential opportunities for efficiency and coordination (including the SCAC, CFRB, MMRs, and potential CYFD ombuds proposals). According to federal guidance existing panels including child death review panels (e.g. CFRB) meet the federal CAPTA requirements for review panels[16]. Similarly, under the previous Cabinet Secretary, CYFD equated the function of the existing CFRB to an ombuds office[17]. The challenge in proposing such an office in New Mexico will be to avoid duplication of efforts while accomplishing best practices in oversight including making recommendations for systemic change and oversight of progress on implementing such changes.

[14] https://tinyurl.com/2011LFCCYFDEVAL
[15] https://tinyurl.com/LFCCYFDRESULTSFIRST
[16] https://www.childwelfare.gov/topics/management/administration/partnerships/oversight/citizen/
[17] https://cyfd.org/news/news/big-plans-for-increased-transparency-accountability-from-cyfd

Table 3. CYFD Protective Services Specific Oversight Mechanisms

Location and Entity	Entity Description	Significant Issues
Internal to CYFD (within agency)		
CYFD Inspector General	Internal issues to CYFD including staff misconduct	Does not publish work plan, reports not public, inherent conflict of interest by working under the leadership of the department they are investigating
Office of Children's Rights	Youth focused advocacy	Unclear results and recent firing of director
Constituent Services	CYFD historically has had constituent services positions to address complaints	Efforts are on an ad hoc basis with no reporting to the public.
Quality Assurance Unit	Conducts case reviews in a different county each month	Reviews done remotely due to pandemic; limited in coverage of state, results of reviews not publically available
External to CYFD (state level)		
Substitute Care Advisory Council (SCAC)	Case review, youth focused	Limited scope (performed 90+ reviews in 2020). More severe cases of maltreatment tend to be in younger cases but focus of SCAC is on older children
District Courts	6 month case review, Children's Court Improvement Commission	Specific case related/specific scope with no summative reports for the public.
Child Fatality Reviews	Child Fatality Review Board (CFRB) and Maternal Mortality Review (MMR)	The CFRB has not released a report since 2015, MMR (created in 2019 by the legislature) is yet to release statutorily required reporting
Court Appointed Special Advocates (CASA)	CASA volunteers advocate for children's best interests in court.	CASA services provide valuable resources for children via case review but the role is advocacy rather than oversight.
Other state level oversight	State Auditor[18]; Attorney General, LFC	Other than financial reviews, investigations often ad hoc
External to CYFD (federal level)		
Administration for Children and Families	Child and Family Services Reviews; IV-E Audit	Likely the strongest and most comprehensive oversight however, Scope is limited and driven by federal priority and publically available information is dated (typically publically reported data is 2 years old

Source: DHHS ACF, CYFD, DOH, LFC Files

JC/EC/al

[18] Note that the FY19 audit of CYFD found both material weaknesses and significant deficiencies with management citing issues with significant turnover, loss of leadership, and oversight as contributing factors.