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MEMORANDUM

TO: Maine Child Death and Serious Injury Review Panel
FROM: Maine Department of Health and Human Services
DATE: April 29, 2022
SUBJECT: Comments on Maine Child Death and Serious Injury Review Panel 2021 Report

The Maine Department of Health and Human Services, particularly the Offices of Child and Family Services (OCFS), Behavioral Health (OBH), and Maine Center for Disease Control and Prevention (Maine CDC) would like to thank the Maine Child Death and Serious Injury Review Panel for its review of cases and development of recommendations to inform strategic priorities for system improvement to increase child safety and the success of families in Maine. DHHS is committed to continued efforts to implement the recommendations outlined in the 2021 Annual Report in collaboration with the Panel and other stakeholders. This response seeks to provide additional context and information on the recommendations directed toward OCFS and Maine CDC.

Additionally, OBH is committed to continuing collaboration with OCFS and community-based behavioral health providers to expand access to appropriate services for parents involved in the child welfare system.

Injury-Specific Observations and Recommendations

Bruising in Pre-mobile Infants

Recommendation (1): Ongoing efforts to educate professionals who interact with young children about sentinel injuries and their significance should continue.

OCFS Response: In 2021, the OCFS Medical Director, in partnership with Maine's Board Certified Child Abuse Pediatrician, engaged in outreach and education efforts to child welfare staff and medical provider organizations, such as the American Academy of Pediatrics Foster Care Committee, regarding sentinel injuries. Information about the significance of sentinel injuries to child abuse and neglect is also included in the OCFS Mandated Reporter Training that all mandated reporters are required to take every 4 years. OCFS will continue to work with providers to emphasize the significance of sentinel injuries.

Abusive Head Trauma

Recommendation (3): The Maine Legislature should appropriate adequate funding to the Maine

CDC for the express purpose of re-establishing the MIPP, thus allowing pursuit of its mission.

Recommendation (4): If funded by the Legislature, the Maine CDC should dedicate at least one full time employee to begin the process of rebuilding the MIPP.
Recommendation (5): MIPP staff should convene a multidisciplinary stakeholder group to develop a workplan consistent with Recommendation 2.

Maine CDC Response: The Maine CDC Adolescent Health and Injury Prevention Program (AHIP) does not currently receive any state or federal funding to support injury prevention activities except those related to suicide prevention. To the extent possible, AHIP works collaboratively with other injury prevention stakeholders to promote effective interventions and conduct surveillance activities. Without additional infrastructure, however AHIP is unable to take a coordinating role in the prevention of unintentional injury such as abusive head trauma.

Failure to Thrive

Recommendation (7): OCFS Leadership should communicate to frontline staff and supervisors regarding the value of Child Abuse Pediatrics consultation in FTT cases and frontline OCFS staff should refer children they are evaluating who have FTT for that consultation.

OCFS Response: OCFS has incorporated expectations regarding consultation with Maine's Board Certified Child Abuse Pediatrician in both the Child Protection Investigation policy and the When to Use Expert Consultation in Assessing Child Abuse and Neglect policy. While the specific condition known as Failure to Thrive (FTT) is not identified in this policy, it would fall within the guidelines for consultation as these cases are generally identified as serious injury cases. Based on this recommendation, OCFS will undertake additional efforts including collaboration between the OCFS Medical Director and the Maine Board-Certified Child Abuse Pediatrician to educate staff, medical providers, and other stakeholders on FTT.

Recommendation (8): The Maine CDC should maintain a robust PHN workforce to ensure adequate availability of services to families who are among those most in need of their support.

Maine CDC Response: Maine CDC is committed to having a robust Public Health Nurse (PHN) workforce. Utilizing comprehensive pediatric health assessments, PHNs serve families by assessing all infants for Failure to Thrive (FTT). In addition, as Certified Lactation Counselors, PHNs are positioned to provide resources for infants whose FTT diagnosis is related to inadequate caloric intake. By meeting in their homes, PHNs form trusting relationships with families which increases successful desired outcomes.

Gun Shot Wounds and Firearm Fatalities

Recommendation (9): Unintentional firearm discharge and suicide by firearm prevention should be part of a comprehensive injury prevention program and strategy focused on the health and safety of Maine's children. This strategy should include evaluation of all current efforts and consideration of any emerging strategies to reduce the incidence of unintentional firearm discharges and deaths.

Recommendation (10): MIPP staff should convene a multidisciplinary group of stakeholders and subject matter experts to develop a workplan consistent with Recommendation 9.

Maine CDC Response: The Maine CDC Adolescent Health and Injury Prevention Program (AHIP) currently engages in significant efforts to prevent firearm suicide deaths and attempts among youth. These include training medical and behavioral health providers in strategies for counseling youth and families on reducing access to firearms in the home; creating and disseminating resources related to lethal means safety, such as those available through the Maine Prevention Store (https://www.mainepreventionstore.com/products/suicide-safety-planning-card); and distributing firearm locks to community providers to offer to families receiving services. AHIP does not currently have sufficient staff or funding to conduct extensive efforts related to the prevention of accidental firearm injuries or deaths.

