New Mexico Department of Justice

New Mexico's Children Deserve Better.

Based on the NMDOJ Investigative Report: Systemic Failures: How CYFD Endangers the Children It's Meant to Protect | nmdoj.gov

20,000+ pages reviewed · 150+ witnesses interviewed · 206 pages of findings

14

Child deaths tied to CYFD lapses (last 2 years)

#1

Worst child fatality rate of all western states

12.6

Children per 1,000 maltr. in NM vs. 7.4 national avg (40% above)

15%

Repeat maltr. In NM vs. 9% national benchmark (360 fewer cases if same rate as benchmark)

New Mexico Department of Justice

ALBUQUERQUE NEWS

Albuquerque family says toddler was failed by system before her death

by: Gabe Chavez
Posted: Jun 4, 2026 / 08:52 PM MDT
Updated: Jun 5, 2026 / 03:13 PM MDT

ALBUQUERQUE, N.M. (KRQE) – An Albuquerque family is mourning the death of a nearly 2-year-old girl after police say her mother abused her, leading to her death. Now, the family said the Children, Youth and Families Department of New Mexico failed to protect the child despite multiple reports of abuse and neglect.

In a statement Thursday, CYFD said there was not enough evidence to substantiate allegations made in a previous report involving Molina from last year involving the infant. The department said it has investigated eight reports of abuse or neglect involving Molina and her children since 2019. According to CYFD, the three most recent reports involved Anastasia.

CYFD defends decision to send American citizen teenager to his abusive, estranged mother in Mexico

by: Jordan Honeycutt, Jessica Garate
Posted: Jul 22, 2026 / 11:07 PM MDT
Updated: Jul 23, 2026 / 10:56 AM MDT

NEW MEXICO (KRQE) – Earlier this month, the Children, Youth, and Families Department of New Mexico drove to the Mexico border and dropped off a 15-year-old in their care. The teen, an American citizen, was expected to cross into an unknown country alone, to an abusive mother he rarely saw.

On July 6, a CYFD employee escorted the boy to the bridge from El Paso into Mexico. CYFD has no jurisdiction to cross an international border. The boy was released to walk over the bridge, the CYFD employee called the mother who said she'd Facetime back with the boy, but he never arrived on the Mexico side. He apparently crossed over several lanes of traffic and walked back into the U.S. Border Patrol checkpoint and then fled into Texas. He was later picked up and taken to a shelter in Texas. In the ensuing days, CYFD secured prescription medications the boy needed and delivered them in person to the shelter.

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PART ONE

Investigation Findings

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Systemic Failures

The NMDOJ investigation identified five core breakdowns endangering New Mexico's children

1 Leadership, workforce & practice breakdowns

Unqualified leadership, accountability avoidance, social worker shortage, crushing caseloads, investigation failures, and permanency delays.

2 Missed removals & premature reunifications

Children left in dangerous homes or returned to unfit caregivers without the services or intervention needed to resolve safety threats.

3 Gaps in protecting drug-exposed infants

1,200+ at-risk newborns per year. CARA untimely implemented. Preventable deaths from fragmented oversight.

4 Partners devalued – law enforcement & foster parents

CYFD impedes 72-hour holds and forensic interviews. Foster parents are often unsupported and face retaliatory measures.

5 Unstable and volatile placements

Children experience placement churn, face physical and emotional harm in CYFD offices, and lack of individualized care in congregate facilities. **Each disruption amplifies trauma.**

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Systemic Failure #1 – Leadership, Workforce & Practice Breakdowns

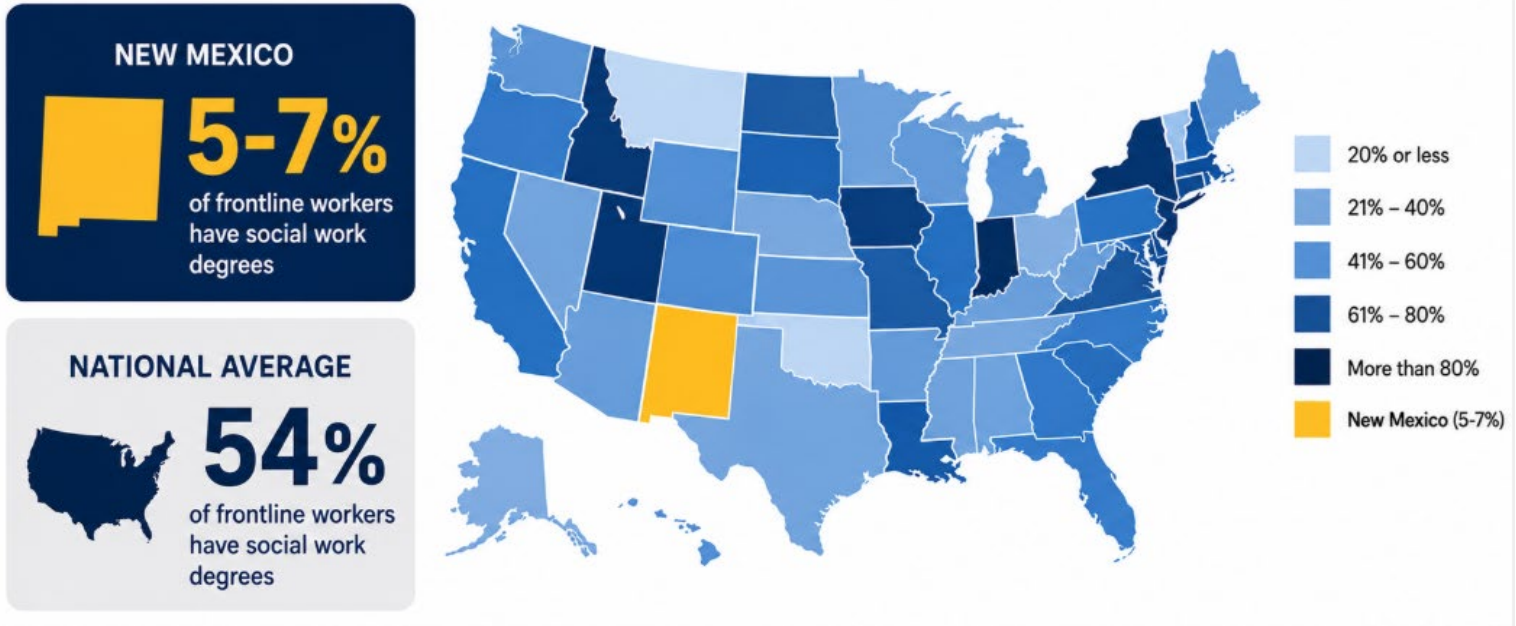
"Do not ever bring that up with me again." — Former Secretary Casados to Associate Director of Permanency when discussing the legal risk of non-social workers conducting assessments.

