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**MEMORANDUM**

**TO:** Maine Child Death and Serious Injury Review Panel

**FROM:** Maine Department of Health and Human Services

**DATE:** March 3, 2023

**SUBJECT:** Comments on Maine Child Death and Serious Injury Review Panel 2022 Report

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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 (CDC) extends appreciation to the Maine Child Death and Serious Injury Review Panel members for their ongoing work to review cases and formulate recommendations that educate constituencies and inform Department goals and strategic priorities for system transformation to increase the safety, stability, health, and happiness of families in Maine. The Department is committed to continued efforts to implement the recommendations outlined in the 2022 Annual Report in collaboration with the Panel and other stakeholders. This response seeks to provide additional context and information related to the recommendations directed to the Department of Health and Human Services.

## Injury Specific Observations and Recommendations

### <u>Ingestions</u>

*Recommendation (3): DHHS/CDC should develop a data tracking or monitoring mechanism to adequately collect data on all pediatric ingestions in Maine, to inform a more complete understanding of the current state of ingestion injuries.*

DHHS/CDC Response: The Maine CDC Adolescent Health and Injury Prevention Program (AHIP) currently monitors data from the Maine Hospital Data Organization on emergency department visits and hospital discharges for a range of injury-related causes, including poisoning. This data could be used to conduct additional analysis of pediatric ingestions that present to the emergency department, but additional resources would be necessary for that analysis to be conducted. Additionally, the Maine CDC AHIP funds the Northern New England Poison Center (NNEPC), and monitors data on NNEPC calls related to ingestions among children.

### <u>Unsafe Sleep</u>

*Recommendation (4): DHHS/CDC in partnership with the OAG/OCME when appropriate, should resume it public health messaging on safe infant sleep, incorporating recent guidance and recommendations from the American Academy of Pediatrics.*

DHHS/CDC Response: The Maine CDC recently went through the competitive procurement process for some of its mass-media public health messaging; this included the safe infant sleep campaigns.
Messaging will resume upon final execution of the agreement, which should happen in the next 30-45 days.

## Systemic Observations and Recommendations

*Recommendation (5): OCFS should continue to train staff to view incidents of potential or actual harm not simply from an intent perspective, but also from a negligence perspective, and in the larger context of a family's actions, capabilities, and protective capacities over time.*

DHHS/OCFS Response: Through the use of the OCFS Structured Decision Making tools, staff are guided to make comprehensive, factually supported decisions that consider safety factors, risk factors, and the totality of the information obtained from parents, children, extended family, and other collateral sources of information. As new caseworkers join the agency, they receive training and coaching support through the Foundations curriculum delivered collaboratively by OCFS and the Catherine Cutler School of Public Policy at USM, as well as from their supervisors throughout their employment. In addition to the knowledge and skills that OCFS CPS Supervisors bring to the position, they also participate in the Supervisory Academy Training which focuses on education, administrative support, coaching and the use of child welfare tools and data to evaluate casework practice. In collaboration with the Catherine Cutler Institute of Public Policy, OCFS is expanding on this training with an overarching Supervision Framework that includes a supervision policy, supervisory competencies, the Supervisory Academy Training, and supervision tools and resources.

*Recommendation (6): OCFS and Maine CDC should partner more regularly to highlight various seasonal or otherwise trending injury patterns via public health messaging.*

DHHS/OCFS Response: OCFS and the Maine CDC work collaboratively to identify and address issues that fall within the purview of both agencies, such as unsafe sleep, drownings, deaths by suicide and falls from windows. One such example is public service announcements that were disseminated last summer after the Department received multiple reports of children falling out of windows. Both agencies are committed to continuing these efforts.

*Recommendation (7): OCFS should continue its provision of lockboxes to families with whom they are involved who have a need to secure potentially dangerous substances in the home. This should be offered both as a secondary and tertiary prevention measure.*

DHHS/OCFS Response: OCFS, in partnership with other DHHS Offices, continues to distribute safe storage lockbox resources for families involved with OCFS during both investigation and

the ongoing case process. This is one strategy of many that the Department is utilizing to address and support families impacted by substance use.

*Recommendation (8): The Governor should propose, and the Legislature should appropriate, adequate funding to the Maine CDC for the express purpose of re-establishing the Maine Injury Prevention Program, thus allowing pursuit of its mission.*

DHHS/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, AHIP is unable to take a coordinating role in the prevention of unintentional injury.

