MASSACHUSETTS
Office of the Child Advocate

Office of the Child Advocate Annual Report

FISCAL YEAR 2023

APRIL 2024
THE COMMONWEALTH OF MASSACHUSETTS
MARIA Z. MOSSAIDES, DIRECTOR

Table of Contents

Letter from the Child Advocate

I am pleased to present the Fiscal Year 2023 (FY23) report of the activities of the Office of the Child Advocate (OCA). The OCA was established to serve both as an ombudsperson to ensure that children and their families receive quality, effective, and timely services that meet their needs, as well as an independent overseer charged with identifying gaps in needed services, providing recommendations for improvements to policies and practices, and conducting investigations when necessary.

The OCA envisions a future where all our Commonwealth's children and their families can thrive. Standing in the way of that vision are challenging times: the pandemic and its aftermath, particularly its impact on children's mental health, has led to a strain on our human services system, leading to high rates of turnover and secondary traumatic stress in our human services workforce. In the face of these challenges, we believe strongly that all of us must work together toward a future where every child is safe and thriving.

To achieve that end, the OCA, as part of a recent strategic planning process, has identified **eight priority goals we believe must be achieved by the Commonwealth**. These goals are bold, and they will guide the OCA's actions in the years to come:

- Children in the care and/or custody of the Commonwealth are safe and receiving the services they need, and the state agencies serving them are continuously improving with well-functioning quality assurance mechanisms in place.
- There is a comprehensive, coordinated statewide approach to supporting families with the aim of reducing child protective service and juvenile justice system involvement, particularly for those families for whom persistent disparities in supports exist and for families with multi-generational involvement.
- Youth receiving state services transition into adulthood with the supports they need to succeed.
- Our state child-serving systems are addressing the needs of traditionally underserved populations, including racially and ethnically diverse populations, LGBTQIA+ youth, and newcomer families.
- The needs of children and youth with high and/or complex behavioral health needs are met, including their needs for timely delivery of and navigation to appropriate support.
- Families and youth, and those who serve them, are aware of the support and services available to them.
- Our state agencies serving children and families use high quality data to inform decision-making and continuous quality improvement.
- The OCA has the expertise, reputation, relationships, capacity, and operational infrastructure to execute its mission.

The OCA works every day toward this vision. In this Annual Report, you will see how the work of the OCA moves us closer toward that reality. In particular, you will see information on the OCA's performance on our core mandated functions, including our reviews of Critical Incident Reports

and reports of child abuse and/or neglect in out-of-home settings, and our operation of a Complaint Line to respond promptly to concerns about the delivery of state services to children.

The OCA also released five research reports this Fiscal Year exploring the systems that impact children and youth, including reports on racial and ethnic disparities in the juvenile justice system, the Child Requiring Assistance system, childhood trauma, and a final report of the Task Force on Child Welfare Data Reporting.

You will also note the development of programmatic activities in addition to the mandated functions and research we do. Some highlights include the creation of a revised and updated mandated reporter training with a profession-specific module for educators; the expansion of the Massachusetts Youth Diversion Program; the implementation and evaluation of a housing support program for Transition Age Youth; and of course the continued operation of the Center on Child Wellbeing and Trauma, which supports the work of child-serving organizations and professionals across Massachusetts with training and technical assistance.

All of these activities are in the service of the goals listed above. Some activities may serve more than one goal – but everything we do is aimed at achieving these ends.

I am grateful to the OCA staff for their tireless efforts on behalf of the Commonwealth's children, especially as we work to grapple with increasingly complex cases and as we develop policy and innovation projects to improve the experiences of children in our Commonwealth. I would like to thank the Legislature, the Governor, our public sector colleagues, advocacy organizations, and families who bring their concerns and ideas to us daily. Without your continued partnership and support, the OCA could not successfully carry out its mission.

Sincerely,

Maria Z. Mossaides

About the Office of the Child Advocate

The Office of the Child Advocate (OCA) is an independent executive branch state agency with oversight and ombudsperson responsibilities, established by the Massachusetts Legislature in 2008.[1] The OCA's mission is to ensure that children receive appropriate, timely and quality state services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have the opportunity to thrive. Through collaboration with public and private stakeholders, the OCA identifies gaps in state services and recommends improvements in policy, practice, regulation, and/or law. The OCA also serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth. The OCA executes its mission by:

- Overseeing and monitoring the services delivered by child-serving state agencies
- Improving the collection, use, and transparency of state agency data
- Identifying gaps in and concerns with how state agencies and systems serve at-risk children, and recommending and advocating for solutions, including changes to improve coordination across agencies
- Advising on and leading efforts for systemic change in policies, programs, and practices affecting vulnerable and at-risk children
- Partnering with state agencies to improve service quality through the development and launch of innovation and incubation projects
- Serving as an ombudsperson, including providing information and referral support, for families who are receiving, or are eligible to receive, services from the Commonwealth
- Promoting child and family well-being

[1] Office of the Child Advocate (OCA) statute, M.G.L. c. 18C

Staff List in Fiscal Year 2023

Maria Mossaides, Executive Director

Operations

- Daniel Arnold, Chief Financial and Aministrative Officer
- Jean Clements, Office Manager
- Ari Fertig, Legislative and Communications Director
- Crissy Goldman, General Counsel
- Bekah Thomas, Senior Policy Manager

Quality Assurance

- Christine Palladino Downs, Senior Director of Quality Assurance
- Dana DeShiro, Quality Assurance Manager
- Renee Franzis , Quality Assurance Manager
- Karen Blake-Robinson, Clinical Specialist
- Nicole Thornhill, Clinical Specialist
- Yosstina Saadallah, Clinical Specialist
- **FY23 Staff Departures:**
- Taylor Lord, Data Analyst
- Karen Marcarelli, Program Assistant
- Janice Neiman, Senior Data and Research Analyst
- Jordan Reinwald, Clinical Specialist

Strategic Innovation

- Melissa Threadgill, Director of Strategic Innovation
- Kristine Polizzano, Juvenile Justice Program Manager
- Alix Riviere, Research and Policy Analyst
- Jessica Seabrook, Research and Policy Analyst
- Morgan Byrnes, Research and Policy Analyst

Executive Summary

This report, which is submitted in accordance with MGL Chapter 18C Section 10, describes the activities of the OCA in Fiscal Year 2023 (FY23), including our statutorily required **oversight and ombudsperson functions** as well as our **policy, research, and implementation projects** and our **work chairing various legislatively-created boards and task forces.**

Statutorily-Mandated Oversight and Ombudsperson Functions

In FY23, the OCA:

- Responded to 482 separate inquiries from family members, foster parents, advocates, attorneys, and various other individuals with concerns or questions about state services for individual children or families on our **Complaint Line.**
- Received and reviewed 319 **Critical Incident Reports**, involving 406 children, from state agencies regarding children or young adults receiving services who died or experienced a near fatality, serious bodily injury, or an emotional injury.
- Reviewed 422 Department of Children and Families (DCF) **reports of supported allegations of abuse and/or neglect of children in out-of-home settings**, involving 621 children.

In FY23, the OCA added **Foster Care Review (FCR) Safety Alerts** to the category of incidents which undergo administrative review. This year, the OCA reviewed 36 safety alerts involving 40 children.

Through those administrative reviews, the OCA noted and is monitoring **increasing fatalities among children** receiving state services, mostly driven by injuries, medical events, and overdoses. The data also indicates an **increase in supported reports of abuse and/or neglect in out-of-home settings,** particularly from congregate care settings and for certain types of DCF foster homes.

Policy Research and Implementation Projects

In FY23, the OCA released the following five research reports exploring the systems that impact children and youth and making recommendations for improvements:

- Identifying Childhood Trauma: Recommendations on Trauma Identification Practices in Child-Serving Organizations (Report released through the OCA-chaired Childhood Trauma Task Force)
- Improving Massachusetts' Child Requiring Assistance System: AN Assessment of the Current System and Recommendations for Improvement 10 Years Post "CHINS" Reform (Report released through the OCA-chaired Juvenile Justice Policy and Data Board)
- Massachusetts Juvenile Justice System: 2022 JJPAD Annual Report (Report released through the OCA-chaired Juvenile Justice Policy and Data Board)
- Racial and Ethnic Disparities at the Front Door of Massachusetts' Juvenile Justice System: Understanding the Factors Leading to Overrepresentation of Black and Latino Youth Entering the System (Report released through the OCA-chaired Juvenile Justice Policy and Data Board)

- Task Force on Child Welfare Data Reporting: Final Report (Report released through the OCA-co-chaired DCF Data Work Group)

The OCA carried out several programmatic activities in addition to the mandated functions and research work conducted. These include:

- Developing a revised and updated mandatory reporter training with a profession-specific module for educators.
- Implementing and expanding the **Massachusetts Youth Diversion Program** in partnership with the Department of Youth Services (DYS) and providing funding to improve DYS operated hardware secure facilities.
- Continuing to partner with the Executive Office of Health and Human Services (EOHHS) on the ongoing implementation and evaluation of a housing support program for Transition Age Youth, which resulted in a FY23 evaluation report as well as a Policy Brief describing the program.
- Continuing to operate the Center on Child Wellbeing & Trauma, which resulted from a prior recommendation from the Childhood Trauma Task Force.

Legislatively, the OCA worked to advance initiatives that will improve wellbeing and service delivery for children involved in the child welfare and juvenile justice system, including but not limited to advancing a foster children's bill of rights, improving the Child Requiring Assistance system, and making key data available; transferring authority of the Child Fatality Review program to a joint chairmanship between the OCA and the Department of Public Health; and addressing the needs of substance exposed newborns.