Ingestions

Recommendation (12): Pediatric ingestion/poisoning prevention should be part of a comprehensive injury prevention program and strategy focused on the health and safety of Maine's children. This strategy should include evaluation of any current efforts and consideration of any emerging strategies to reduce the incidence of ingestions/poisonings in children.

Recommendation (13): MIPP staff should convene a multidisciplinary group of stakeholders and subject matter experts to develop a workplan consistent with Recommendation 12.

Maine CDC Response: The Maine CDC Substance Use Prevention Program works with State and community stakeholders to prevent accidental ingestions. Maine CDC has distributed 526 medication lock-boxes through community partners to support safe storage of medications and other substances, and Maine CDC-funded local substance use prevention partners actively promote drug take-back days to ensure appropriate disposal of potentially dangerous medications. Maine CDC Adolescent Health and Injury Prevention Program continues to provide financial support to the Northern New England Poison Center (NNEPC). NNEPC is a critical resource for families and medical providers in the event of an accidental ingestion or poisoning. Without funding or staffing for unintentional injury prevention, Maine CDC AHIP is unable to engage in additional accidental ingestion prevention activities.

Unsafe Sleep Related Deaths

Recommendation (17): The Maine CDC Maternal and Child Health Program should continue its focus on unsafe infant sleep related deaths, including public awareness and education messaging.

Maine CDC Response: The Maine CDC Maternal and Child Health (MCH) Program intends to maintain a focus on preventing unsafe infant sleep related deaths. The MCH Program currently collaborates with sister offices across DHHS, including the Office of Children and Family Services and Office of MaineCare Services, as well as with programs within Maine CDC, including WIC and PHN. The MCH Program also collaborates with all 25 Safe Sleep Certified Birthing Hospitals. In addition to providing awareness and educational messaging related to safe sleep, the MCH Program and its partners also support the distribution of cribettes at no cost to families to reduce barriers to providing safe sleeping environments for infants.

Systemic Observations and Recommendations

Failure to Consult with Child Abuse Pediatrics Subspecialty Services

Recommendation (20): The major healthcare organizations who provide pediatric care in Maine, as well as OCFS, should collaborate with Spurwink Services to support at least two Child Abuse Pediatricians as well as the sustainability of their services.

OCFS Response: Through a contract with Spurwink Services and by leveraging MaineCare resources, OCFS has supported the employment of one Board-Certified Child Abuse Pediatrician, as well as other staff to support the efficacy of the program. The contract includes funding to support an additional pediatrician with this sub-specialty should this resource become available.

OCFS Staff - Workforce

Recommendation (21): OCFS administrators should continue their regular analysis of workload metrics to ensure Maine's workforce management practices are consistent with accepted standards for best practice in child welfare.

OCFS Response: In 2019, OCFS partnered with Public Consulting Group (PCG) to develop child welfare's Workload Analytic Tool. The tool has served as the basis for the OCFS Workload Report, which was first published in 2019 and annually since 2020. Currently, OCFS is in the process of developing a reporting structure for the Workload Analytic Tool data to be available to PCG and the OCFS Data Team within Katahdin, the new OCFS Child Welfare Information System. Measures of workload currently include a wide variety of factors such as policy and procedure expectations for staff, length of tenure of staff, weighting for custody cases vs. services cases, the average number of critical case members in an investigation or case assigned to a caseworker and other relevant factors. OCFS continues to evaluate other factors for inclusion, as well as strategies to utilize the tool to distribute workload at the district level.

Recommendation (22): OCFS administrators should continue to contract for services that provide for the clinical support of OCFS staff and those contracts should include an evaluation component for the services being provided.

OCFS Response: OCFS agrees that clinical support for OCFS is vitally important and continues to contract for clinical support services, including the consultation these clinicians provide on child death, serious injury, or other complex cases. In response to this recommendation OCFS will consider methods for evaluating the effectiveness of the contracted service.

Recommendation (23): OCFS administrators should continue their evaluation of best practice standards for the provision of after-hours coverage and request any necessary funding or support to meet those standards.

OCFS Response: In partnership with frontline staff, OCFS continues to explore best practices for after-hours emergency coverage and has engaged the services of Casey Family Programs and the Capacity Building Center for States (which works with public child welfare organizations to build the capacity necessary to strengthen child welfare practice) to research models utilized by other states nationally. As noted in the 2021 Annual Report, Governor Mills has included in her proposed supplemental budget,16 CPS caseworker and 3 CPS supervisor positions to provide resources to implement a new structure for these services.

OCFS Staff - Practice

Recommendation (25): OCFS should continue to look for ways to increase the efficiency of its

staff and reduce the need for duplicative work, while maintaining an appropriate focus on safety, permanency, and well-being for children and families.