Leadership Crisis

- **Unqualified executive leadership.** Former Secretary lacked child welfare credentials; made personality-driven, rather than child-centric decisions.
- **Patronage hiring.** Son-in-law, granddaughter, granddaughter's boyfriend, and personal friends placed in key roles.
- **Culture of retaliation.** Employees mistreated or pressured to resign for raising legitimate concerns.

Workforce Strain

- **Acute social worker shortage.** As of December '25, roughly **5%** of front-line PSD staff – and **18%** of supervisors – hold an active social work license.
- **Chronic turnover.** PSD turnover has **exceeded 30%** for three consecutive years – often 3x the national optimal rate of 12%. New hires leave fastest.
- **Crushing caseloads.** PPW caseloads above 60 average (*Kevin S.* max: 15). One investigator carried **150 open investigations** – 10x standard.
- **Training & supervision gaps.** Caseworkers assigned before training is complete; supervisors routinely skip pre-initiation, closure and "3+" staffings.



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Systemic Failure #1 – Leadership, Workforce & Practice Breakdowns

"…Home visits were often skipped entirely—and in some instances, investigators fabricated documentation to indicate compliance." — Former Investigations Supervisor.

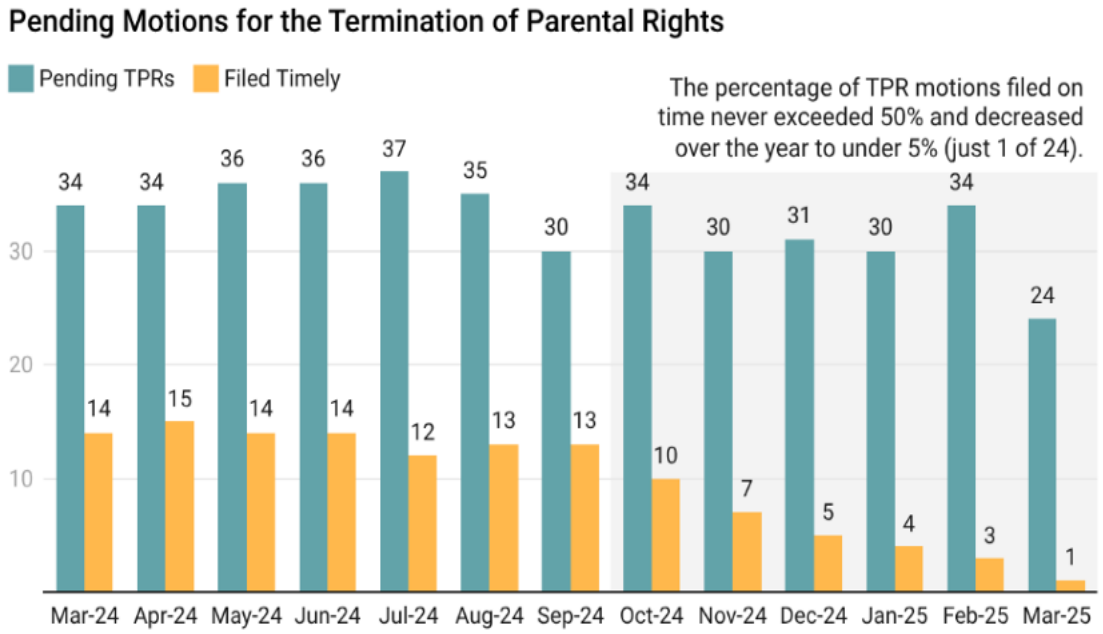

Figure 7. *Number of total pending termination of parental rights motions, including those filed timely, March 2024-March 2025. Reproduced from CYFD's March 2025 Data Evaluation Unit report.*

Flawed Investigations & Permanency Practices

- **Deficient interviews.** Non-offending caregivers, siblings, and key collateral witnesses routinely not contacted; over-reliance on parental accounts.
- **Skipped home visits.** Mandatory home observations frequently bypassed; hazardous conditions ignored or explained-away.
- **Misuse of SDM tools & safety plans.** Safety and risk tools misapplied; hollow and unenforced safety plans used to close cases prematurely.
- **Service coordination gaps.** Resource/service referrals to families routinely not made, or without meaningful follow-up.
- **Unsupported investigative decisions.** Misunderstanding of evidentiary threshold; Nearly 80% of investigations deemed unsubstantiated on average.
- **PPW performance lapses.** Lack of communication; irregular assessment of level of care; missed transportation duties; neglect of educational needs.
- **Permanency delays.** Untimely permanency reports; court no-shows; TPR deadlines ignored; Nominal adoptions finalized.

"We have cases where the judges are making us come in weekly, essentially to scold CYFD about their lack of movement on cases where kids should be adopted." — Youth Attorney.

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Systemic Failure #2 – Missed Removals & Premature Reunifications

What the Law Requires

State law is clear: when family preservation conflicts with a child's health and safety, the child's interests take precedence.

What CYFD Does

CYFD has inverted its mandate—prioritizing reunification at any cost—returning children to caregivers with substantiated histories of abuse and dangerous neglect, without ensuring necessary family services.

NEW MEXICO CHILDREN'S CODE

"A child's health and safety shall be the paramount concern."

- Section 32A-1-3(A) – Legislative purpose of the Children's Code.

What Former CYFD Investigators Say:

- Former investigator in southern NM recalled being "pressured to leave children in homes with overwhelming amounts of animal waste, serious structural damage, and a lack of basic utilities."
- Metro investigator confirmed that "the pressure to reduce backlog often incentivized superficial investigations."
- Investigator was instructed by supervisors to sanitize her report to hide the warnings she gave prior to child's death.