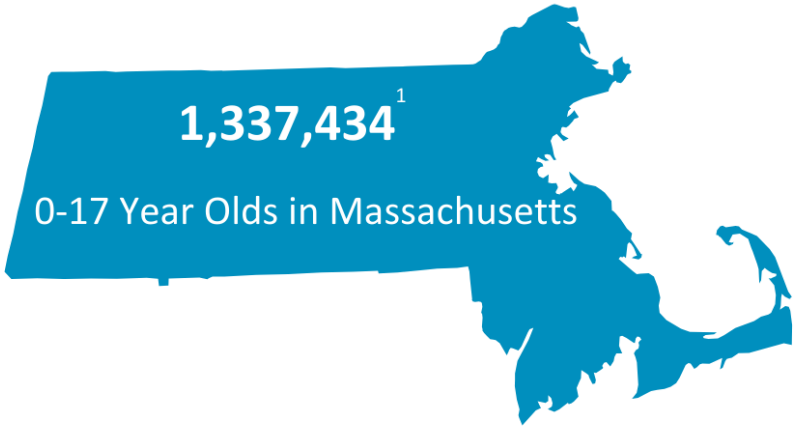
OCA-Chaired Boards and Task Forces

Finally, the OCA led a myriad of boards and task forces that advance conversations and create critical connections between key partners, such as:

- The Juvenile Justice Policy and Data Board
- The DCF Data Work Group,
- The Childhood Trauma Task Force
- Child Fatality Review

Through the activities conducted in FY23, the OCA is working to ensure the safety and wellbeing of children who interact with state systems. Protecting the most vulnerable and at-risk children from adverse outcomes requires a focus on understanding and directly addressing disparities, increasing availability of and access to quality state services, averting unnecessary systems involvement, promoting upstream prevention, and encouraging data-informed decision making. The OCA stands ready as partners and collaborators to provide system navigation to individuals, identify gaps in state services, and work toward continuous improvement of policy, practice, regulations, and laws. This work and the dedication of multi-sector partnerships will help ensure that the Commonwealth's children can thrive.

Data Snapshot of Children in Massachusetts



Gender [1]

49% Female, 51% Male

Identify as Trans [4]

5.3%

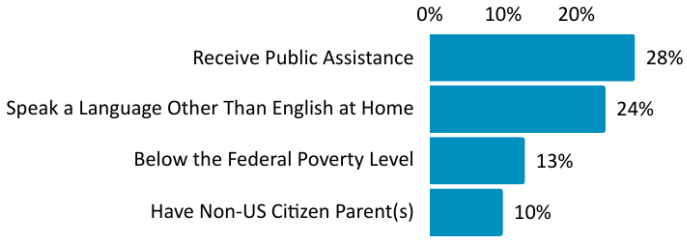
LGBTQ+ [4]

22%

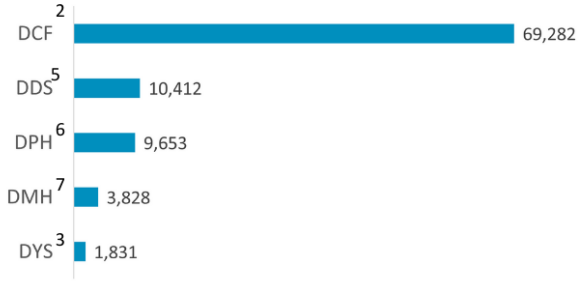
Living with two or more ACEs [1]

13%

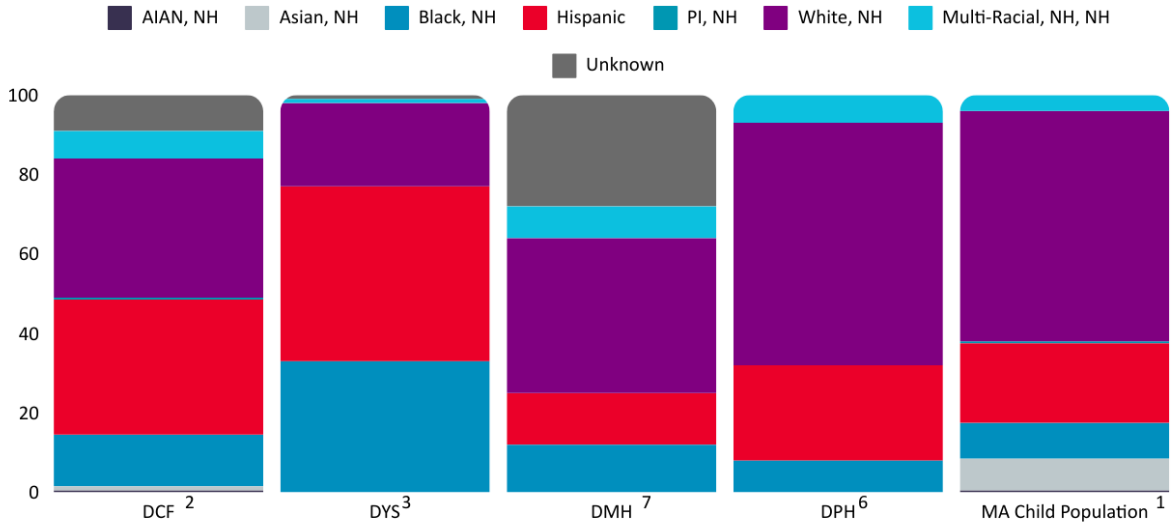
Relevant Demographic Information [1]



Recieved State Services From...



Race & Ethnicity of State Service Recipients Compared to General Population



Citations:

1. Kids Count Data Center, 2022. Note: ACEs = Adverse Childhood Experiences
2. FY23 DCF "Consumer Child" count for age open at **any time** while R&E breakdown is for open at **end of year**
3. Number of MYDP participants, Overnight Arrest Admissions, Pretrial Detentions, First-Time Commitments, and YES Transitions, JJPAD FY23 Annual Report
4. MCLGBTQY Annual Recommendations FY 2024
5. Active/Eligible children under the age of 18 as of 6/30/2023. Race ethnicity breakdown is not currently available.
6. DPH Bureau of Substance Addiction Services and Youth Violence Prevention Programing only, JJPAD FY23 Annual Report
7. DMH Full, limited and community services JJPAD FY23 Annual Report

Statutory Mandates

The OCA is required by statute (Chapter 18C of the Massachusetts General Laws) to perform several functions to ensure that children involved with an executive branch agency, particularly children served by the child protective services or juvenile justice systems, receive timely, safe, and effective services. Fulfilling these duties is our top priority and include the following:

- **Complaint Line**: [2] Respond to concerns about state services provided to individual children or families. Family members, foster parents, advocates, attorneys, and other various individuals contact the OCA Complaint Line to express concerns, ask questions, or receive resources and information about a service a child is receiving, or eligible to receive.
- **Critical Incident Reports**:[3] Receive and review reports from state agencies regarding children or young adults receiving services who die or experience a near fatality, serious bodily injury, or an emotional injury.
- **Foster Care Review Safety Alerts:**[3] Receive and review Department of Children and Families (DCF) Foster Care Review safety alerts (as of July 2022).
- **Supported Reports of Abuse and/or Neglect in Out-of-Home Settings**: [3] Receive and review DCF reports of supported allegations of abuse and/or neglect of children in out-of-home settings.

Investigations

The OCA may initiate a formal investigation when the OCA determines the actions or inactions of a reporting agency were egregious and significantly contributed to the harm of a child or young adult. Typically, it is a critical incident report that brings cases to our attention for investigation, though the OCA has discretion to investigate any matter that aligns with our statutory oversight obligations.

Office of the Child Advocate Investigative Report: Harmony Montgomery, 2022

Office of the Child Advocate Investigative Report: David Almond, 2021

Table 1: OCA By the Numbers, Fiscal Year 2023

Statutory Mandate	Reports or Inquiries	Children Involved
Complaint Line[4]	482	NA
Critical Incident Reports Received	319	406
Foster Care Review Safety Alerts Received[5]	36	40
Supported Reports of Abuse and/or Neglect in Out-of-Home Settings	422	621

[2] See Appendix E: Glossary of Terms for definitions of Critical Incident Reports, Foster Care Review, Foster Care Review safety alert, Supported Reports of Abuse and/or Neglect in Out-of-Home Settings.
[3] Foster Care Review safety alerts are not a statutory obligation of the OCA, however they are reviewed and analyzed in the same fashion as Critical Incident Reports. For more information about Foster Care Review safety alerts, see page 30.
[4] This number includes both complaints and calls related to information and referrals.
[5] While the receipt and review of Foster Care Review safety alerts are not statutorily mandated functions, it is treated as such for the purposes of this report.

The OCA uses the information reported to our office in these key areas to inform our work across the state child-serving systems. The OCA works not only to address situations that have already occurred, but also to identify preventative actions the state can take in the future to reduce the incidences of harm to all children and young adults. We analyze and use the information reported to our office to inform recommendations for policy and practice changes to prevent future risks to children. We also identify trends where the Commonwealth would benefit from greater data gathering and analysis. Our work in this area informs our day-to-day oversight of state agencies, our participation in the Child Fatality Review program, as well as our various other boards and commissions and related research projects.

When a complaint or report is received, the OCA quality assurance staff conduct an immediate review to learn more about the circumstance and the reporting agency's involvement with the child and family. When the OCA determines the actions or inactions of a reporting agency may have contributed to the complaint or incident, or that the child, young adult, or family is not receiving quality services to meet their needs, we may request additional reports from the agency, speak with staff, and/or further review case records to learn more about the family's history and involvement with the agency. When the OCA identifies an individual case practice concern or system-wide pattern or trend, we contact the agency involved and take necessary steps to resolve the matter.

