Department of Children, Youth and Families (DCYF) Oversight Board

Board Meeting Record

Thursday, July 17, 2025, 9:00 am – 1:00 p.m., virtual meeting & Helen Sommers Building

Members in Attendance: Katie Biron, Rep. Tom Dent, Dr. Ben de Haan, Dr. Marian Harris, Pamela Javier, Ruth Kagi, Dr. Diane Liebe, April Messenger, Mary Sprute Garlant, and Senator Claire Wilson

Staff in Attendance: Lyscha Marcynyszyn, PhD, *Executive Director* & Nickolaus Colgan, *Administrative Coordinator*

Public in Attendance: Kathy Elkins, *community member*, Jamie Williams, *foster parent*, Kristina, *community member*, Tristan Fujita, *community member*, Jim Theofelis, *NorthStar Advocates*, Jill May, *Washington Association for Children and Families*

Only public attendees who chose to identify themselves during the meeting, or who made public comment, are recorded in the official meeting minutes.

Welcome, Roll Call, and Opening Remarks

The meeting was called into order at 9:05 a.m. and co-chair Senator Claire Wilson started the meeting with introductions. Lyscha Marcynyszyn did roll call of DCYF Oversight Board members and quorum was met. Lyscha proposed approval of May 15, 2025, meeting minutes and asked for any edits to the draft minutes. With no proposed edits, Lyscha requested a motion be made for approval, Katie Biron made a motion to approve the minutes and Ruth Kagi seconded. Lyscha requested all in favor to approve, all present voted aye. There were no nays or abstentions.

Access to Substance Use Disorder Treatment | Sarah Veele, PhD, Director, DCYF Office of Innovation, Alignment & Accountability, Michelle Balcom, MSW, Early Learning Program Manager, Jimmy Vallembois, Substance Use Disorder Program Manager, Kym Ahrens, MD, Juvenile Rehabilitation Medical Director

Dr. Sarah Veele and her DCYF colleagues provided an update on opioid use disorder, opioid treatment, and prevention access for (a) caregivers on the pregnancy support pathway, (b) caregivers who are involved in child welfare, and (c) youth and young adults in Juvenile Rehabilitation. The presentation highlighted the continuum of care from prevention to treatment, recovery, and maintenance. This expert panel also presented about the services and supports offered by DCYF and community partners, as well as successes, challenges, and progress the agency and multiple systems such as the Department of Health, Healthcare Authority, WA State Hospital Association, and other external community partners and families are experiencing.

Questions/Takeaways:

- For those people and families who did not access Opiod Use Disorder (OUD) Treatment, is there an assumption that there were other factors beyond lack of access?
    - Yes, the data do not simply indicate that someone tried to access treatment, but was unable to receive it, there are many other factors why people couldn't access treatment.
- Could you please clarify what the "RDA" acronym means? Research and Data Analysis, they are a division within the Department of Social and Health Services (DSHS).
- Medicaid is key to accessing treatment, does DCYF see the eligibility of these youth seeking treatment being impacted by the One Big Beautiful Bill that Congress passed?
    - We suspect it will, but I am cautious to make any concrete statements without doing a full review of the bill. There is certainly a risk.

    - There isn't necessarily a change to eligibility, but there are added barriers including the requirements around work and pursuing work as well as having to reapply every six months versus annually.
        - There is a 90-day exemption from release from a carceral institution for people to get these requirements in place.
    - Is the 90-day exemption a reference to the Section 1115 Waiver? Washington state has a Section 1115 Waiver in place for the Department of Corrections that is now expanded to Juvenile Rehabilitation spaces with Medicaid.
        - That is correct and the Section 1115 Waiver has not been touched. The barriers mentioned are going to affect those people following the 90-day exemption and could have an impact on maintaining that coverage.
    - DCYF is very aware of the potential impacts from this bill and has teams including the partnership prevention departments looking into these impacts right now.
- When it comes to building trust with the families for participating in the services you are offering, what is your sense of how many people will opt into these services?
    - The Plan of Safe Care (POSC) is not optional, but it is very much family centered and focused and part of the caseworker's requirement to create that POSC.
    - The Community Based-Pathways are voluntary as well as the Pregnancy SUD Pilot. DCYF hopes that by starting to build relationships, even if people don't opt into services, they are at least having positive engagement with community providers at every step, leaving the door open for receiving resources in the future if they want them.
- Will part of your intervention plan include early relational health and supporting parenting relationships?
    - DCYF is strengthening relationships with hospital National Intensive Care Unit (NICU). NICU staff have reported to DCYF that they see the baby as the patient, and we are working with them and opening the conversations up to include the whole family as this is an opportunity to talk about parenting, the parenting relationship, and a child's unique needs.
    - Community Based-Pathways offers a multitude of services across Washington state that can help with parenting classes, playgroups, peer support, and additional parent support. DCYF also really highlights early learning in their safe care plans (e.g., Head Start, Early Childhood Education and Assistance Program (ECEAP), their licensed childcare programs) as an opportunity for another support system for families to learn about.
- Are these families automatically eligible for Working Connections Childcare?
    - Childcare is something offered in both POSC and Community Based-Pathways.
    - Any time a person is involved in an ongoing case, childcare will be provided.
        - The transition to Working Connections Childcare comes from either of the above paths and they will help the parents, with support from Help Me Grow, get signed up for everything they need, including childcare, WIC, and paid family medical leave. These organizations offer help every step of the way and are excellent at navigating these systems.
- There are concerns because the legislature did not fund appropriately the birth to age 3 ECEAP. Additionally, there was not the necessary funding for SB 6109 which was to look at the Fentanyl response and how the state is supporting children and families.

