

**To:** Chairperson Virginia Lyons and members of the Senate Health and Welfare Committee

**From:** Aryka Radke, Esq., Deputy Commissioner, DCF

**Date:** April 11, 2022

**Re:** H. 265, Office of the Child, Youth and Family Advocate

On behalf of the Department for Children and Families, I would like to propose the following changes to the current draft of H. 265, as passed by the House. Our recommendations to specific changes are centered around three main points.

1. The Office must not be adversarial.

It is essential that this office be non-adversarial in order to permit the free flow of information, create trust, and allow for maximum opportunity for different parties and individuals to engage with each other in problem-solving and an honest attempt to create stronger systems, healthy families, and a robust, accountable system, as the legislation seeks. To that end, DCF makes the following specific recommendations:

- a. The Office should be called the Office of the Child, Youth and Family Ombudsman. This is a title currently used by the national trade group of such offices (“United States Ombudsman Association”) and creates an implication that the office is intended to investigate and mediate complaints by consumers. The use of the term “advocate” immediately implies that the office is in conflict with the Department and that the Department does not itself have an advocacy role in its work with families.
- b. §3202(b)(1) provides that the Oversight Commission must recommend qualified applicants for the position of advocate. The Department recommends that this language include a minimum number of applications to be sent to the Governor. Further, the Governor should have an opportunity to reject all of the candidates and ask the Commission to send a new slate of names for her/his review.
- c. Under§3204(d), the Advocate position can be immediately taken over by the Deputy Advocate for an unspecified period of time. At the very least, this time period should not exceed that which the Advocate themselves would have had remaining on their term. Further, the Department recommends at best that this language be stricken in its entirety, since there are no requirements of the deputy advocate, and such an individual may be wholly unprepared for the duties of the office.
- d. The OCA’s duties should not be solely focused on DCF, but should include the work of other partners, such as courts, attorneys, and public and private education providers to ensure that the systems that surround families are also engaged in the work of improving the lives of families through systems-wide improvements.

- e. The OCA should be placed in the offices of Vermont Legal Aid. This will give the advocate access to professional advocates with the experience not only in individuals cases, but also in systems work. Further, VLA has experience working with many entities in State government and has a track record of successful collaboration and problem-solving.
2. A priority of the office should be a focus on furthering the safety culture within DCF and the communities it serves.
    - a. Accordingly, the OCA should, as its first order of business, be given the opportunity to engage in work to understand the important of Safety Science in the provision of services by family services organizations. To do this, **DCF recommends that the engagement of the services of a Safety Science expert be budgeted into the OCA's first year of work. DCF recommends such engagement through the National Partnership for Child Safety (NPCS).** The NPCS, initially formed in 2018, is a quality improvement collaborative whose aim is to improve child safety and reduce child maltreatment fatalities through the application of safety science and shared data. It is supported by Casey Family Programs and a technical assistance team that includes the University of Kentucky and Michigan Public Health Institute. Casey is actively training New England OCA's in this model. DCF joined the NPCS in 2018.
    - b. The initial year of the OCA should be focused on individual complaints of children, youth and families. As you heard in testimony, DCF does an excellent job addressing complaints, but it is always important to ensure that there are no missed opportunities to improve DCF's efforts to ensure the individuals and families we serve are heard and their concerns adequately addressed. Further, this kind of work will lay the groundwork for collaboration, as the individual will understand better the system and its challenges through direct engagement. Moreover, having a refined scope will enable both the OCA and DCF to put processes in place to support this work, receive appropriate training and narrowly target on an area of expressed concern by the community.
3. Specific Changes to the Existing Draft
    - a. The language in §3203(a) provides only that the advocate "may" have a professional degree. However, this means that the advocate may not. It is important that the advocate have some significant experience and education or training in the field of child welfare, and this should be specifically outlined in the legislation. DCF recommends the following:
      - i. The advocate must be "qualified by reason of education, expertise, and experience, and who shall have a professional degree in law, social work, public health, or a related field."
      - ii. The bill should clearly state what is expected of the deputy advocate. If the intent is to have an administrative assistant, as the New Hampshire advocate

recommended, then that individual should not be permitted to replace the advocate without adequate training and experience.