While the OCA reviews all complaints and reports received from all child-serving state agencies, the OCA's mandate is to focus in particular on the children in the care and/or custody of DCF and the Department of Youth Services (DYS).[6] Complaints about DCF and reports received from DCF undergo a thorough review of the family's DCF electronic record. The purpose of this review is to understand the family and their needs, to substantively review DCF's understanding of the family and their needs, and to evaluate DCF's efforts to assist and engage the family and protect the child from harm. In this context, the OCA will identify what worked well and where there are opportunities for improvement in policy and case practice across the system or with the specific family. **The OCA confirms that all the case practice concerns identified through the OCA's review are resolved appropriately and in a timely manner to ensure the safety and well-being of the children involved and/or to improve services to the family.**

The following section of this report explains these core functions, findings, and actions taken based on data received through these core functions in FY22 and FY23. Additional years of data are presented where possible to provide context and elucidate trends. In aggregate, these data inform OCA's special initiatives and oversight of state agencies.

[6] See Appendix E: Glossary of Terms for a definition of State Custody. Please note, children in State Custody are not always placed out-of-home.

Complaint Line

One of the most critical OCA statutory functions is responding to concerns about state services provided to children. The OCA Complaint Line is available Monday through Friday, 9 am to 5 pm for anyone to express concerns or seek information and resources about a state service a child is receiving or eligible to receive.

When an individual contacts the Complaint Line, OCA staff most often provide support and resources for the individual to address their concerns directly with the state agency involved. When the OCA determines that the decision-making of an agency places or could place a child at substantial risk, the OCA will contact the appropriate state agency to seek more information and/or assist in the effort to resolve the concern. As mandated reporters, if the OCA is concerned for the imminent safety of a child, the OCA will immediately file a report of child abuse and/or neglect with DCF.[7]

Individuals who contacted the Complaint Line in FY23 were usually parents (48% of initial contacts[8]), though grandparents (12%), other relatives (5%), foster parents (8%), attorneys, case workers, school personnel, and mental, behavioral or medical health providers (10%), and children themselves (2%) also submit inquiries. Anyone with concerns for a child receiving state services is encouraged to contact the OCA.

Overview of Complaint Line Inquiries

Complaint Line data are presented for initial contacts. Though each initial contact is represented as one instance, there are substantial back and forth conversations and information gathering efforts between the OCA and the complainant for each contact. While data on the back-and-forth conversations are not reflected in this report, the OCA is working to improve our record collection systems to capture the number of follow-up calls that occur for each complaint to provide a better picture of the scope of the OCA Complaint Line work.

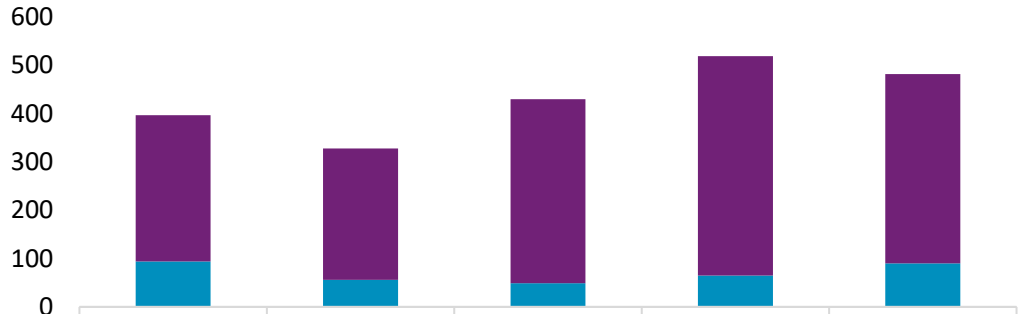
The OCA received 482 Complaint Line inquiries in FY23. Eighty one percent of inquiries (392) involved a complaint while 19% (90) were requests for information or a referral.[9] This represents a seven percent decrease in overall contacts in FY23 compared to FY22 and is the first year-over-year decrease since FY20. The OCA received substantially more information and referral inquiries in FY23 as compared to FY22 (65 in FY22 to 90 in FY23; a 38% increase). Despite repeated attempts, the OCA was unable to make contact with the person who reached out to the Complaint Line in 54 inquiries, which is 11% of the total inquiries received.

[7] To report suspected child abuse and/or neglect, contact the Department of Children and Families (DCF). During regular business hours (8:45am – 5:00pm Monday-Friday), call the DCF Area Office that serves the city or town where the child lives. Nights, weekends, and holidays, call the Child-At-Risk-Hotline at 1-800-792-5200. For more information, visit: https://www.mass.gov/how-to/report-child-abuse-or-neglect

[8] An i**nitial contact** on the OCA Complaint Line is defined as an individual's first contact with the OCA Complaint Line. Any follow-up contact with the same individual about the same issue is not included.

[9] A **complaint** is defined as contact with the Complaint Line to express dissatisfaction about services provided to a child in the Commonwealth. An **information and referral** inquiry is defined as contact with the Complaint Line to request information, referrals, or education on a specific topic and does not express dissatisfaction with any agency or program that provides services to a child of the Commonwealth.

Figure 1:
Initial Complaint Line Inquiries by Record Type and Fiscal Year
n = Initial Inquiries



	FY19 (n=397)	FY20 (n=328)	FY21 (n=430)	FY22 (n=519)	FY23 (n=482)
Complaint	303	272	381	454	392
Information/Referral	94	56	49	65	90

Complaints

Consistent with prior fiscal years, 74% of the **complaints** received by the OCA in FY23 involved DCF (290 of 392). This is expected given the OCA mandate to focus on children and families involved with DCF and the size of the DCF consumer population compared to other service-providing state agencies.[10] Complaints involving the Probate and/or Juvenile Court (32, 8%) and a public school or the Department of Elementary and Secondary Education (31, 8%) were the second most frequently occurring. The OCA also received complaints involving services provided by the Department of Mental Health (10, 3%), the Department of Developmental Services (8, 2%), MassHealth (3, >1%), the Department of Public Health (3, >1%), the Department of Youth Services (3, >1%) and a police department (1, >1%).[11]

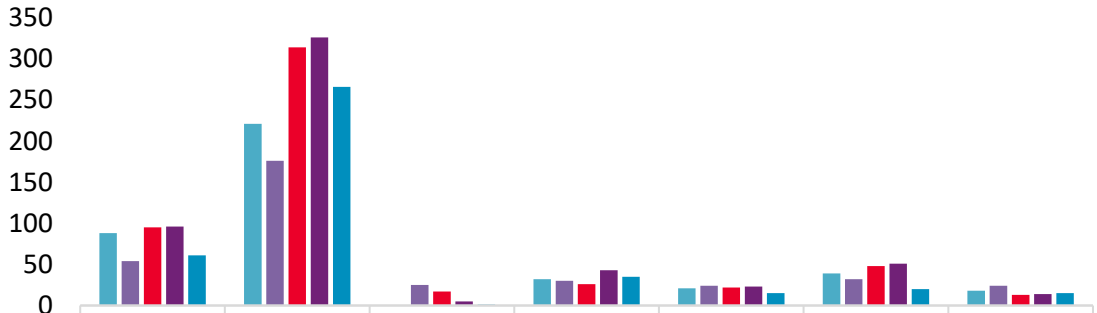
Also consistent with prior fiscal years, many individuals who contacted the OCA during FY23 expressed more than one issue. In FY23, OCA staff identified 413 unique complaints in the 392 complaint inquiries. Complaints most frequently relate to concerns for a child's wellbeing (64%), allegations of abuse and/or neglect (15%), education (8%), legal matters (5%), and healthcare (4%).[12]

Figure 2 provides a comparison of complaint classifications year-over-year from FY19 through FY23. With the exception of "Other", there was a decrease in every category in FY23 compared to FY22.[13] This includes a 61% reduction in the number of complaints about the legal system, a 36% reduction in complaints about abuse and/or neglect, and an 18% reduction in child welfare

[10] DCF served 80,019 parents/caregivers, children and young adults involved in 22,913 protective cases that included 38,548 children aged 0-17 in FY23.
[11] Number of calls will not sum to 392 nor will percentages sum to 100% because Complaint Line inquiries may involve more than one or no agency.
[12] Number of calls will not sum to 392 nor will percentages sum to 100% because Complaint Line inquiries may involve more than one concern.
[13] See Appendix E: Glossary of Terms for Complaint Line category definitions.

complaints. These reductions may be in part related to the return to a more normalized state of operations post the COVID-19 pandemic state of emergency.

Figure 2:
Initial Complaint Inquiries by Fiscal Year (FY19-FY23)
n = Total Complaints



	Abuse and Neglect	Child Welfare	COVID-19	Education	Healthcare	Legal	Other
FY19 (n=419)	88	221	0	32	21	39	18
FY20 (n=365)	54	176	25	30	24	32	24
FY21 (n=535)	95	314	17	26	22	48	13
FY22 (n=558)	96	326	5	43	23	51	14
FY23 (n=413)	61	266	1	35	15	20	15

The OCA in Action: Supporting Transition Aged Youth

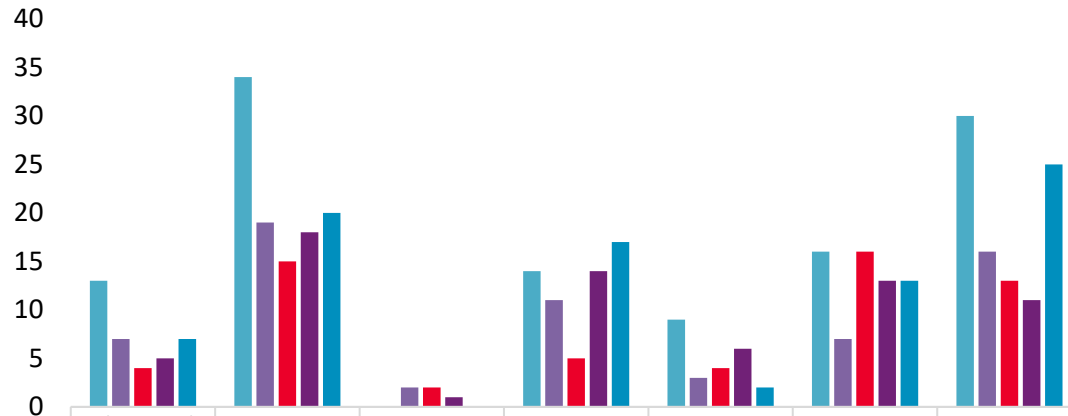
Amy*, a therapist, called the OCA Complaint Line regarding Julia*, a seventeen-year-old patient who was kicked out of her parents' house. Amy was concerned that Julia's parents were financially exploiting her as they were receiving financial assistance for Julia but keeping the funds for themselves and not providing housing or other basic needs. Because of this exploitation, Julia was not able to purchase food and other necessities for herself. The OCA asked Amy to encourage Julia to call the OCA. The next day, Julia called the OCA and stated that she wanted DCF to place her in foster care as the temporary housing arrangements she made with a friend were untenable. Julia was facing homelessness and had no means to provide for her basic needs. Julia asked for the OCA's assistance in advocating for DCF to place her in foster care. With the OCA's guidance, Julia wrote a letter to DCF stating why a foster care placement was in her best interest. The OCA also contacted DCF regarding Julia's needs. Julia and the OCA's advocacy resulted in a DCF foster care placement where she was able to remain in the same school and receive therapeutic support to help with symptoms of depression and anxiety. Shortly after her placement, Julia turned 18-years-old and signed on for voluntary services through DCF. Julia remains in foster care and once she graduates from high school this school year, plans to attend college, with DCF's financial support for tuition.