DCYF Oversight Board Statute Updates and Themes Discussion | Lyscha Marcynyszyn, Executive Director, Sharon James, Government Compliance and Enforcement, Office of the Attorney General

Lyscha Marcynyszyn provided an overview of the DCYF Oversight Board 2.0 vision and was joined by Sharon James from the Attorney General's Office to answer any legal or statute focused questions. This presentation included an overview of the statute, the work that's been done to date, and a summary of themes from a HB

1661 “Looking Back to Move Forward” subcommittee meeting. This subcommittee met once and consisted of board members who were present for the creation of DCYF.

Questions/Takeaways:

- The objective of the HB 1661 Listening Session was to look at the Board’s history to move forward as a part of continuous quality improvement. The session included three main questions:
    - What was the original rationale for “oversight”?
    - Do you feel the Board has been able to carry out its function?
    - What challenges do you see as we move forward?
- The writers of this bill had a very ambitious vision but didn’t give the board a large staff to do that work.
- This is a very helpful summary of the Board’s history and of areas that we need to focus on to provide in-depth recommendations in our Annual Legislative Report.
    - The current structure of the Annual Legislative Report does not appear to be a “value add” to the Governor’s Office or DCYF because there are so many required outcomes to focus on.
- One question I’ve always had is the process by which the Board does oversight. We submit the Annual Legislative Report with recommendations, but then what? Is there anything else in the statute that can be used to actually affect oversight?
    - The Board ultimately doesn’t have oversight over the Secretary of DCYF since they are appointed by the Governor, so it’s in a challenging spot.
    - The Board is in a unique position to reflect on how it previously functioned, which was to be more reactionary than advisory.
    - We want to collaborate with DCYF on priority areas and influence the agency on prioritizing workforce well-being, so the Board is also not completely advisory.
    - This seems like a better place to take the board, more strategic and priority focused rather than reactionary.
    - Based on how the legislation is written, the Board does seem more advisory than oversight, but it does have a purpose that makes it a little over the line from an advisory board. The key missing area for outright oversight is specific powers in the statute to enforce the recommendations made by the Board.
    - The Board seems to sit between three bodies, the legislature, DCYF, and the Governor’s Office and the statute describes working collaboratively with them.
- It was made very clear at the first meeting that this would not be an advisory board, that we were to be an oversight board. There are already a lot of advisory boards and that is not where we are headed. This does not mean we run DCYF, but we can chime in from time to time and we should have a little bit of “teeth” in what we do.
- A unique point about the DCYF Oversight Board is that the process for its creation originated with the Governor through an Executive Order that led to the Blue-Ribbon Commission Report. Through that process the question becomes how are the executive branches held to account when the legislature passes a new law?
- We have no line in statute stating that we have control over a gubernatorial appointee, but if we are engaged in a process that was originally created in the Governor’s Office which sought to create a partnership with the legislature to define what accountability should be, much of the Board’s success is tied to how the governor feel about us and whether or not we are seen as an intrusion into the executive branch.
    - We are unable to function as intended without strong support and understanding from the Governor’s Office.
- With the mention of the board should have “teeth” what does that look like?
    - It is a hard question to answer. The Board should have the ability to challenge DCYF leadership if we feel like they are not going in a direction that best supports infants, children, youth and

families. It comes back to a discussion that we've been having since the beginning, what does oversight mean?