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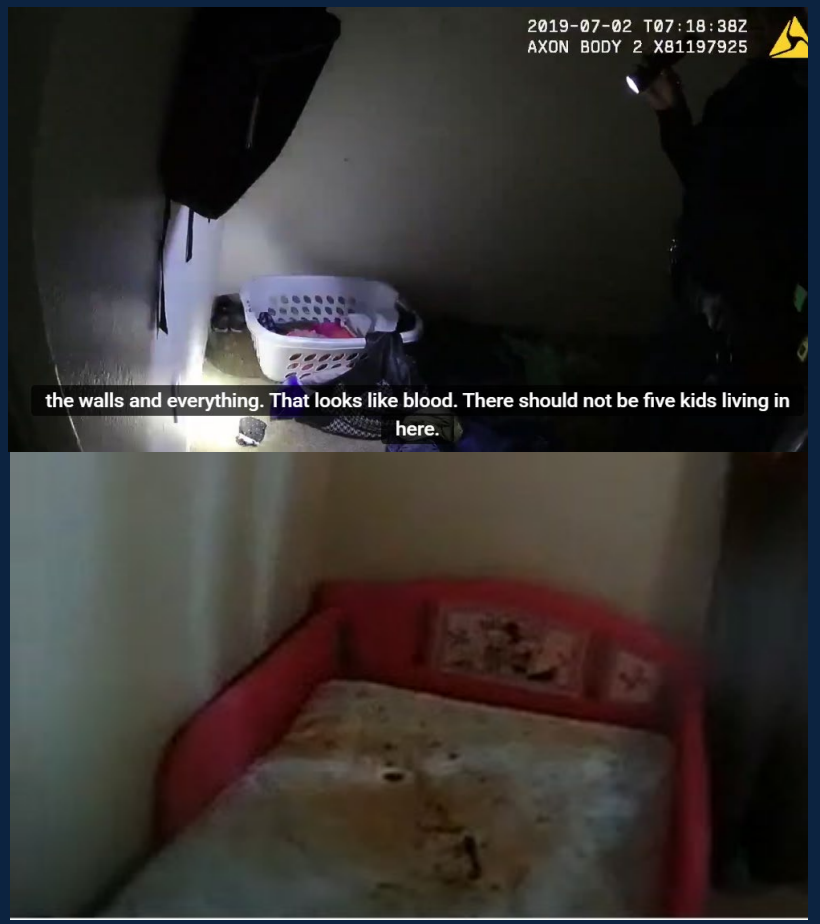
Elena, 16 Years Old

FLAWED INVESTIGATIONS & PREMATURE REUNIFICATION

7 investigations. 0 meaningful interventions.

- Elena was nonverbal, blind, and entirely dependent on her mother for survival.
- CYFD investigated seven referrals from police, school personnel, and medical providers. Documented missed medical appointments and hazardous living conditions (trash, urine/feces in Elena's living area, bug infestation, insufficient food). Twice resulted in criminal charges.
- CYFD determined that there were "no services needed." Closed cases without providing the family any meaningful services.
- Elena found emaciated, with pressure sores, insect bites, and maggots on her body. Mother admission to not changing, feeding, or caring for Elena for a week. *Cause of Death: Malnutrition and dehydration from prolonged neglect.*

Despite Elena's horrific death, CYFD employee testified in court *in favor of releasing* Elena's mother so that her remaining children can be reunified with her.



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Lucas, 8 Months Old

REUNIFICATION DESPITE ONGOING HARM

23 abuse and neglect reports. Fatal outcome.

- Four children (including Lucas) born drug-exposed. Admission to prolonged meth use.
- Eight-month-old Lucas died after being found wedged between a mattress and the wall in a filthy, drug-filled home. *Cause of death: Asphyxia due to an unsafe sleeping environment. Meth toxicity in Lucas's system was a significant contributing factor.* Three of his five siblings tested positive for meth.
- 18 unsubstantiated investigations despite credible reports of physical abuse, parental drug use, and medical neglect.
- CYFD approves trial home visit with remaining siblings after Lucas' death. Positive drug tests continue. Daycare workers document new injuries.

CYFD sought reunification of Lucas' siblings with their mother four days after mother's indictment for death of Lucas. Children would have been reunified had mother not been sentenced to 12 years in prison.

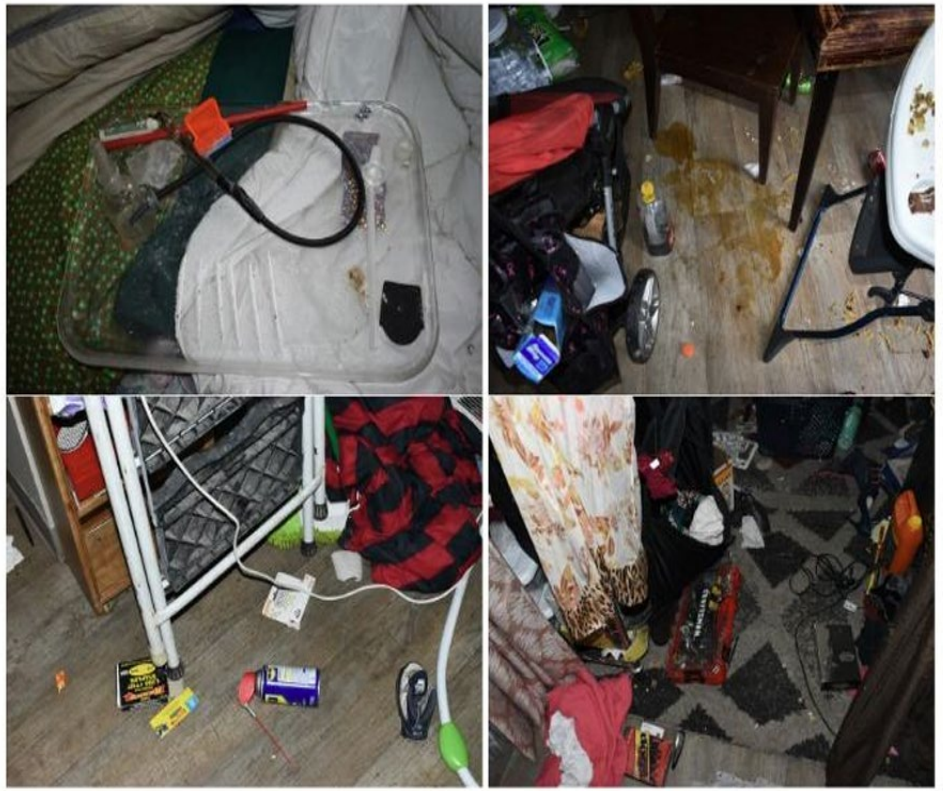

Figure 11. *Photos from APD investigation on June 17, 2022. Clockwise from top left: Cocaine, meth, and drug paraphernalia; stains and rotting food; tools and chemicals; and aerosol spray.*

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Isabella, 1 Year Old

PREMATURE TRIAL HOME VISIT

Reunification despite continued danger indicators.