*The names in this and all subsequent vignettes have been changed.

Information and Referral

The OCA fielded 90 **information and referral** inquiries in FY23.[14] Inquiries about health care and COVID-19 decreased while inquiries regarding the legal system remained the same. For the past three years, inquiries about the education system, such as receiving or adhering to an Individualized Education Plan, increased. The number of FY23 information and referral inquiries received is higher than those received before the emergency response to the COVID-19 pandemic. Information and referral inquiries related to abuse and/or neglect and child welfare increased very slightly from FY22 to FY23 but are lower than pre-pandemic numbers. These inquiries include what to do in case of suspected abuse and/or neglect or how DCF responds to allegations of abuse and/or neglect. Inquiries related to "Other" issues, such as state service and systems navigation, the OCA's stance on policy debates and legislative actions, and requests for previously released reports more than doubled from FY22 to FY23 but have not returned to pre-pandemic levels.

Figure 3:
Information and Referral Requests by Concern Category (FY19-FY23)
n= Number of Referrals



	Abuse and Neglect	Child Welfare	COVID-19	Education	Healthcare	Legal	Other
FY19 (n=116)	13	34	0	14	9	16	30
FY20 (n=65)	7	19	2	11	3	7	16
FY21 (n=59)	4	15	2	5	4	16	13
FY22 (n=68)	5	18	1	14	6	13	11
FY23 (n=84)	7	20	0	17	2	13	25

[14] Counts will not sum to total number because there may be multiple requests for information and referral in a single inquiry.

The OCA In Action: Academic Support Navigation

Cindy* called the OCA to inquire about educational resources, including how to obtain an educational advocate for her son, Jake*. Jake, a seventh grader with attention deficit hyperactivity disorder (ADHD) and dyslexia, was supposed to receive one-to-one (staff to student ratio) academic support as required by his individualized education plan. However, Cindy explained that Jake was not receiving that academic support and the school was attempting to expel Jake. Further complicating the matter, Jake was being bullied by his peers at school and needed social and emotional support. The OCA provided a list of educational advocacy organizations to Cindy and explained and referred her to the Problem Resolution System (PRS) at the Department of Elementary and Secondary Education (DESE). The OCA was also able to connect Cindy with her local Family Resource Center to get Jake therapeutic support.

Critical Incident Reports

The OCA statute requires state agencies[15] providing services to children or young adults to notify the OCA if a child who is receiving a state service suffers a fatality, near fatality, serious bodily injury, or emotional injury.[16] These are called "critical incident reports" (CIRs). From FY19 to FY21, there was a steady increase in critical incident reports received, from 196 in FY19 to 347 in FY21. FY23 reflects the second year-over-year reduction in reports received since FY19, with 320 critical incident reports received in FY22 and 319 received in FY23.

The number of critical incident reports submitted by each agency is not a qualitative comparison between agencies. The number of children and young adults served by each agency varies significantly as do the challenges faced by the populations served. Critical incident reports do not necessarily reflect evidence of wrongdoing by an agency; a critical incident can result from a car crash, illness, or other reasons that are likely unrelated to the services provided by the reporting agency.

Figure 4 shows year-over-year trends related to critical incident reports received from state agencies for the past five fiscal years. Given that DCF serves more children and families than any other Executive Office of Health and Human Services (EOHHS) child-serving agency,[17] DCF unsurprisingly continued to submit the majority (84%) of the total number of critical incident reports to the OCA between FY19 to FY23. Additionally, a prime difference between DCF's critical incident reports and those from other child-serving agencies is that DCF reports critical incidents involving children in its custody, children and young adults receiving services, and children and young adults whose families had any DCF involvement within the preceding 12

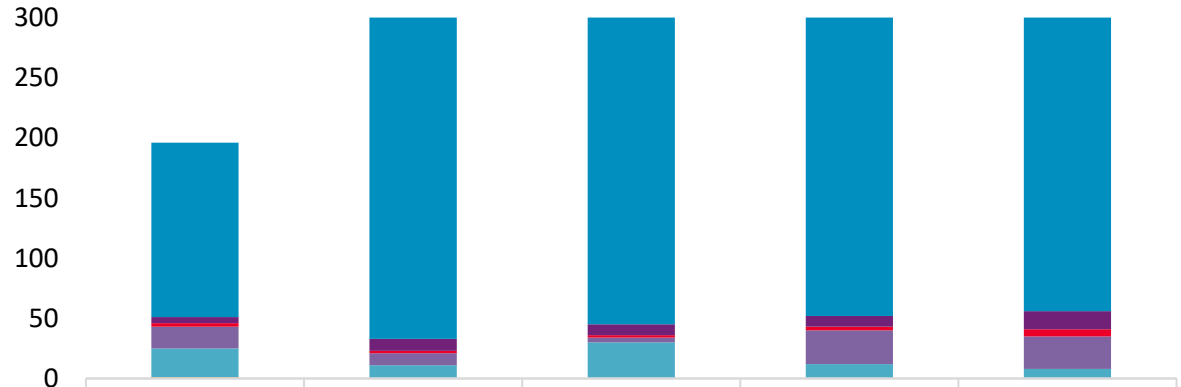
[15] Most often, the OCA receives critical incident reports from the state agencies organized under the Executive Office of Health and Human Services (EOHHS). During FY23, the OCA received critical incident reports from Department of Children and Families (DCF), Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and Department of Youth Services (DYS).

[16] See Appendix E: Glossary of Terms for definitions of fatality, near fatality, serious bodily injury, and emotional injury.

[17] At the end of FY23, DCF served 80,019 parents/caregivers, children and young adults involved in 22,913 protective cases that included 38,548 children aged 0-17. Of those 38,548 children, 80% (30,856) remained at home with services as needed.

months. Other EOHHS child-serving agencies only report critical incidents to the OCA for children and young adults currently receiving services. [18] This difference in reporting requirements contributes to there being a larger number of DCF critical incident reports submitted to the OCA.

Figure 4:
CIRs Received by State Agencies
(FY19-FY23)
n= Distinct Reports



	FY19 n= 196	FY20 n= 328	FY21 n=347	FY22 n=320	FY23 n= 319
DCF	145	295	302	268	263
DDS	5	10	9	9	15
DMH	3	2	2	3	6
DPH	18	10	4	28	27
DYS	24	11	30	12	8
NA	1	0	0	0	0

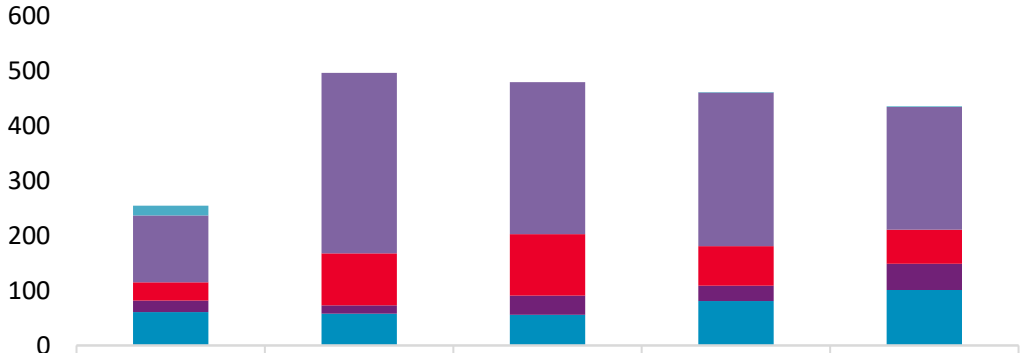
A critical incident report can contain more than one critical incident (fatality, near fatality, serious bodily injury, emotional injury) and/or pertain to more than one child.[19] Additionally, multiple agencies may submit a report regarding the same child or young adult if the child or young adult receives services from multiple agencies. For this reason, the number of critical incident reports does not equal the number of critical incidents, nor the number of children and young adults involved.

In FY23, the OCA received 319 reports involving 436 critical incidents and 406 children/young adults. Figure 5 describes year-over-year trends in the type of critical incident a child experienced from FY19-FY23. Overall, there was a decrease in reported emotional injuries (from 280 in FY22 to 224 in FY23) and serious bodily injuries (from 72 in FY22 to 62 in FY23) and an increase in reported fatalities (from 81 in FY22 to 101 in FY23) and near fatalities (from 28 n FY22 to 48 in FY23) compared to prior years.

[18] The Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and Department of Youth Services (DYS).
[19] See Appendix B: Critical Incident Reports for more information.