- An important question to answer in this process is, who is DCYF partnering and communicating with as they create legislation? This is not the only place where work is being done, and we don't want to be duplicative; there are a lot of different advocacy tables with discussions happening.
    - It would be helpful to ensure that we are part of these ongoing conversations with the different tables of stakeholder groups.
- One of the struggles that the Board has experienced is getting positions on the board filled. There have been great strides, but we are still missing key voices.
    - There was a recommendation from the Office of Family and Children's Ombuds (OFCO) stating the importance of court engagement, but we haven't had the judicial role filled for a long time. With all positions filled, the expertise of the board would be enhanced.

Public Comment | Co-Chair Dr. Diane Liebe

Kathy Elkins, *community member*, Kathy expressed concern over missed opportunities to protect children and help reduce false allegations. She asked that Policy 2350, which prohibits parents and caretakers from recording interviews during child abuse investigations, be changed. She stated that DCYF staff might jot down notes during these interviews, but research shows they aren't able to capture everything and most importantly, capture it accurately. She stated that the training DYCF staff receive distorts their lens. Kathy provided quotes from the training DCYF provides that she finds problematic and said that DCYF staff are trained to suspect abuse. She ended by stating that school administrators are required to use scripts when conducting threat assessments and recommends DCYF do that same.

Jamie Williams, *foster parent*, Jamie expressed concern about the direction the child welfare system is headed. She stated that healthcare providers have never had to advocate this much to keep children safe, going as far as to refuse discharging patients, to their parents. She continued that vulnerable children are being sent home to unsafe environments. She stated that the 200% increase in critical incidents is not inevitable, they are a direct result of policy decision HB 1227. She continued that legislative change needs to take place, and we need to stop pretending that just offering services in a dangerous situation will magically make it better. She concluded by stating that the priority needs to be removing children from unsafe environments.

Kristina, *community member*, Kristina shared her concerns about the recommendations provided in OFCO's 2025 Critical Incident Report. She believes that kids are dying because of HB 1227, and are being left in unsafe homes. She continued that a family's history needs to be considered and asked how many of the fatalities and near fatalities were from families with numerous intakes? She stated that there is a need for more case workers who are required to always do more with fewer resources. She also stated that caseloads are too high and there is too much turnover in this field of work. She ended by saying that it is important for kids to be with their families, but not at the cost of their lives. Not requiring certain family services to be mandatory is not helpful.

Tristan Fujita, *community member*, Tristan spoke about HB 1227and the 2025 Critical Incident Report from OFCO. She believes the recommendations from the OFCO report point out issues with HB 1227. She provided an example of a situation where DCYF staff, based on their experience in previous cases, believed that the court would deny a dependency petition and as a result, the child passed away. She stated that we see the problems with HB 1227, but nothing is done about it, and there needs to be legislative changes. She continued that cases are not always just about fentanyl and provided the example of a home where the parents were using fentanyl and a four-year-old got access to a loaded gun and shot their mother. She concluded that this situation needs to be looked at holistically, really looking at how drug use impacts a parent's ability to care for their children.

Jim Theofelis, *NorthStar Advocates*, Jim appreciated the robust conversation the Board had this morning and was happy to hear there was passion to still lean on the content from the Blue-Ribbon Commission's Report. He continued that an area he hopes the board focuses on is accountability. For example, the Board is not hearing a lot about FFPSA, especially toward adolescents. He shared his concern about the dissolution of DCYF's Adolescent Unit and doesn't believe that anything really replaced it. He noted that while it wasn't perfect, at least there was a team focused specifically on adolescents every day. He ended by stating that HB 1929 established 90-day housing for young adults exiting inpatient treatment and he is excited to announce North Star Advocates is starting that program.

Jill May, *Washington Association for Children and Families,* Jill explained her organization represents child welfare providers, including in-home services, group care, and independent living. She continued that when listening to DCYF Oversight Board meetings she doesn't hear any conversations about the interactions between DCYF and providers, the ones who are carrying out the contracts that DCYF created. She continued that as the Board considers oversight in its next iteration; she hopes providers' experiences and voices are included because it's currently a missing piece of the conversation.

Written Public Comment:
Elizabeth Liston, *community member*, Elizabeth wrote about how the federal government has refused to ratify the United Nations Convention on the Rights of the Child (CRC) despite signing it 35 years ago. She continued that the CRC is the most ratified human rights treaty in history and 196 other countries have adopted it. She ended by encouraging the DCYF Oversight Board and Washington state to push for basic human rights for children and effect real change.