- Isabella born extremely premature and drug-exposed, spending five months in the NICU. Discharged to great-aunt due to physical violence and drug use in home.
- She thrived under her great-aunt's care. CYFD endorsed trial home visit despite: (1) prior substantiated abuse/neglect; (2) father's 20+ felony arrests/convictions for child abuse, drug trafficking, and firearms offenses; (3) three drug-exposed children; (4) parents' failure to attend early intervention services; (5) lack of bonding; (6) inability to contact parents; and (7) Isabella dirty, unfed, and bruised after unsupervised visits.
- 42 days later after trial home visit started, Isabella killed by her mother. *Cause of death: Homicide by blunt trauma to face, head, and neck.* Isabella's seven-year-old brother told forensic interviewers Isabella was slammed against a wall by their mother.

A CYFD worker told Isabella's great-aunt, "We knew she shouldn't have gone back." Several employes temporarily placed on administrative leave but remain with Department.

Figure 14. *Photos from APD investigation on August 2, 2025. Clockwise from top left: Rotten food and trash in bedroom; syringes, naloxone, and marijuana; and unsanitary bathroom.*

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Systemic Failure #3 – Gaps in Protecting Drug-Exposed Infants

"When we called CYFD…they told us there's a CARA plan in place, this baby is safe to go home. Then we discharged the baby on a Thursday and that baby came back on a Sunday. And he passed away, he died…I still have PTSD from it. The look on his face when he came back through the unit was like pure panic on the baby's face. And the mom was like, I couldn't get him to stop crying. So I dipped the pacifier in fentanyl and gave it to him." — NICU nurse, after conveying concerns to CYFD with discharge of drug-exposed newborn to parents.

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Systemic Failure #3 – Gaps in Protecting Drug-Exposed Infants

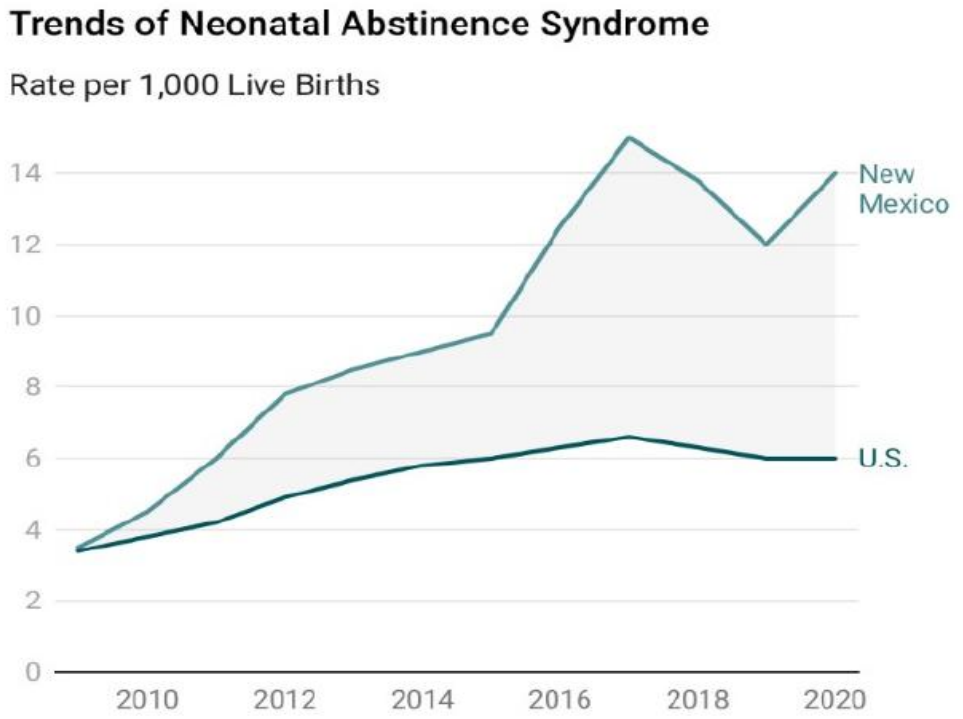

Figure 16. *Rates of NAS in New Mexico compared to nationwide, 2009-2020. Reproduced from LFC CARA Program Evaluation (October 27, 2023).*

CYFD's Implementation Failures

- **Missed statutory deadline by 2+ years.** Regulations to guide hospitals and medical providers required by January 2020 not issued until February 2022.
- **No training, no awareness.** Many NICU nurses report not being trained on CARA; **42%** of CARA families surveyed didn't know what a CARA plan was 11 months later.
- **Toothless plans.** Only 15% of CARA families accepted referrals to substance-use treatment; 19% declined; **Nearly half** were never referred at all.
- **Plans a proxy for safety.** Existence of CARA plans became grounds to screen-out abuse/neglect reports despite ongoing safety risks and service refusal by parents.
- **Diffuse responsibilities.** Patchwork of duties between CYFD investigators and Family Services Division, MCO care coordinator, and DOH CARA Navigator.
- **Unqualified safety monitors.** Often lacked training, accountability, or willingness to protect newborns they are overseeing.
- **July 2025 policy directive.** CYFD unclear on how many newborns impacted by Governor's directive requiring filing of abuse/neglect petitions.

Senate Bill 42 (2025) seeks to address many of these issues.

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Systemic Failure #4 – Undermining Law Enforcement

"CYFD's main mission is not the child's safety. Their number one goal is to keep kids with family, no matter what." — Former APD Detective.

The Investigative Cost

- **Resists 72-hour holds.** Officers told situations "don't qualify" for a 72-hour hold despite no such legal restriction.
- **Premature returns to danger.** Children returned to abusive caregivers within hold period, prompting repeat police calls.
- **Forensic interviews compromised.** When children are returned prior to hold expiration, caregivers refuse CART exams and forensic interviews.
- **Barriers to cooperation.** Prolonged communication challenges and inconsistent application of policy.

Case Study – "Alexis D."

- **Escalating danger.** Law enforcement responded to 176 calls for service and made 60+ notifications to CYFD.
- **Failure to act.** CYFD screened out reports, ignored school and hospital concerns, returned children after violent incidents, dismissed Alexis' pleas for help, and declined hold after child pointed gun at deputies.
- **BCSO becomes child welfare agency.** BCSO's BHU took lead in stabilizing the family, securing wraparound services, therapy, educational support, transportation, and housing assistance.