Table 2 describes the nature of those critical incidents in terms of what caused the incident, such as a medical event, violence, unintentional injury, or overdose.[20] Similar to past fiscal years, reports were most often the result of a child witnessing someone overdose on substances, reflecting the ongoing seriousness of the opioid epidemic and its effect on children. Injuries and medical events were the second and third most frequently occurring incident. The increases in fatalities and near fatalities were primarily driven by injuries, medical events, and overdoses.

Figure 5:
Critical Incident Reports by Fiscal Year (FY19-FY23)



	FY19	FY20	FY21	FY22	FY23
Other	18	0	0	1	1
Emotional Injury	122	329	277	280	224
Serious Bodily Injury	33	95	112	72	62
Near Fatality	21	15	35	28	48
Fatality	61	58	56	81	101

Table 2: Nature and Outcome of Children's Experiences in Critical Incident Reports

Outcome	Injury	Medical	Overdose	Physical Abuse	Sexual Assault	Suicide/ Attempt	SUID	Other/ Unknown	Violence	Total
Fatality	10	52	6	1	0	3	16	9	4	101
Near Fatality	11	3	26	0	0	7	0	0	1	48
Serious Bodily Injury	26	1	5	15	1	6	0	0	8	62
Emotional Injury	6	7	162	0	0	12	20	10	7	224
Other	0	0	0	0	0	0	0	1	0	1
Grand Total	**53**	**63**	**199**	**16**	**1**	**28**	**36**	**20**	**20**	**436**

[20] See Appendix E: Glossary of Terms for definitions of each of the categories named in Table 2.

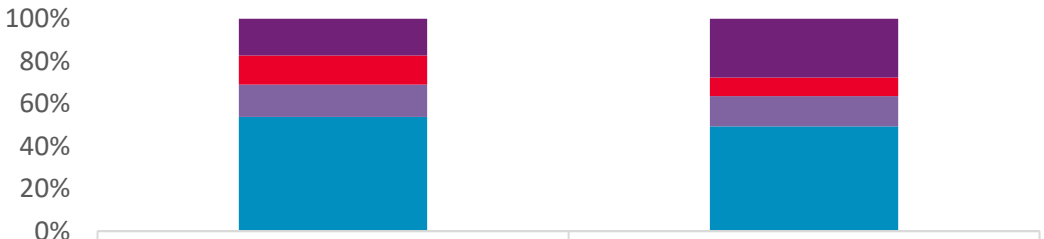
Demographics

Of the 406 children who experience a critical incident, sex[21] is available for 404 children (99%). Of those, approximately 52% were identified as male, and 48% were identified as female. While more children identified as males appeared in reports compared to females, the distribution of outcomes is similar among males compared to females. Reports involving children identified as females were slightly more likely to result in near fatalities while children identified as males resulted more in fatalities. Figure 6 describes the proportion of reported outcomes for children identified as males compared to children identified as females.[22]

Figure 6:[23]

Sex of Children Appearing in CIRs, Stratified by Event Outcome

n= Unique Children



	Female (n=193)	Male (n=211)
Fatality	34	60
Near Fatality	27	19
Serious Bodily Injury	30	31
Emotional Injury	106	107

Age is available for all children appearing in the reports. The children involved ranged from infants under one-year-old to 24-year-olds. Reports involving infants were mostly the result of a Sudden Unexpected Infant Death, death from a complex medical condition, or suspected abuse resulting in serious bodily injury. Reports involving very young children ages one to four mostly resulted from emotional injuries, specifically witnessing someone overdose. Reports involving children ages five to nine mostly resulted from emotional injuries and fatalities due to complex medical conditions or unintentional injuries, while reports involving 10- to 14-year-olds and 15- to 19-year-olds predominantly related to emotional injury from witnessing an overdose. Very few reports involved 20- to 24-year-olds; those reports mostly related to serious bodily injury and fatality related to substance use and unintentional injuries. Figure 7 describes the number of reports received for each age group, and the outcome the child experienced.

[21] Sex/Gender as reported by agency; sex/gender identification may vary by agency and may not reflect the child's identity or sex identified at birth.

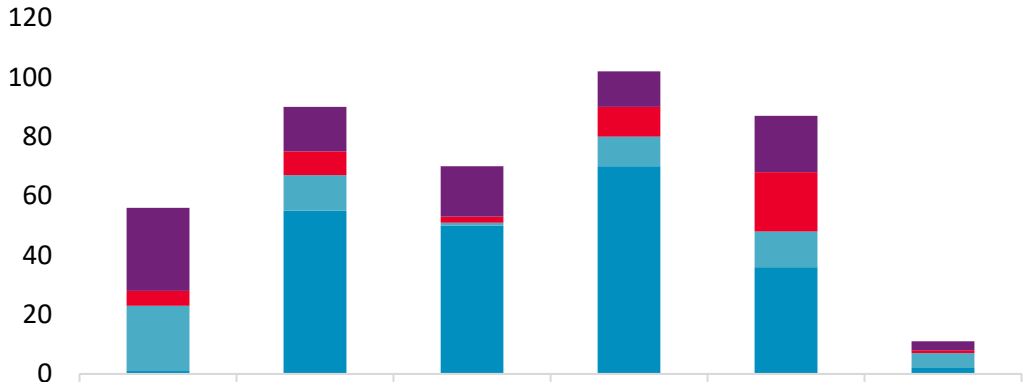
[22] Demographic information, such as age, gender, race, and ethnicity are collected at the time the report is received either from the critical incident report, a representative at the reporting agency or through DCF's electronic database. Data on the sexual orientation of children who are the subject of a report, and whether they identify as transgender, is currently only available for a very small proportion of CIRs the OCA receives. Given the very high percentage of "unknowns", that data is not reported here. However, the OCA continues to prioritize improving the frequency and accuracy of demographic information reported to the OCA, including sexual orientation and gender identity, and we hope to be able to provide additional demographic data in future reports.

[23] Counts will not equal total because one child can experience multiple outcomes.

Figure 7:[23]

Age of Children Appearing in CIRs, Stratified by Event Outcome

n= Unique Children



	Under 1 (n=85)	1 to 4 (n=81)	5 to 9 (n=60)	10 to 14 (n=92)	15 to 19 (n=88)	20 to 24 (n=11)
Fatality	28	15	17	12	19	3
Near Fatality	5	8	2	10	20	1
Serious Bodily Injury	22	12	1	10	12	5
Emotional Injury	1	55	50	70	36	2

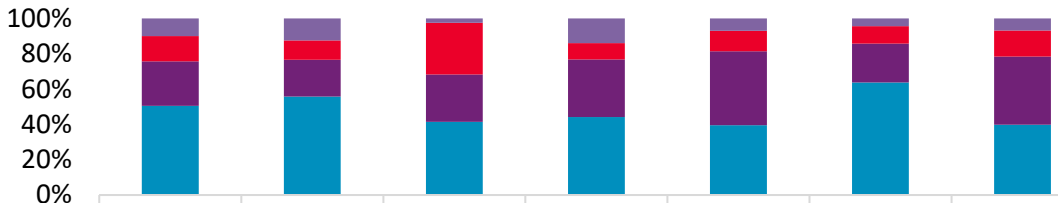
The OCA is dependent on the reporting state agencies for demographic data. Race and ethnicity information was available for 81% of the children appearing in critical incident reports (327 children). Most frequently, the race and ethnicity of children who passed away was unknown (53 of the 101 CIRs about a child fatality), and 43 of those fatalities were reported by an agency other than DCF. American Indian/Alaskan Native and Asian or Pacific Islander children did not appear in any CIRs.

Proportionally, more children of color appear in critical incident reports when compared to the general population of children in Massachusetts, but fewer children of color appear in critical incident reports compared to the DCF child consumer population. White children are disproportionally overrepresented in critical incident reports compared to the DCF child consumer population.[24] This overrepresentation is driven by emotional injuries resulting from witnessing an overdose.

Children of color are overrepresented in fatalities, near fatalities, and serious bodily injuries as compared to the DCF consumer population. Reports involving Hispanic children were the result of serious bodily injuries more often compared to other race/ethnicity categories, and reports involving Black children were the result of a fatality more often than other race/ethnicity categories. Figure 8 and Figure 9 describe the proportion of reports that involved children of specific race and ethnicities, by event outcome and excludes cases where the race/ethnicity was unknown, therefore this analysis should be interpreted with caution.

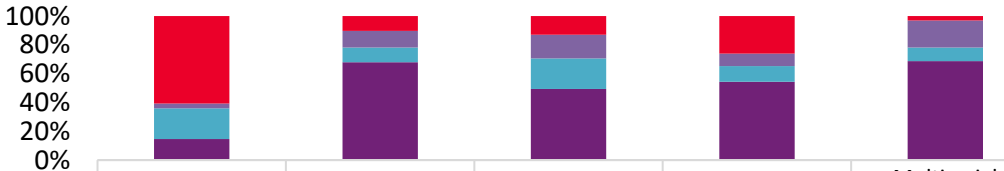
[24] DCF submitted 82% of CIRs; use caution while interpreting this finding.