Laila Donaldson, *parent,* Laila wrote about her nonverbal and autistic child who was abused multiple times by their father. She took her child to the children's hospital and contacted CPS/DCYF who deemed that there were no problems nor safety issues. She continued that she has a protection order against him, but the courts did not enact one for her child. She concluded by writing that HB 1227 is responsible for this lack of action and views it as a death sentence for many children.

Jamie Jo Hiles, *foster parent*, Jamie wrote that DCYF is failing to protect foster children, which has resulted in deadly consequences. She stated that her former foster daughter, Oakley Carlson, was thriving in her home until she was returned to a dangerous situation with clear red flags that DCYF ignored. Jamie wrote that from the day that Oakley vanished through today, there are still no answers. She continued by asking the DCYF Oversight Board to enact real oversight of DCYF, suggesting complicity in the agency's failures. She ended by asking the DCYF Oversight Board to use its power to force DCYF to do better.

2025 Office of the Family and Children's Ombuds Report on Child Fatalities and Near Fatalities in Washington State| Patrick Dowd, Director Office of Family and Children's Ombuds

Patrick Dowd presented on the 2025 Office of the Family and Children's Ombuds Report on Child Fatalities and Near Fatalities in Washington State. The Office has a statutory duty to report on child fatalities and near fatalities and to review these critical incidents, which are documented in DCYF's Administrative Reporting System (AIRS) and therefore known to DCYF.

Questions/Takeaways:
- OFCO receives AIRS notifications from DCYF of child fatalities and near fatalities.
- They examine these critical incidents to:
    - Identify current safety issues for children in the home.

    - Determine if the critical incident qualifies for a child fatality review (CFR) or child near-fatality review (CNFR).
    - Determine if any DCYF action or conduct warrants OFCO initiated investigation.
    - Identify systemic child welfare issues.
- What is an example of what might fall under the category of child maltreatment?
    - An example is, if an infant's death is determined as sudden and unexpected, meaning it is not attributed to physical abuse or neglect, but in the Administrative Incident Reporting (AIR) report it might describe other circumstances including substance use disorder by the parents or caregivers or drug paraphernalia being in the home. This could be considered an unsafe sleep environment that would contribute to neglect. While we cannot pinpoint a cause and say definitively that this was attributed to physical abuse or neglect, there's enough concerns here that we want to capture that.
- Is there any differentiation between legal fentanyl, for example fentanyl patches prescribed by a doctor versus not legal? Or are they all lumped in the same category?
    - These data include prescription medication as well as medically assisted treatment that a parent might have, which a child that might accidentally have access to. In our data, we haven't drilled down enough to make a distinction like this yet.
- Recommendations from the report include:
    - Expand inpatient and outpatient resources for substance use disorder treatment for pregnant and parenting women particularly for those families with young children, infants, and toddlers.
    - Increase efforts to engage fathers.
    - Explore the use of in-home dependencies. This provides a court structure with a longer period to engage the family and court oversight, not just of the parents, but also the department. If there is a services plan for the department to supply concrete resources and referrals and if those are not occurring the parents have rights to go back to the court and state, the department is not helping. This is not a solution per se, but it's a concept worth exploring, which would take a significant shift in perspective of nearly everyone involved in the traditional dependency process.
- During public comments, we heard testimony about child safety concerns due to HB 1227. Did OFCO consider making a recommendation about a change to that law, if you think that's something that the legislature should be looking at?
    - OFCO did consider that, but we did not make that recommendation. In reviewing the fatalities and near fatalities data there was not a certain point in many of the cases where we could say, "if only HB 1227 had not been enacted the department would have filed."
    - What is a more common situation is when there was an open family assessment response, or CPS investigation and during that involvement with DCYF, the department didn't have a factual basis to seek removal under HB 1227, or before HB 1227 was enacted and once that case is closed, multiple months later there is a critical incident. That is the dynamic that is more prevalent.
    - It is important to recognize the impact of SB 6109, which was passed after HB 1227, because it indicates that the legislature recognized that there needs to be a response to the fentanyl crisis that specifically helps guide DCYF, professionals, and judicial officers in these cases.
        - I have seen a shift in practice within the department about when they do go to court and seek a pickup order, and remove a child, that the affidavit and the dependency petition lay out the basis for why these circumstances constitute imminent risk of physical harm, which is the standard under HB 1227, is met. The department is much more detailed in articulating the connection and describing the parents' substance use disorder, their current circumstances in the home, the conditions of the home, the vulnerability of the child, and how those circumstances directly impact the parents ability to safely meet all of the child's basic needs, and why these circumstances in this case indicate imminent risk of physical harm.