Figure 20. *BCSO drone footage on February 16, 2025, showing seven-year-old Charles pointing firearm*

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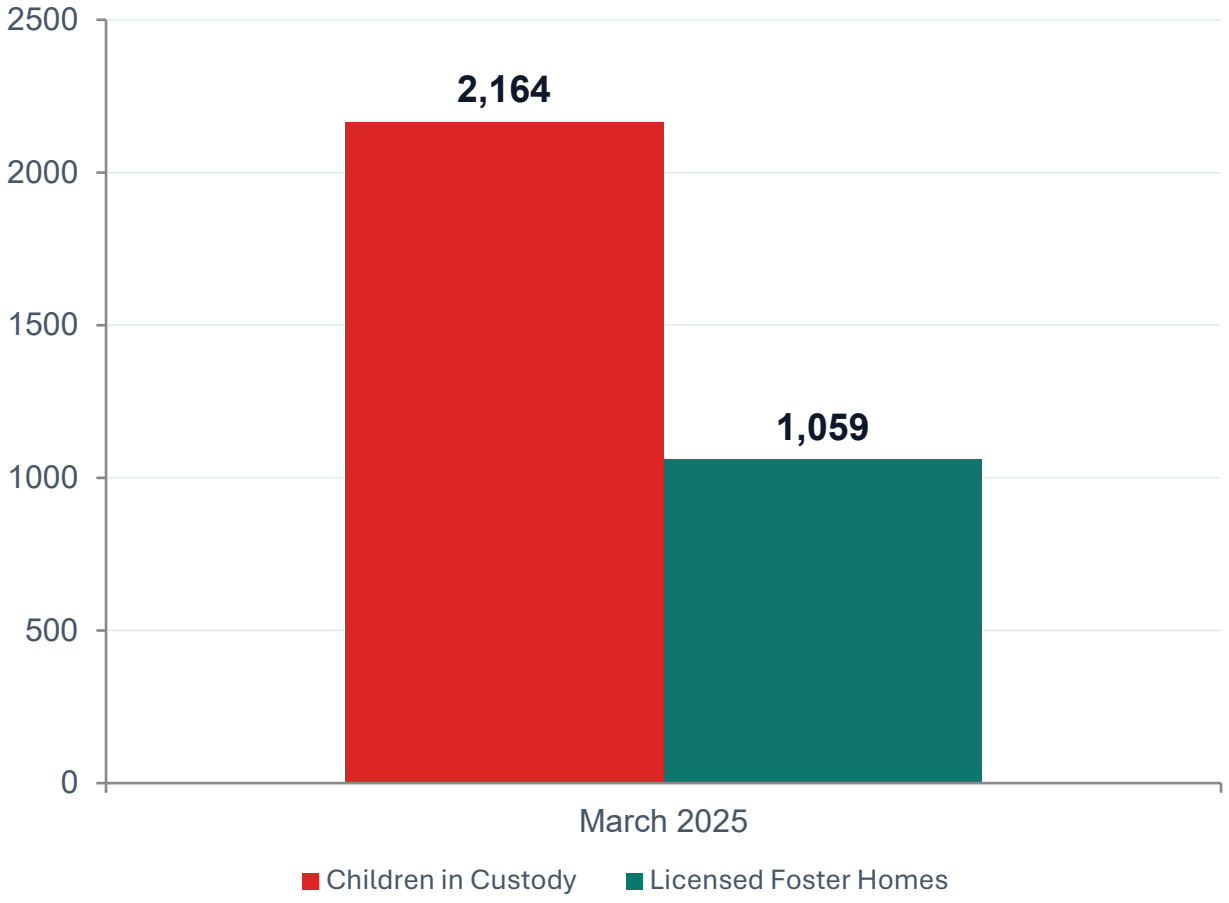
Systemic Failure #4 (cont.) – Devaluation of Foster Parents

2,164 Children. 1,059 Homes.



3

net new foster homes gained per month (March '24-'25)

26%

of foster families not renewing their license

- **Discouragement of foster parent networks.** Peer support groups stifled.
- **Foster Parent Bill of Rights violated.** Treated as expendable "babysitters."
- **Retaliation.** Removal of children without notice or justification; threat of prosecution; license non-renewal; complaints shared with offending employee.

"If [CYFD] doesn't like you, they can take your kids and there's nothing you can do."
— New Mexico foster parent.

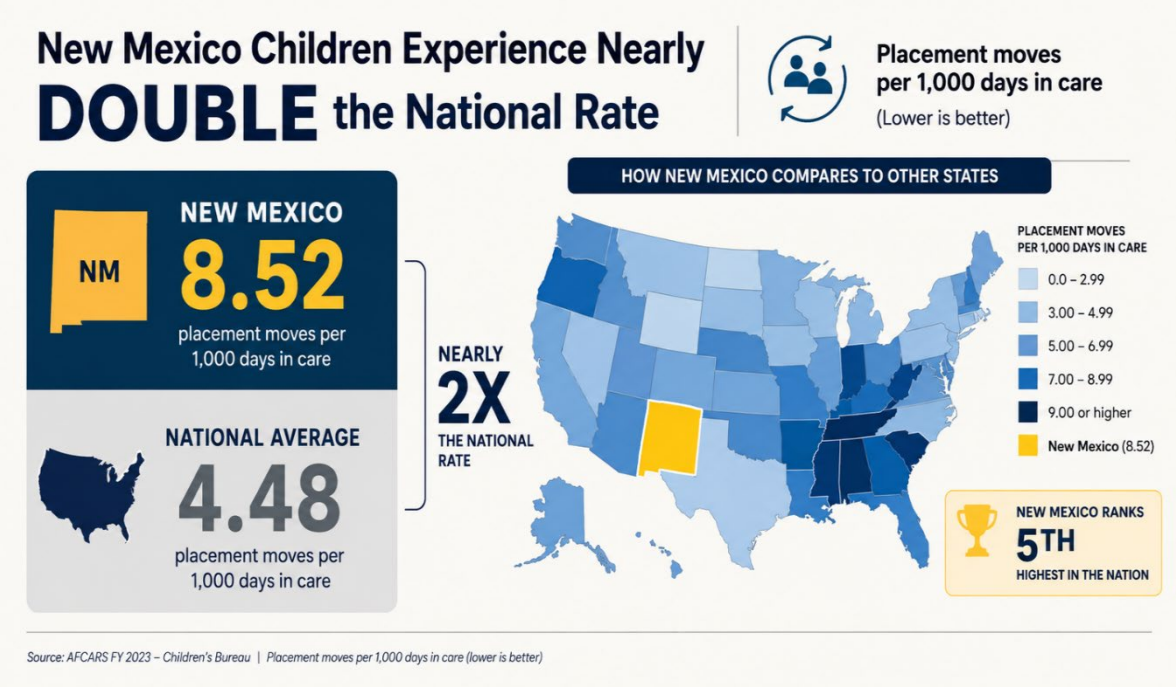
New Mexico Department of Justice

Systemic Failure #5 – Unstable & Volatile Placements

"What's the point of living if I'm going to live here forever?"— 10-year-old boy living in CYFD office, to APD officer.