*Recommendation (9): OCFS should continue its use of safety science in its review of adverse case outcomes.*

DHHS/OCFS Response: OCFS continues to implement the Maine Safety Science Model (MSSM). In addition to the case review process, OCFS has facilitated orientation sessions for staff and the community, begun leadership training, and in 2023 will implement the use of this model in continuous quality improvement and licensing processes. OCFS is committed to understanding systemic factors influencing child welfare casework practice and the safety of children in Maine.

*Recommendation (10): DHHS should develop a comprehensive, statewide, interdepartmental child abuse and neglect prevention plan that includes data monitoring and outcome measures, to ensure prevention activities are achieving the desired goals.*

DHHS Response: The Department, in partnership with the Maine Child Welfare Action Network, is developing the framework for a statewide child and family well-being plan focused on the primary, secondary, and tertiary prevention of child abuse and neglect. The workgroup will seek the input of additional stakeholders in the development of the plan.

*Recommendation (11): OCFS should continue efforts to recruit and retain after-hours investigators.*

DHHS/OCFS Response: OCFS partnered with frontline staff to research and develop the after-hours emergency coverage structure that now exists, and Governor Mills included 16 CPS caseworkers and three CPS supervisor positions in the 2022 supplemental budget to create this unit. To date, OCFS has hired the three regional supervisors and 13 of the 16 caseworker positions for after-hours coverage. All staff have been trained and are working their assigned shifts. The original workgroup continues to meet to review after-hours practice, identify areas of success, and address implementation challenges.

*Recommendation (12): OCFS and its law enforcement partners should continue efforts to develop/deliver interdisciplinary training to law enforcement and OCFS staff around the state.*

DHHS/OCFS Response: OCFS, law enforcement, medical providers, and legal representatives have continued to meet in response to a recommendation by Casey Family Program and Collaborative Safety in their 2021 report that recommended the development of joint protocol agreements and increased collaborative efforts to jointly investigate allegations of child abuse and/or neglect. This group has met for the past year and developed proposed legislation to improve information sharing. Additionally, law enforcement and CPS are developing a "Cops and Caseworkers Training" to build relationships between staff at the local level and work toward a common understanding of issues impacting families.

*Recommendation (13): OCFS should develop a protocol for in depth review and assessment of chronically maltreating families who repeatedly come to the attention of OCFS over a long period of time.*

DHHS/OCFS Response: OCFS agrees that there should be resources available to evaluate families with a chronic history of maltreatment and unsuccessful interventions. Court Ordered Diagnostic Evaluation (CODE) provide comprehensive psychological evaluations and full case file reviews. Currently, CODE services are not readily available in each community with only 3 psychologists trained to perform the evaluations statewide and waitlists of 6-9 months. Decisions regarding which families could benefit from this service are made jointly by OCFS and the OAG. OCFS has proposed a budget initiative in the Governor's proposed budget to increase oversight of the CODE program and increase the rate for these evaluations with the goal of expanding the number of evaluators and improving the accessibility of CODEs. For families with no court intervention, district staff may request a team decision making meeting with the Program Administrator or a case review for families with complex histories.

*Recommendation (14): OCFS, OBH, and OAG should work together to develop a functional system of evaluators for complex child maltreatment cases in all areas of the state.*

DHHS/OCFS Response: OCFS has proposed a budget initiative in the Governor's proposed budget that would improve the system for Court Ordered Diagnostic Evaluation (CODE). Oversight of the service would be moved to the State Forensic Service which would employ a qualified professional to oversee the program and train evaluators to bolster the roster of qualified evaluators statewide. The rate for CODEs would also be increased to bring it in line with the rate paid for other State Forensic Service evaluations, which would further incentivize professionals to complete the training and take on this work.

*Recommendation (16): OCFS should view repeated missed well child appointments as sufficient cause to investigate a child's safety more thoroughly, particularly in the context of additional risk factors.*

DHHS/OCFS Response: DHHS agrees that medical providers play a crucial role in the primary prevention of child abuse and neglect and that a family's failure to attend well child appointments should be viewed in the context of safety and risk when allegations meet the threshold for child welfare intervention. Issues such as missed well child appointments are one of many factors assessed as part of a comprehensive investigation through the collateral contact that is conducted during the investigation process, although it does not, in and of itself,

necessarily constitute child abuse and/or neglect.  Families have the responsibility to ensure the safety, health and well-being of their children and in doing so have the right to determine the frequency and type of treatment so long as it does not cross the threshold to meet the definition of child abuse and/or neglect.