- The results we've seen from addressing the lethality of high potency synthetic opioids in the child welfare field is quality trainings provided by the Administrative Office of the Courts on SB 6109, on the impact of fentanyl and synthetic opioids and how to balance the potential harm of removal with the priority of ensuring safety of the child considering the impact of fentanyl.

DCYF Briefing: 2025 Increase in Critical Incidents and Response | Vickie Ybarra, PhD, Assistant Secretary, Partnership, Prevention, and Services, Dorene Perez, Deputy Secretary of Child Welfare

This presentation by Dr. Vickie Ybarra and Dorene Perez focused on the increase in critical incidents during Quarter 1 2025 (Q1 2025). They provided updates on what resources are available to families as preventative efforts. Their presentation was a follow-up to Patrick Dowd's presentation and described how OFCO and DCYF use different criteria for inclusion of critical incidents in their analysis.

Questions/Takeaways:

- DCYF noted that there is a little bit of a difference between the data that the Office of Family and Children's Ombuds report versus DCYF. The primary difference is that their reports are limited to those child fatalities and near fatalities that are prescribed by RCW 74.13.640, which DCYF is required to review. Both agencies focus on maltreatment and families where there has been child welfare involvement in the last 12 months.
- DCYF reviews only those child fatalities and near fatalities that are associated with maltreatment and involve prior child welfare involvement within the preceding 12 months, in accordance with RCW 74.13.640.
- The number of critical incidents for Q1 of calendar year 2025 tripled over the same period for last year.
- The total number of DCYF-reviewable critical incidents: 22 in Q1 2025 vs. 9 in Q1 2024.
- 68% of Q1 critical incidents were opioid-related, 32% were non-opioid related.
- A significant portion of these critical incidents are among children birth to 3.
- When you say your data referenced "moderate to high needs?" Are you referring to families in need of housing, in treatment, or those experiencing economic stability?
    - We have done some targeted case reviews and data analysis trying to understand the needs of those families, and most commonly we see families that have high treatment needs, high mental health needs among adults and children, instability, and families who have a child with special needs.
- DCYF responses to date:
    - Safe child consults for every case involving opioid use and a child under the age of 3.
    - Mining expertise of front-line staff: Healthcare Providers Service Organization (HPSO) info-gathering sessions.
    - Geographical hot spots: Highlighting services for local staff and providers.
    - Increasing caseworker training for neglect and medically complex cases.
- Katie Biron: Could you please restate and maybe clarify what you said about critical incidents? It sounds like when you drill down into the data, critical incidents aren't happening. It sounds like it's a family that's struggling, that DCYF is becoming aware of, because there are some issues arising, but not enough for removal. Then when we see a critical incident, it's a high-risk family that has tipped into crisis. Is this understanding, correct?
    - This is basically correct. This is the case for the majority of the critical incidents we are seeing. We are seeing some critical incidents that occur in children that we have filed on, but that is the minority of the cases.
    - Once a case is closed and it is deemed that there is no safety risk to the child, DCYF cannot continue to be involved if families are not willing to participate in services.

- We are talking about fatalities and near fatalities which is the tip of the iceberg of what we see in morbidities related to child abuse, neglect, and maltreatment. I understand you can't legally step in once a case is closed, but when thinking about things on a larger spectrum, something like the Family First Prevention Services Act (FFPSA) comes to mind and the need to really work on prevention. As a developmental pediatrician, I want to say that we're looking at the tip of the iceberg for what these families and children are actually experiencing.
    - Vickie Ybarra agreed that there is substantial need for prevention, especially as families in communities across the state experience increased economic stress and will experience more as we see Medicaid, SNAP, and other important social services reduced.

Closing Remarks and Adjourn

- Co-chair Senator Claire Wilson noted the challenges surrounding the topics today and how all the services discussed fall under discretionary income. She continued that all individuals deserve these services and that the earlier we invest in services and people, the greater the impact.
- Co-chair Dr. Diane Liebe noted that in DCYF's presentation there was a list of items they wanted to accomplish, but what wasn't mentioned was that they all have a price tag and that some of these things were in the works before funding was withdrawn. She continued, it is important that we all continue to advocate for these resources.

Co-Chair Senator Wilson thanked all attendees for their time today.

Adjourned at 1:00 pm on Thursday, July 17, 2025.