Excessive Placements

- **Youth perspectives on placement transitions.**
  - **"Jacob L."** – Over 30 placements during 5 years in state custody. CYFD ignored physical assaults, discontinued school transport, and skipped required visits. Jacob described his time as "hell."
  - **"Emma F." –** Over 20 placements, including multiple congregate facilities and CYFD offices. Assaulted, fed frozen food, and placed with violent relatives. CYFD sanctioned multiple times.



Traumatic Stays in CYFD Offices

- **Underreporting to LFC.** Review indicates CYFD leadership underreported number of children in offices to LFC.
- **Sexual assault, self-harm, violence.** Frequent police dispatches for violence, sexual assault, threats of suicide, and contraband.
- **No privacy, no routine.** Children sleeping in storage closets and conference rooms. Confidential attorney calls monitored.
- **Staff misconduct.** Security guard told one teen she needed "a good old-fashioned ass whooping"; another pushed her to the floor.
- **Executive order, but…** The Governor's January 2026 executive order bans office stays beginning March 1, 2026. But CYFD made the same commitment before.

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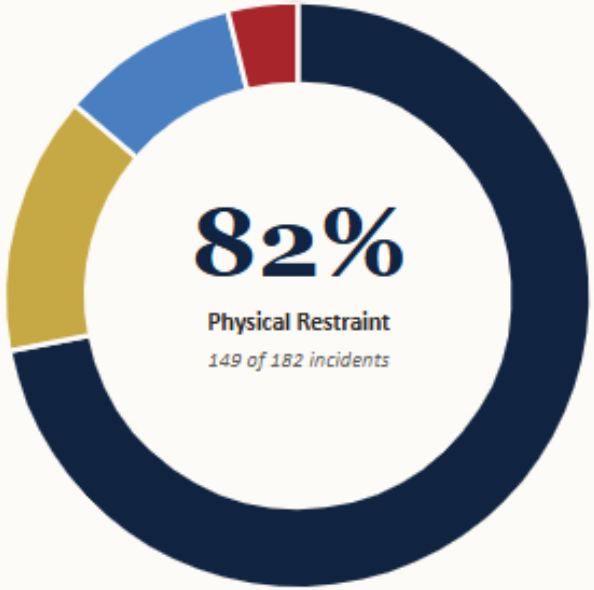
Systemic Failure #5 – Unstable & Volatile Placements

Congregate Care

- **Wrong setting for most youth.** Long-term non-clinical group placements produce 2.5x higher delinquency, worse education outcomes, and higher risk of physical abuse than family-based care.
- **Fiscal Mismanagement.** CYFD uses part of appropriation to expand community-based behavioral health resources on contracts with AMIKids/YDI.
- **Frequent law enforcement calls.** Analysis of five Bernalillo County congregate facilities demonstrated resident-on-staff and peer-to-peer violence; threatened self-harm and suicidal/homicidal ideations; inappropriate relationships with staff; consumption of alcohol; and possession of contraband.

KEY FINDING Of 182 critical incidents occurring in New Mexico's congregate care facilities in Q4 of 2025, 82% (149 of 182) involved some form of physical restraint. Chemical-only accounts for 14% and seclusion for 4%. Average 7 incidents per child.



131	**Physical only** 72% of incidents
26	**Chemical only** 14% of incidents
18	**Both physical & chemical** 10% of incidents
7	**Seclusion** 4% of incidents

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Joshua, 16 Years Old

POOR CASE MANAGEMENT + POOR FACILITY

Warehoused and forgotten.

- Red flags ignored. Former LCA Deputy Director raised objections to AMIKids' expansion. Previous sanctions and CAP. Approved anyway.
- **April 12, 2025.** 16-year-old Joshua H. died by suicide in a bathroom at after 22 months in CYFD custody. Joshua entered the bathroom at 7:40 a.m. He was found at 8:36 a.m. by another resident – not staff.
- Licensing violations. CYFD's own post-death investigation found: staff on cell phones, no suicide-prevention training, inadequate supervision, incomplete personnel files.
- CYFD case management failures. Unrealistic placement options, discontinued mental health resources, reassignment of PPW, and untimely permanency.

"If I was missing, do you think anybody would be putting fliers up for me?" — Joshua H., weeks before his death