OCFS Response: As OCFS continues to review and revise policies in collaboration under the Collaborative Agreement with the Muskie School at the University of Southern Maine. In part, this work is focused on reducing redundancy and increasing efficiency while ensuring quality service delivery to children and their families. These same goals were also incorporated into the development of the new child welfare information system, Katahdin. In addition, OCFS has convened a workgroup that includes frontline staff to review the Child Protection Investigation policy for redundancy and to determine best practices regarding timeframes for completion of investigation activities while also achieving goals related to child safety, permanency, and well being.

Recommendation (26): OCFS should, in addition to its continued attention to caseworker workload, consider the complexity of the supervisory role and include analysis of supervisor level metrics in its ongoing workload analysis.

OCFS Response: OCFS agrees that the role of the supervisor is of critical importance to the quality and efficacy of child welfare services. As part of the Cooperative Agreement, a Supervision Framework is being developed that includes supervisor competencies, policy and practice guidance, the Supervisory Academy Training, and other tools, including those related to coaching. Evaluation of supervision skills is a component of this structure. OCFS is also examining staff to supervisor workload ratios.

Recommendation (27): OCFS should continue to make use of the resources available through the Maine Coalition to End Domestic Violence Child Protective Services initiative and ensure that caseworkers and supervisors have access to the co-located DV/CPS liaisons provided through that initiative.

OCFS Response: Through the Rural Child Welfare Grant, the Maine Coalition to End Domestic Violence (MCEDV), has co-located Domestic Violence Advocates in the child welfare district offices. These staff serve as a resource to caseworkers and supervisors in cases involving domestic violence and abuse. OCFS values the expertise that staff from MCEDV bring to case consultations related to situations in which domestic violence and abuse is a factor. In addition, through the Cooperative Agreement, OCFS is working to review and revise all child welfare policies, including the Domestic Violence and Child Abuse and Neglect policy. Workgroup members include staff from MCEDV and the Domestic Violence Resource Centers who are assisting and ensuring the policy incorporates current best practices, researching evidence-based treatment methodologies, and ensuring that consultation with providers of certified domestic violence intervention programs is included as part of the expectations when an investigation or case involves concerns of domestic violence.

Recommendation (28): OCFS should include RADs in decisions related to investigation outcomes, findings of child maltreatment, and case closure when those cases include child deaths and serious injuries.

OCFS Response: As outlined in the OCFS Team Decision Making process, district staff are expected to consult with the Regional Associate Directors for initial decision-making, as well as at the conclusion of a Child Protection Investigation in cases involving child deaths and/or serious

injuries.

Recommendation (29): OCFS should continually review its training curriculum, for both initial training and continuing education, to ensure that OCFS staff have the most up to date information in the field to optimize their casework and decision making.

OCFS Response: This is part of ongoing efforts outlined in the Cooperative Agreement.

Recommendation (30): OCFS should ensure that its staff have awareness of and access to the services of professionals with subject matter expertise in areas including, but not necessarily limited to, Child Abuse Pediatrics and adult and child psychopathology.

OCFS Response: OCFS has convened a workgroup with the Office of Behavioral Health (OBH) to support effective coordination between child welfare staff and adult behavioral and mental health providers and address any barriers. Initial efforts include the development of a guidance document that was recently disseminated to behavioral and mental health providers working with families involved with child welfare. OCFS anticipates that additional work will include engaging community partners to identify strategies to strengthen these partnerships in support of families. In addition, OCFS continues to work in collaboration with other stakeholders, including the State Forensic Service, Office of the Attorney General, and the Maine Judicial Branch, to explore strategies to increase expert consultation services given the challenge of access to Court Ordered Diagnostic and Evaluation Services in Maine. This work will continue, and OCFS is committed to helping build and support a sufficient cadre of evaluators statewide who have the experience and expertise to conduct these evaluations.

Subject matter expertise in child abuse pediatrics is made available to staff through OCFS' contract with Spurwink Services which provides a significant portion of the funding for Maine's board certified Certified Child Abuse Pediatrician and staff who support the work of the Pediatrician.

Multidisciplinary Child Welfare System

Recommendation (31): OCFS administrators and providers of community based behavioral health services should continue to collaborate to build the capacity and skill set of the behavioral health workforce in Maine, as it relates to child and family health and wellness.

OCFS Response: In addition to the efforts outlined above, OCFS has provided funding to increase the availability of evidence-based services, including trauma-focused cognitive behavioral therapy (TF-CBT) through investing in training and ongoing support to increase the availability of and ensure fidelity to the treatment models.

Within OCFS, the Family First Program Manager has undertaken the role of researching and identifying best practices utilizing the IV-E Clearinghouse, California Clearinghouse, and other resources to inform current efforts to improve service delivery to families in Maine as well as future program development. This is a new role in the last few years and has been beneficial for both OCFS and the Department as a whole.

OCFS publishes an annual report on the Children's Behavioral Health Services system of care that provides data and insight into evidence-based services available throughout the State and ongoing efforts to improve children's behavioral health services.