Figure 8:
Outcome of CIRs Stratified by Race and Ethnicity of Children Appearing in the Report



	All CIRs	Emotional Injury	Fatality	Near Fatality	Serious Bodily Injury	MA population	DCF Population
Multiracial, NH	32	25	1	6	3	4%	6%
Black	46	22	12	4	5	9%	13%
Hispanic	81	42	11	14	18	20%	34%
White	162	112	17	19	17	58%	35%

Figure 9:
Race and Ethnicity of Children Appearing in CIRs Stratified by Event Outcome
n= Unique Children



	Unknown (n=85)	White (n=162)	Hispanic (n=81)	Black (n=46)	Multiracial (n=32)
Fatality	54	17	11	12	1
Near Fatality	3	19	14	4	6
Serious Bodily Injury	19	17	18	5	3
Emotional Injury	13	112	42	25	22

Critical Incident Report Analysis by Event Outcome

Fatality: A fatality occurs when a child between the age of birth to 24 who is receiving state services dies. In FY23, the OCA received 101 fatality critical incident reports related to the death of 94 unique children, which is substantially more than reported in the prior four years (FY22, 81; FY21, 56; FY20, 58; and FY19, 61). This increase is consistent with public health data: nationally and in Massachusetts, child fatalities increased for the first time in three decades in 2021.[25] In FY23, the increase in critical incident report fatalities was mostly driven by medical

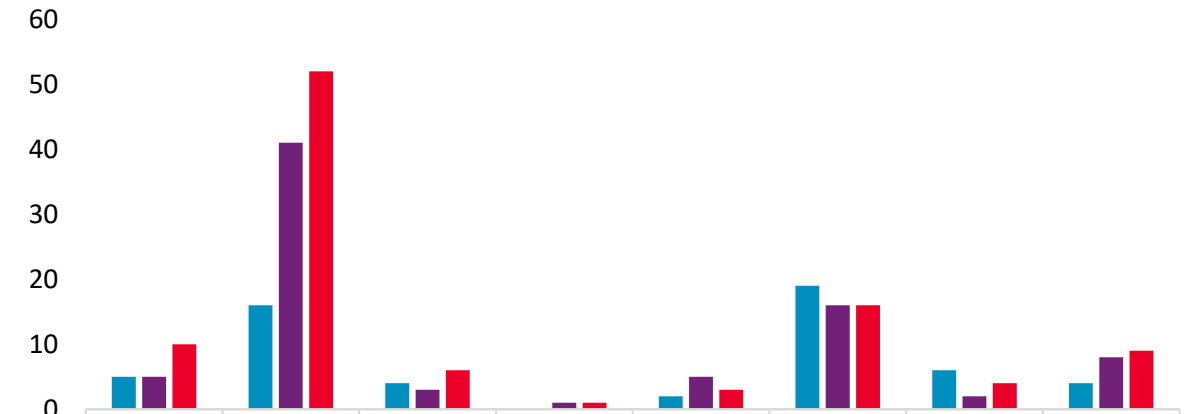
[25] Child Fatality Review FY22 Annual Report, FY22 Child Fatality Review Annual Report, https://www.mass.gov/doc/fy22-child-fatality-review-annual-report/download ; Woolf SH, Wolf ER, Rivara FP. The New Crisis of Increasing All-Cause Mortality in US Children and Adolescents. JAMA. 2023;329(12):975–976. doi:10.1001/jama.2023.3517; In Calendar Year 2020, 390 Massachusetts children under the age of 18 died, whereas 397 died in 2021. Final death counts are not yet available, but preliminary vital statistics data show that at least 403 child residents died in 2022 (Massachusetts Registry of Vital Records and Statistics. (n.d.). "Open Death File". https://www.mass.gov/orgs/registry-of-vital-records-and-statistics)

events (49 children, 52 reports) and unintentional injuries (9 children, 10 reports), as well as a slight increase in the number of overdose (5 children, 6 reports) and violence-related fatalities (4 children, 4 reports).

Reported fatalities from medical events nearly tripled from FY21 compared to FY23. The increase in reported medical event related deaths is primarily the result of reporting from the Department of Public Health (DPH). While DPH reported one death in FY21, they reported 20 deaths in FY22 and 27 deaths in FY23. Additional research is needed to determine whether this is an actual increase in the number and rate of fatalities among children receiving services from DPH, or a result of improved critical incident reporting.

The increase in injury-related fatalities resulted from an increase in such reports from DCF. DCF reported five injury-related fatalities in FY21, two in FY22 and 10 in FY23. Substantial increases in the types of injuries that caused fatalities were not observed, apart from a small increase in the number of reported drownings. None of the children were in DCF custody at the time of the injury-related fatality.

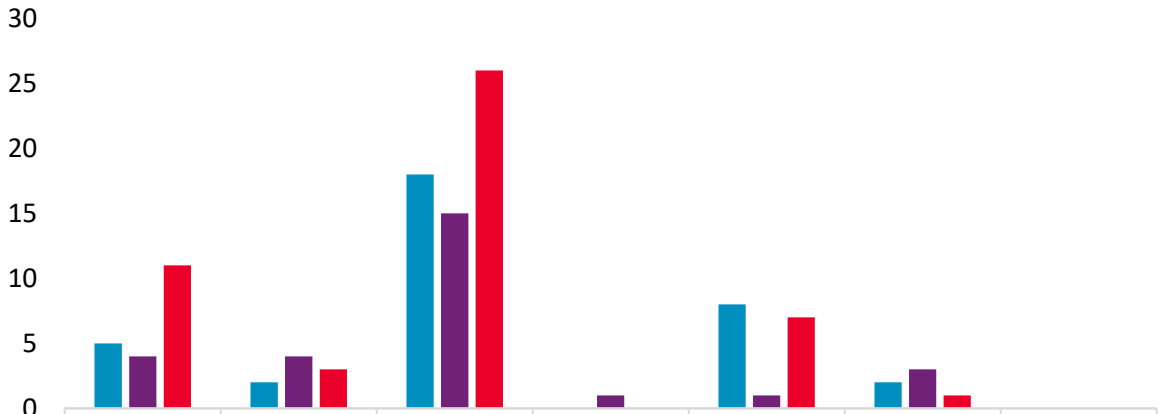
Figure 10:
Cause of Fatalities in CIRs
(FY21-FY23)



	Injury	Medical	Overdose	Physical Abuse	Suicide	SUID	Violence	Other
FY21	5	16	4	0	2	19	6	4
FY22	5	41	3	1	5	16	2	8
FY23	10	52	6	1	3	16	4	9

Near Fatality: Near fatalities are accidental, the result of a medical condition, or the result of abuse and/or neglect. A verbal certification by a physician that the child or young adult's condition is considered life-threatening is needed for an incident to be designated a "near fatality." In FY23, near fatality critical incident reports increased (48 near fatalities were reported in FY23, compared to 28 in FY22, 35 in FY21, 15 in FY20, and 21 in FY19). This increase is driven by overdoses and unintentional injuries. All other categories either remained the same or decreased slightly.

Figure 11:
Cause of Near Fatalities in CIRs
(FY21-FY23)



	Injury	Medical	Overdose	Physical Abuse	Suicide Attempt	Violence	Other
FY21	5	2	18	0	8	2	0
FY22	4	4	15	1	1	3	0
FY23	11	3	26	0	7	1	0

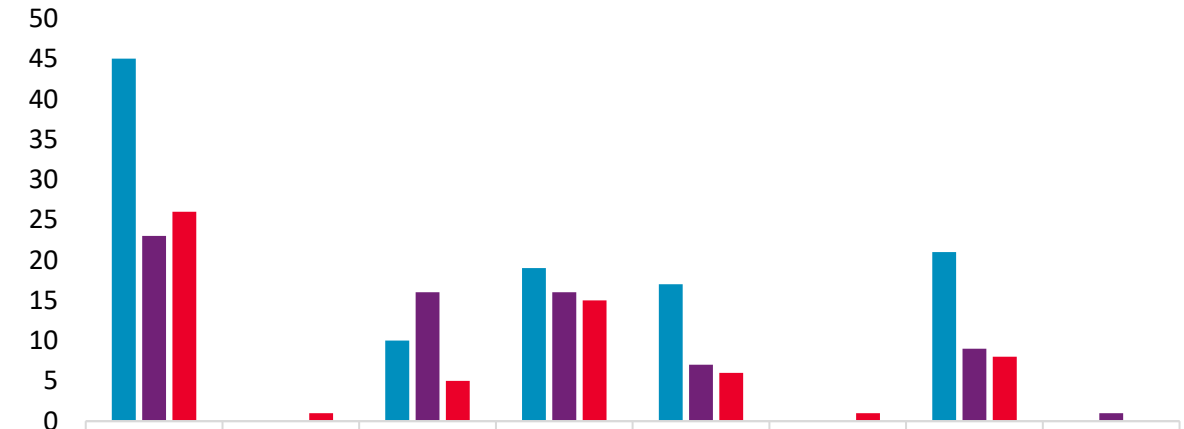
Serious Bodily Injury: Serious bodily injuries are accidental, the result of an underlying medical condition, or the result of abuse and/or neglect and lead to bodily injury "which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress."[26]

Serious bodily injuries decreased in FY23 with 62 reported serious bodily injuries compared to 71 in FY22, 112 in FY21, 95 in FY20 and 33 in FY19. The largest reduction came from overdoses. Considering the number of reported near fatal overdoses increased during the same period, this may be a reporting artifact:[27] when near fatal overdose and serious bodily injury overdose reports are combined, the number remains stable from FY21 through FY23 (28 in FY21, 31 in FY22 and 31 in FY23).

[26] M.G.L. c. 18C § 5

[27] A reporting artifact refers to an inconsistency or distortion in data that arises not from an actual change in the phenomenon being measured but rather from issues related to data collection, reporting methods, or other procedural factors.

Figure 12:
Cause of Serious Bodily Injury in CIRs
(FY21-FY23)



	Injury	Medical	Overdose	Physical Abuse	Suicide Attempt	Sexual Assault	Violence	Other
FY21	45	0	10	19	17	0	21	0
FY22	23	0	16	16	7	0	9	1
FY23	26	1	5	15	6	1	8	0

As of the release of this report, Massachusetts-specific public health data about hospitalizations for FY23 were not yet available for comparison; therefore, we cannot determine whether the increase in near fatalities and decrease in serious bodily injuries is unique to child and youth receiving state services or is occurring more broadly among children in Massachusetts.

Emotional Injury: **An emotional injury occurs when a child is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, suicide, or violent act.**[28] Emotional injury is consistently the most frequent critical incident reported. However, the OCA received fewer reported emotional injuries in FY23 compared to any other reporting year (224 in FY23 compared to 280 in FY22).