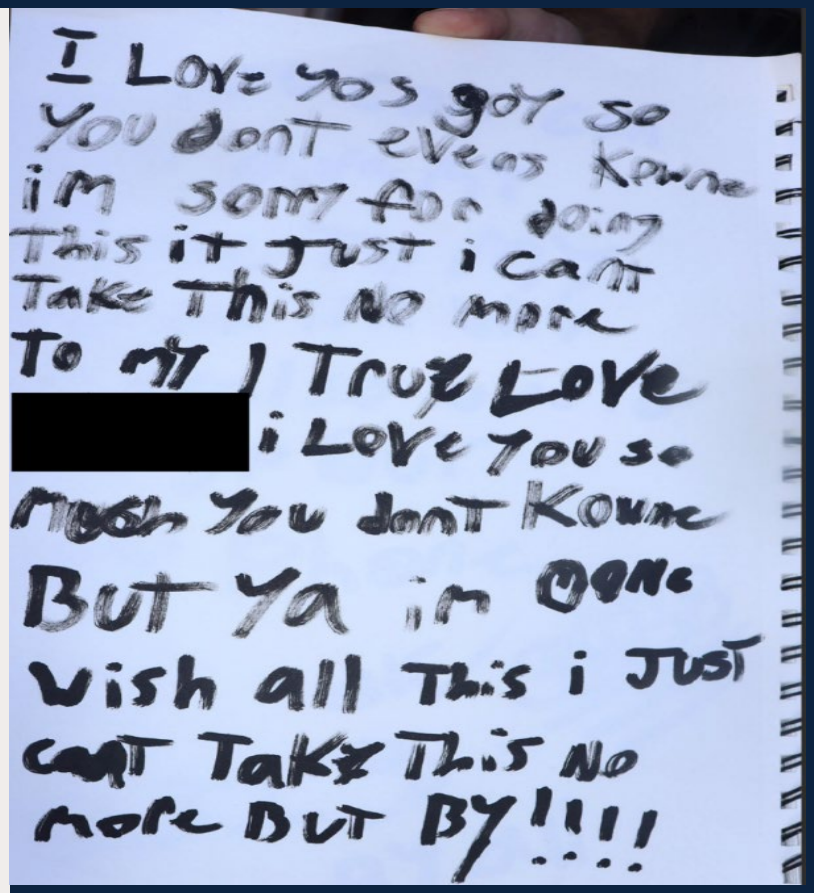

Figure 28. *Joshua H.'s suicide note found at AMIKids.*

Confidentiality Law Was Written to Protect Children. CYFD Uses It to Protect Itself.

CYFD's resistance to external oversight:

CYFD has demonstrated a clear aversion to transparency, including ignoring or impeding records productions to: OSA; *Kevin S.* Co-Neutrals; NMSP; Independent auditors; and Child Advocate.

WHY NMDOJ FILED SUIT

Weaponizing Confidentiality

§32A-4-33 shields families' and children's identities — not the agency's conduct.

OBSTRUCTION OF THE NMDOJ

The NMDOJ made 12 requests for records pertinent to its investigation and was shuffled between IPRA custodians and General Counsel's office. Both stonewalled, failing to recognize a law enforcement entities' exemption from confidentiality laws.

Retaliation Against Whistleblowers

CYFD used confidentiality laws to punish the people caring for New Mexico's children.

THE CASE THAT DEFINES IT

A Silver City grandmother assisted prosecutors on a child abuse case. Without notice, CYFD removed the foster child from her care the same day, alleging she violated confidentiality laws.

New Mexico Department of Justice

Questions & Answers

New Mexico Department of Justice

Legislative and Policy Blueprint for Child Welfare Reform

1–35

Legislative Proposals

New legislation and/or statutory amendments

36–50

Necessary Policy Changes

Administrative reforms CYFD can implement directly

New Mexico Department of Justice

PART ONE · REC. 1–35

Legislative Proposals

FIVE AREAS OF REFORM

01 Leadership, Workforce & Practice Improvements

02 Child Safety & Reunification

03 Protecting Drug-Exposed Infants

04 Valuing Law Enforcement & Foster Parents

05 Placement Safety & Stability

Legislative Proposals

REC. 1

Cabinet Secretary Qualifications & Training

Amend Section 9-1-5 NMSA to require CYFD's cabinet secretary hold professional child welfare experience. Require leadership to complete recurring training in child welfare best practices and legal mandates.

REC. 2

Prioritize Social Worker Hiring

Prioritize recruiting and hiring social workers for family-assessment roles, incentivize BSW/MSW attainment by existing staff, and phase-in licensure requirements for COMs and supervisors.

REC. 3

Higher Education Partnerships

Strengthen partnerships with schools of social work, improve internship-to-employment pipelines, and enhance field opportunities. Supplement existing federal stipends and/or evaluate loan repayment options, with multipliers for practitioners in rural counties.

REC. 4

Establishing Caseload Standards

Establish clear, evidence-based caseload guidelines for Investigations, Permanency, and Licensing & Support Units, with phased implementation aligned to staffing benchmarks.

Legislative Proposals

REC. 5

Evaluate Structural Changes

Review organizational structure to promote efficiency, ensure leadership subject-matter expertise, and ensure each component aligns with child-centric mission. Consider removing Licensing and Certification Authority and/or the Juvenile Justice Division.

REC. 6

Professionalize Abuse & Neglect Investigations

Adopt trauma-informed interviewing, require collateral sources be contacted before closure, leverage law enforcement expertise, and conduct unannounced home visits.

REC. 7

Investigation Transparency

Require body-worn cameras during investigator interactions with victims, caregivers, and collateral witnesses, balanced against confidentiality and public-records considerations.

REC. 8

Codify Investigation Findings Options

Clarify the standard of proof for substantiating allegations and consider adding an “inconclusive” finding category. Existing dichotomy in policy is insufficient.

Legislative Proposals

REC. 9

Mandating Sworn Testimony & Reports

Require all CYFD employees to submit court reports and testify under oath, subject to penalties for perjury.

REC. 10

Dashboard Data & Periodic Audits

Require CYFD and HCA to track more granular placement and safety data, with external audits of publicly reported dashboards by LFC, OCA or IG.

REC. 11

Value Youth Feedback

Implement youth advisory panels and foster-care exit surveys; publish findings and incorporate results into practices.

REC. 12

Expand Intervention Standing

Amend Section 32A-4-27 NMSA to allow Attorney General intervention in Abuse and Neglect proceedings where an eligible intervenor faces credible risk of retaliation, or in other exceptional circumstances.

Legislative Proposals

REC. 13

Clarifying Amendments to OCAA

Amend the Office of Child Advocate Act to ensure: 1) real-time, direct access to CYFD's case management system; 2) ability to contact and interview staff related to Child Advocate investigations; and 3) timely records and responses from CYFD personnel, with option to escalate issues to leadership.

REC. 14

Elevate Internal Complaints to OCA

Require CYFD's Constituent Affairs and Advocacy units to share all complaints with the Office of the Child Advocate, to identify violation of federal or state constitutional rights, reckless disregard of health/safety of a child, or repeated policy violations.

REC. 15

Confidentiality Statute Review

Reevaluate Section 32A-4-33 to protect family privacy while eliminating overbroad interpretations that impede reasonable transparency and informed public oversight. Consider civil remedy/penalty framework for misuse of confidentiality provisions.

REC. 16

Dedicated Critical Incident Team

Create a dedicated rapid-response team within PSD to investigate fatalities and critical incidents, reporting findings to the secretary and Child Advocate.

Legislative Proposals

REC. 17

Criteria for Safety Plans & Monitors

Codify standards requiring safety plans to be specific, comprehensive, actively monitored, explicit on consequences for noncompliance, and closed only upon safety being assured. Clearly outline eligibility criteria for safety monitors.