- b. The language in §3205 requires DCF to provide the advocate with “all reports related to actual physical injury to child or youths in the custody of the Commissioner or a significant risk of such harm.” **The term “reports” is ambiguous. We recommend that DCF provide “notification” to the advocate.** This clarifies that DCF is passing on the information rather than creating a report that is outside and in addition to any of the other responsibilities of DCF when such an event occurs. Further, this is an indication that the advocate is, in fact, intended to be adversarial, since children in DCF custody are only a small number of those who are the subjects of child safety interventions. Notably DCF’s Central Intake and Emergency Services unit (CIES) received 18,507 calls of suspected child abuse/neglect in 2021, and that 4,423 of these were accepted for Child Safety Intervention. Consequently, DCF requests that it be required to “notify” the advocate within 48 hours of the fatality of a child or youth in our custody. As a practical matter, the documents in the file will likely be available to the advocate pursuant to other sections of this law, and a “written report” is not necessary.
- c. The language requiring DCF to provide all instances of seclusions and restraints should be deleted until such time as DCF has an IT system that can adequately organize and track this information. If this language stays in the bill, the language should be modified to state that it is “seclusions and restraints within the meaning of the Licensing Regulations for Residential Treatment Programs in Vermont.” In addition, notification is not always immediately provided to DCF by the provider. Consequently, **DCF recommends that it “notify” the advocate** of the seclusion or restraint within 72 hours of receipt of notification by the provider, and that DCF provide the advocate with any written notification or report by the provider.
- d. In section §3208(a), the language should be clarified that the confidential records of the advocate are not subject to the open records law, but that records created by the advocate and not otherwise confidential under law are subject to the open records law.
- e. In §3208(b), referencing §4921(e)(1), the draft states that the advocate can provide documents to courts, parties, and attorneys in juvenile proceedings, health and mental health care providers, educators working with a family, foster families, and mandated reporters. This language is taken from 4921, which sets out how information in the hands of DCF may be provided to others. However, by referencing to this section of the statute, it leaves out DCF itself, making it impossible for the advocate to provide relevant documents, not already in DCF possession, to DCF. This will frustrate the role of the advocate and put DCF in position of trying to assist both the family and the advocate while potentially being excluded from certain information. **The advocate should have the ability to share documents with DCF** when it is in the interests of the child, youth or family, or in the interests of seeking to improve the state system of care.

- f. §3208(c) provides that the advocate can publicly disclose information *except* about a youth or if there is an ongoing law enforcement investigation or prosecution. DCF recommends that this also include a prohibition on releasing names of other family members or foster parents or kin in kinship placements.
4. **Provide in the law for a slow integration of the different goals of the advocate.** For the first year, the advocate should have an opportunity to engage with stakeholders, learn about safety science (*see* 2(a) above), take calls from individuals who are seeking assistance in their involvement in the court processes, and spend time listening to stakeholders – courts, attorneys, DCF workers and management, educators, kin, etc. – to obtain a sure footing in the system as a whole.
- a. DCF recommends that §3202 be significantly scaled back to include only:
    - i. Only one portion of (b)(3) (make appropriate referrals; and investigate those complaints where the Advocate determines that a child, youth or family may be in need of assistance from the Office); and
    - ii. (b)(4) (support children, youths, and families by providing information about recipients’ rights and responsibilities related to Departmental services); and
    - iii. (b)(7) (submit a report to the General Assembly and the Governor)

5. **The Department needs an internal process for confidential review of cases involving significant safety incidents.** The Department believes that a confidential process, such as the Safe Systems Learning Review, in which everyone involved in a case involving a significant negative safety event is able to share information in a non-judgmental manner so as to strengthen our systems and prevent further harm. This system should be similar to a peer review committee in the medical field. To that end, the Department proposes the following language:

*The Department shall prepare a report to the Legislature, to be submitted not later than December 1, 2022, recommending a process for an internal DCF review of fatalities and near-fatalities, and making recommendations for proposed legislation for such a process to ensure adequate and robust case-specific and systems review in these cases.*