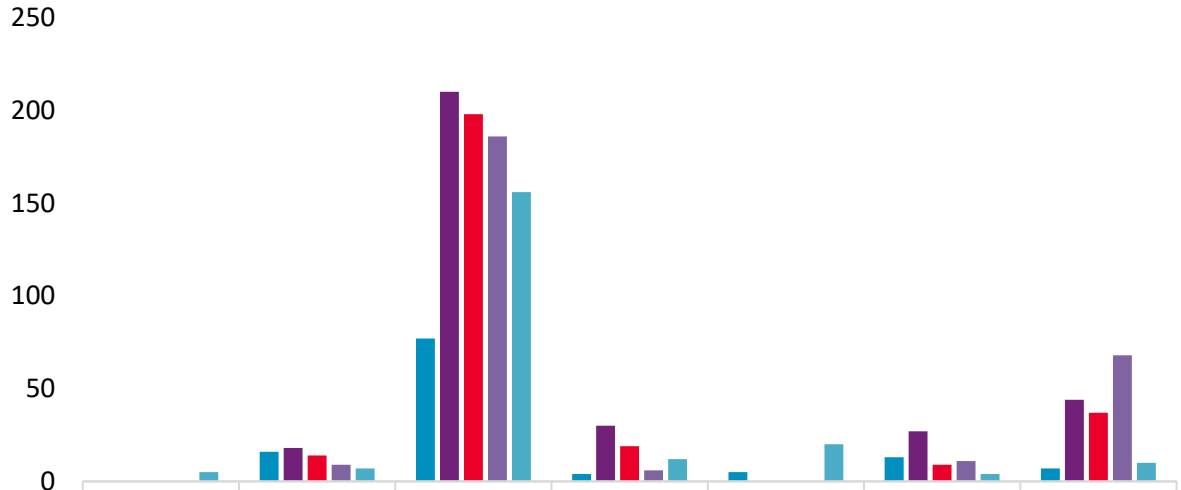
Witnessing an overdose remained the leading cause of reported emotional injuries in FY23; the OCA received 162 witness to overdose critical incident reports. This represents the lowest number of witnesses to overdose emotional injury reports the OCA has received since FY20, and a four-year downward trend in the number of witnesses to overdose reports received. Concurrently, DPH reported an increase in the rate of overdose fatalities in 2022.[29] This mismatch between public health data and critical incident reporting may be caused by under-

[28] The OCA term and definition of **emotional injury** is not consistently used in child welfare or scientific research. As such, emotional injuries are best understood as a type of Adverse Childhood Experience (ACEs), a term coined by the Centers for Disease Control (CDC) to describe examples of abuse, neglect, and household dysfunction that could be potentially traumatic for children and have a lifelong impact on their overall health, safety, and well-being. The OCA uses the term emotional injury to differentiate between a child witnessing an event (ex. seeing a caregiver overdose) from a child being the direct victim of the event (ex. overdosing themselves) in any setting, such as a home, community, or any other out-of-home setting.
[29] Department of Public Health. (2023, June). Massachusetts Executive Office of Health and Human Services. https://www.mass.gov/news/massachusetts-opioid-related-overdose-deaths-rose-25-percent-in-2022

reporting by certain child and youth serving agencies, improved substance use interventions and safety planning by DCF, or fewer parents engaging in substance use. More research is necessary to understand the difference between these data trends.

Reversing the decrease seen in FY22, the OCA received 12 reports regarding a child witnessing a person who attempted or died by suicide in FY23. This number, however, is still substantially lower than the number of reports received in FY21 and FY20. Reports regarding a child or youth witnessing violence decreased in FY23 compared to prior years, with seven such reports received. Figure 13 presents year- over-year data about the nature of emotional injuries children experienced as described in the critical incident reports received by the OCA.

Figure 13:
Cause of Emotional Injuries in CIRs
(FY19-FY23)



	Injury	Medical Events	Overdose	Suicide	SUID	Violence	Other
FY19		16	77	4	5	13	7
FY20		18	210	30	0	27	44
FY21		14	198	19	0	9	37
FY22		9	186	6	0	11	68
FY23	5	7	156	12	20	4	10

Causes of Critical Incidents

The OCA categorizes and analyzes all events that led to the injury or death of the child involved in the critical incident. The Office of the Chief Medical Examiner makes the final determination regarding the cause and manner of death; the critical incident report to the OCA provides information about the nature and circumstances of the event that led to the injury or death of a child or young adult.

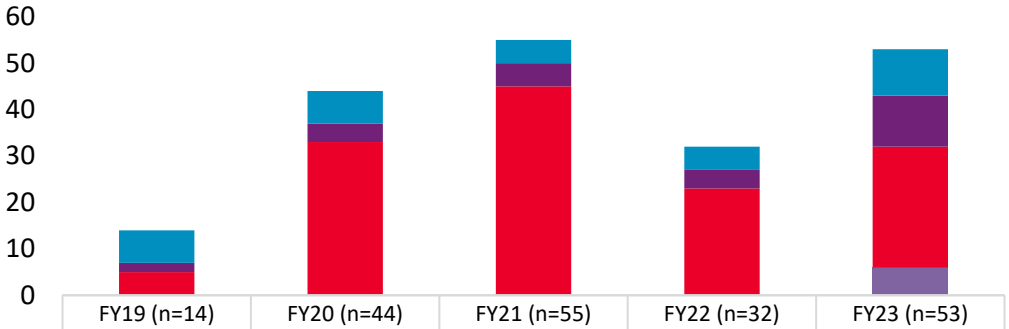
Injury

The OCA observed a steady increase in injury-related critical incidents from FY19 through FY21, followed by a reduction in FY22 and then an increase in FY23. Childhood injury is often

preventable, but nationwide more than 7,000 children and youth aged zero to 19 died because of unintentional injuries in 2019, according to the most recent available national data.[30]

Nationally, the leading causes of child unintentional injury include motor vehicle crashes, drowning, and falls; this is consistent with Massachusetts-specific public health data and critical incident reports submitted to the OCA. In FY23, car crashes (10), falls (9), and drownings (8) were the most frequently reported unintentional injuries to children receiving state services. Falls and motor vehicle crash data are similar to previously years, but there was an increase in reported drownings.[31] Reports also documented six emotional injuries caused by a child witnessing an unintentional injury. The injuries were caused by a parent or sibling dying in a car crash (3) or a drowning event (3).

Figure 14:
Unintentional Injuries in CIRs by Outcome (FY19-FY23)



	FY19 (n=14)	FY20 (n=44)	FY21 (n=55)	FY22 (n=32)	FY23 (n=53)
Fatality	7	7	5	5	10
Near Fatality	2	4	5	4	11
Serious Bodily Injury	5	33	45	23	26
Emotional Injury					6

Overdose

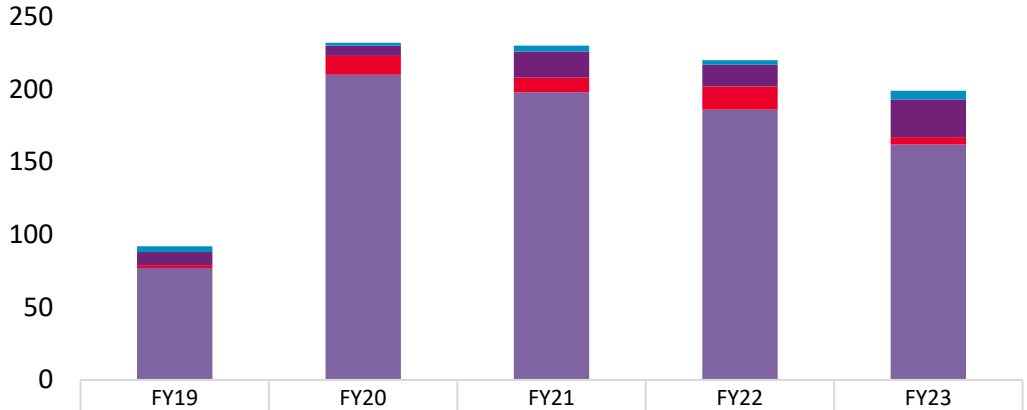
Nationally in 2021, the most recent year of data available, almost 51,000 people died from drug overdoses, making it a leading cause of accidental death in the United States.[32] Illicitly manufactured fentanyl, heroin, cocaine, or methamphetamine comprised 85% of drugs involved in overdose deaths nationally.[33] Approximately 2,300 Massachusetts residents died of an overdose that year.[34]According to the CDC, those deceased residents include 119 youth between the ages of 15-24, with an additional 476 25–34-year olds, and 630 35 to 44-year old's

[30] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control https://www.cdc.gov/injury/features/child-injury/index.html
[31] For more information about causes of injuries appearing in Critical Incident Reports, see Appendix C: Additional Core Function Data, Table 10. Number of Children Who Sustained Specific Types of Injuries.
[32] Centers for Disease Control and Prevention, Drug Overdose Deaths https://www.cdc.gov/drugoverdose/deaths/index.html
[33] Centers for Disease Control and Prevention, Overdose Death and the Involvement of Illicit Drugs https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html
[34] Massachusetts Department of Public Health, Data Brief: Opioid-Related Overdose Deaths among Massachusetts Residents, December 2022 https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-december-2022/download

dying the same year in Massachusetts.[35] In Massachusetts, as is the case nationally, men consistently die of overdoses more frequently than women.

The OCA recognizes the deep impact the ongoing opioid epidemic has on children. The critical incidents reported to the OCA reflect the worst-case scenarios of a child experiencing drug exposure or a child witnessing a fatal or life-threatening overdose, but the issue is much more widespread. The critical incident reports do not account for the children who live with the reality of substance use in their lives when that substance use does not, or has not yet, resulted in a situation qualifying as a critical incident report.