REC. 18

Broaden Application of FINCOS

Review expansion of the Family in Need of Court Ordered Services Act to cover repeat noncompliance with treatment plans.

REC. 19

“Aggravated Circumstances”

Amend Section 32A-4-28 NMSA to remove court discretion in determining whether ‘reasonable efforts’ are required prior to terminating parental rights.

REC. 20

High-Risk Reunification Review

Require multi-disciplinary, secretary-approved review before reunification for caregivers with substantiated abuse or repeat neglect.

Legislative Proposals

REC. 21

Justifying Reunification Plans

Require an ‘exceptional circumstances’ justification in court reports when CYFD seeks to maintains a reunification plan despite a new substantiated finding during unsupervised or trial home visits.

REC. 22

Track & Report Failed Reunifications

Publicly track and report all reunifications that result in a subsequent substantiated abuse or neglect referral within a defined period, and use this data to target practice improvements.

REC. 23

Timely Adoption Full-Disclosure Process

Establish a mandatory, time-bound adoption full-disclosure process for accurate recordkeeping and faster finalizations.

REC. 24

Specialized Infant Units

Create a dedicated substance-exposed infant team trained in neonatal abstinence syndrome, addiction, relapse patterns, safe sleep, and infant attachment. Cultivate community partnerships and facilitate tailored resources.

Legislative Proposals

REC. 25

POSC Compliance Audits

Require annual audits confirming Plans of Safe Care are actually created, monitored, and completed — not just checked off.

REC. 26

Centralized POSC Tracking

Build a statewide electronic tracking system for Plans of Safe Care to ensure government entities and disparate service providers can monitor whether referrals, treatment, and follow-up occurred after hospital discharge.

REC. 27

Notification on 72-Hour Hold Release

Amend Section 32A-4-6 NMSA to require CYFD notify law enforcement upon release of a 72-hour hold.

REC. 28

24/7 Crisis Support Line

Establish a clinician-staffed crisis line for foster parents to reduce reliance on law enforcement for behavioral escalations.

Legislative Proposals

REC. 29

In-House Clinician Consults

Mandate a dedicated CYFD clinical team, working with Turquoise Care coordinators, to support children with specialized needs. Team to provide expert consultation to caseworkers, ensure timely access to evaluations and services, and support placement stability.

REC. 30

Judicial Review of Excessive Placements

Require judicial review whenever a child experiences more than three placement changes within 1,000 days, to address recurring causes of placement disruption.

REC. 31

Congregate Care Ban — Under 12

Codify a presumptive ban on congregate care for children under 12 absent acute psychiatric or medical necessity.

REC. 32

Clinical Certification of Necessity

Require independent licensed-clinician certification (not by CYFD or facility staff) that congregate care is necessary and that less-restrictive family-based options were unsuccessful. Certification to be asserted in permanency hearing reports.

Legislative Proposals

REC. 33

Judicial Review of Length of Stay

Require heightened evidentiary findings every 30-60 days after entry into congregate care, presuming a prompt return to a family-based setting unless proof of continued necessity or insufficient alternative placement(s).

REC. 34

Inspections & Staffing Standards

Require regular LCA inspections of congregate facilities and enforce minimum staff-to-child ratios and mandate that direct care staff demonstrate relevant child welfare or caregiving experience and undergo trauma-informed training.

REC. 35

Statewide Exclusion Registry

Establish uniform investigation standards for congregate facilities and a statewide registry for substantiated staff misconduct.

New Mexico Department of Justice

PART TWO · REC. 36–50

Necessary Policy Changes

Administrative and internal reforms CYFD can — and should — implement independent of new legislation.

Necessary Policy Changes

REC. 36

Improve New Employee Training (NET)

Extend new-hire training to 8-12 weeks (California/Arizona model) with built-in shadowing, VR and simulation tools, and pathways tailored to each unit.

REC. 37

Enhance Employee Retention

Pair new hires with peer mentors and offer counseling for vicarious trauma. Consider retention bonuses and pay differentials for licensed social workers.

REC. 38

Recurring, Targeted Training

Require periodic training in family assessments, legal requirements, and community resources. Develop robust, enforceable continuing education for non-social workers.

REC. 39

Demand Supervisory Oversight

Mandate supervisory compliance with pre-initiation and closure staffings, escalation for repeat reports to COMs, and critical review service referrals and safety/risk assessments.

Necessary Policy Changes

REC. 40

Align Records Retention

Maintain screened-out referrals in the case management system for the same duration as screened-in referrals, so investigators can see a family's full history.

REC. 41

Zero Tolerance for Retaliation

Establish clear procedures for reporting and adjudicating retaliation claims. Substantiated retaliation results in mandatory discipline, reviewed by the IG.

REC. 42

Require Broadened Engagement

Guarantee participation in planning meetings and court proceedings for the full care team — foster parents, therapists, educators, and tribal representatives.

REC. 43

Recurring Training on SDM Tools

Retrain investigators and permanency workers on proper use of structured decision-making tools and override criteria, with annual recertification.

Necessary Policy Changes

REC. 44

Law Enforcement / CYFD Coordination

Place dedicated law enforcement liaisons within CYFD offices to strengthen mutual understanding of practices and improve coordination during investigations.

REC. 45

Joint CYFD / Law Enforcement Training

Develop a joint training curriculum for PSD employees and SVU/CACU detectives on forensic documentation, abuse indicators, and trauma-informed interviewing.

REC. 46

Expedite Non-Relative Home Licensing

Speed up licensing for non-relative resource homes without lowering standards, and support families with clear communication channels, peer networks, timely reimbursement, periodic ‘levels of care’ assessments, and case-planning involvement.

REC. 47

Full Information Upon Placement

Ensure foster parents receive essential medical, behavioral, and educational information before a child's placement, as required under the Foster Parent Bill of Rights.

Necessary Policy Changes

REC. 48

Guarantee Respite Opportunities

Provide foster parents a minimum number of paid respite days each year to support caregiver well-being and reduce burnout.

REC. 49

Educational Continuity

Keep children in their school of origin unless a change is demonstrably necessary, preserving existing IEPs and support networks.

REC. 50

Demanding PHP Compliance

Enforce PHP's obligations under the Turquoise Care contract to expand community-based behavioral health services and reduce reliance on congregate care.

New Mexico Department of Justice

Questions & Answers