

Executive Board

LR 288

February 12, 2018

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Division of Children and Family Services

Department of Health and Human Services

Good afternoon, Chairman Watermeier, and members of the Executive Board. My name is Matt Wallen (M-A-T-T-W-A-L-L-E-N) and I am the Director of the Division of Children and Family Services in the Department of Health and Human Services (DHHS).

I am here to testify in opposition to LR 288, which creates the Nebraska Child Welfare Death and Abuse Special Oversight Committee to study the prevalence and related circumstances of abuse, sexual abuse and death in Nebraska's child welfare and juvenile services systems.

The Division of Children and Family Services currently works with, participates on, or is subject to oversight and recommendations by roughly 30 different committees, commissions, workgroups, advisory organizations, and task forces. The Division is obviously subject to ongoing permanent oversight by the HHS and the Appropriations Committees of this Legislature. The oversight groups identify both our strengths and the ways in which we can improve how we provide services to children and families. We thoroughly review the recommendations provided to us by each organization and take the necessary steps to address the issues identified. The committee called for in LR 288 would be duplicative and unnecessarily.

In addition to the existing stakeholder advisory groups, the Inspector General of Nebraska Child Welfare, the Foster Care Review Office, the Child and Maternal Death Review Team, the Nebraska Governor's Commission, and federal oversight, it is unclear why a separate legislative entity is needed.

In fact, the Health and Human Services Committee already provides necessary legislative oversight, as it can call a hearing concerning the Division of Children and Family Services at any time. Over the past couple weeks the Health and Human Services Committee held oversight briefings on the Office of Inspector General for Nebraska Child Welfare's annual report and special report on sexual abuse; caseload standards, and workforce initiatives. Additionally, any Senator can, and does, request the agency's presence at a meeting or for a briefing at any time.

The Division of Children and Family Services attempts to share all records and information as allowed by law with the entities conducting case reviews. As I mentioned previously, each of these groups makes recommendations that the Division reviews thoroughly and tries to address based on state and federal requirements, and in consideration of other initiatives the Division may already be implementing.

In addition to the overarching concern of duplicate oversight, LR 288 lists several items the committee would study, including child deaths and abuse incidents, background checks, staff training and the OIG's recommendations.

- **Child Deaths and Abuse Incidents:** The Inspector General of Nebraska Child Welfare and the Child and Maternal Death Review Team both review cases of child deaths and the Inspector General reviews cases involving serious injury. As you are aware, the Inspector General shared several recommendations with the Department and external stakeholders. The Department has implemented several of the recommendations and is working on several others. The Department also conducts an internal review of policy and practice to identify any systems issues that may need to be addressed by training, policy or procedure updates or other change in practice.
- **Background Checks:** The Department follows the federal requirements for conducting background checks for all out-of-home care providers and also requires all providers of direct services to children and families to have thorough background checks as identified in the Department contracts. Compliance with this requirement is steered by the Inspector General's review of cases; the federal government; accreditation reviews of our contracted providers; and Department audits of contracted providers.
- **Staff Training:** The Department continually assesses and updates staff training as necessary. Changes are made based on recommendations from external and internal reviews. The Department trains staff on the use of Structured Decision Making (SDM®) as the evidence based model to assess for safety and risk. Updates to training have and are being made based on recommendations from the Inspector General and based on the Children and Family Services Review.
- **Inspector General Recommendations:** The Division meets with the Inspector General for Nebraska Child Welfare regularly to review and discuss recommendations. The Department has fully implemented over 20 recommendations made by the Inspector General and is working on several others.

In addition to being held accountable by the Health and Human Services Committee, the OIG, the legislature, system stakeholders, and all the citizens of Nebraska; in addition to the 30 organizations and commissions that oversee and recommend system improvements; the Division submits over 30 quarterly and annual reports to the legislature for your review. These reports detail everything from specific expenditures, to program performance, to overall system metrics.

To be clear, I do not object to oversight or transparency, and I believe we are holding ourselves to a high standard in that regard. The Division of Children and Family Services is always open to working with senators and all stakeholders, and will continue to collaborate with the legislature to ensure our system protects the children in our care. However, I do oppose LR 288 given duplication of existing oversight structure, which also takes more of our time away from serving Nebraskans.

Thank you for the opportunity to testify before you today. I am happy to answer any questions you may have.