Figure 15:
Overdose Events in CIRS by Outcome
(FY19-FY23)



	FY19	FY20	FY21	FY22	FY23
Fatality	4	2	4	3	6
Near Fatality	9	7	18	15	26
Serious Bodily Injury	2	13	10	16	5
Emotional Injury	77	210	198	186	162

The number of reported critical incidents in which a child experienced an overdose increased in FY23 to 37 (six fatalities, 26 near fatalities, and five serious bodily injuries). Five children appeared in more than one report of an overdose.

The OCA data does not account for fatal or near fatal overdoses of children in Massachusetts who were not receiving state services at the time of the overdose. However, this is the fifth year of increases in a row (from 15 in FY19 to 22 in FY20, 32 in FY21 and 34 in FY22), and while the number of increases is small, it is a concerning trend, especially considering CIR reported fatalities doubled from FY22 to FY23. All of the fatalities involved opiates. The children involved were two (1 child), 15 (3 children), 17 (1 child), and 18-years-old (1 child).

Most of the 32 unique children who experienced an overdose were not in state custody and care at the time of the event, however, five children were living in out-of-home placements. One of those children died, while three were near fatally injured and one suffered a serious bodily

[35] Massachusetts Department of Public Health, Opioid-Related Overdose Deaths, All Intents, MA Residents – Demographic Data Highlights, June 2022 https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2022/download

injury. Two children overdosed in their out-of-home placement, two in a public place, and the setting of the event was not ascertainable for one event. Two children obtained substances while on a day pass from placement and three were missing from their placement when they overdosed. Substances involved included Benadryl (2), Fentanyl (3), Percocet (1) and Metformin (1), and several incidents involved more than one substance, including alcohol and marijuana.

Emotional Injury: Witness to Overdose

Experts point to witnessing an overdose as an Adverse Childhood Experience.[36] The negative impact of witnessing an overdose is compounded by the fact that children exposed to overdoses are often also victims of maltreatment, which puts them at increased risk of complex trauma. Critical incidents involving children who witnessed an overdose comprised two thirds (or more) of all emotional injury events from FY19 through FY23. The OCA received 101 critical incident reports involving 156 children witnessing an overdose in FY23. More than one third of those reports involved a child between one and six-years-old. In FY23, of the 156 unique children who witnessed an overdose, 81% resulted in near fatalities to the person who overdosed, while 19% resulted in fatalities. Seven of those children were in state custody when they witnessed the overdose. Those overdoses took place in foster home(s) where a peer or person other than their foster parent or biological parent overdosed.

Physical Abuse

Physical abuse is the non-accidental commission of any act by a caregiver which causes or creates substantial risk of physical injury to a child.[37] In FY23 DCF received 20,271 allegations of physical abuse of children, of which they supported[38] 1,681 allegations.[39] While the number of physical abuse critical incident events reported to the OCA increased sharply from FY19 (6) to FY20 (21), they decreased slightly from FY21 to FY23 (19, 18, and 16 respectively). One physical abuse report in FY23 resulted in a fatality and 15 resulted in a serious bodily injury. All of the children were four-years-old or younger, with 10 of the 16 under the age of one. In the DCF investigation of each incident, the child's parents were determined to be the perpetrator in six incidents. The perpetrator was not identified in six incidents of physical abuse. Other perpetrators included a sibling, a custodial grandmother (two children, one incident), and a mother's boyfriend. Three children were in state custody at the time of the reported physical abuse. All three sustained serious bodily injury. One was in a foster home, one was in their

[36] Wisdom AC, Govindu M, Liu SJ, Meyers CM, Mellerson JL, Gervin DW, DePadilla L, Holland KM. Adverse Childhood Experiences and Overdose: Lessons From Overdose Data to Action. Am J Prev Med. 2022 Jun;62(6 Suppl 1):S40-S46. doi: 10.1016/j.amepre.2021.11.015. PMID: 35597582; PMCID: PMC9761611.

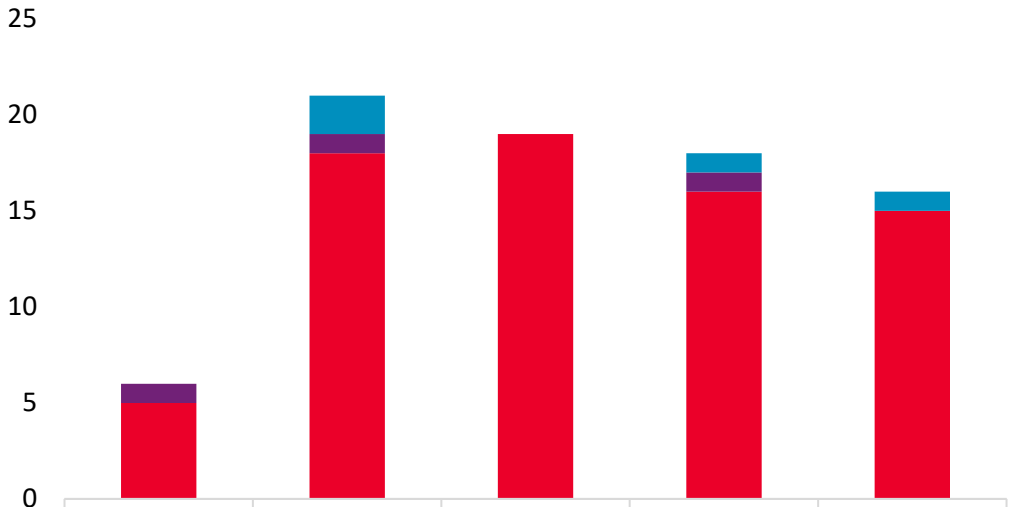
[37] Michell, K., Nolte, K., Turner, H., Hamby, S., Jones, L. (2018, January) Exposure to Medication Overdose as an Adversity in Childhood. https://www.sciencedirect.com/science/article/abs/pii/S0882596317304359

[38] When DCF receives a report of abuse and/or neglect (51A), DCF gathers information to determine whether to "screen in" an allegation based on whether it meets DCF criteria for suspected abuse and/or neglect. Once screened in, the case is assigned for a child protective response (51B) to determine whether there is "reasonable cause to believe" that child abuse and/or neglect occurred. The 51B is then "supported" if there is reasonable cause to believe the allegations are valid. For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.

[39] In FY22 DCF received 19,256 allegations of physical abuse of children of which they supported 1,649 allegations. DCF reports critical incidents involving children in its custody, children and young adults receiving services, and children and young adults whose families had any DCF involvement within the preceding 12 months. Other EOHHS child-serving agencies only report critical incidents to the OCA for children and young adults currently receiving services.

home, and the setting of the physical abuse in the third case could not be determined upon review by the OCA.

Figure 16:
Physical Abuse Events in CIRS by Outcome
(FY19-FY23)



	FY19	FY20	FY21	FY22	FY23
Fatality	0	2	0	1	1
Near Fatality	1	1	0	1	0
Serious Bodily Injury	5	18	19	16	15

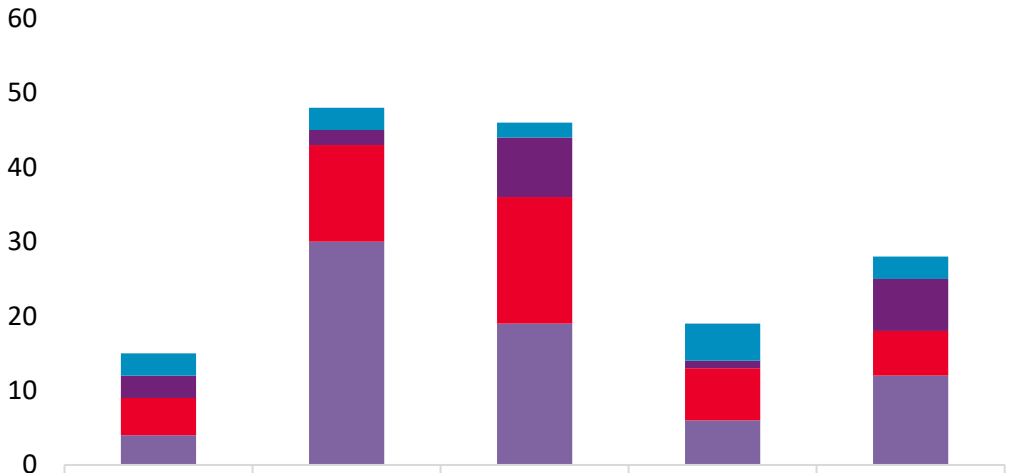
Suicide and Suicide Attempts

According to the Massachusetts Department of Public Health, "suicides are a significant yet largely preventable public health problem."[40] Suicide and suicide attempt critical incidents reported to the OCA increased in FY20 and FY21 and decreased in FY22. In FY23 the OCA received three critical incidents concerning the suicide death of a youth. During that same time frame, the OCA received seven reports of a near fatality and six reports of serious bodily injury due to a suicide attempt. All suicides and attempts resulting in death or bodily injury involved youth aged 12-20.

Emotional injuries caused by witnessing a suicide or suicide attempt increased in FY23 to 12. Ten (10) of the events resulted in a death and two resulted in a near fatality. In half of the reports (6) a child witnessed their parent's suicide or suicide attempt, and in four reports they witnessed their sibling's attempt or death. Children who witnessed a suicide or suicide attempt ranged from two to fifteen-years-old, and half (6) were 13 or older.

[40] Injury Surveillance Program.(2021, Fall). DPH COVID-19 Data Brief 2020 Suicides, Suicide Attempts, and Suicidal Ideation in Massachusetts. Massachusetts Department of Public Health. https://www.mass.gov/doc/covid-19-data-brief-2020-suicides-suicide-attempts-and-suicidal-ideation-in-massachusetts-0/download

Figure 17:
Suicide and Suicide Attempt Events in CIRS by Outcome (FY19-FY23)



	FY19	FY20	FY21	FY22	FY23
Fatality	3	3	2	5	3
Near Fatality	3	2	8	1	7
Serious Bodily Injury	5	13	17	7	6
Emotional Injury	4	30	19	6	12

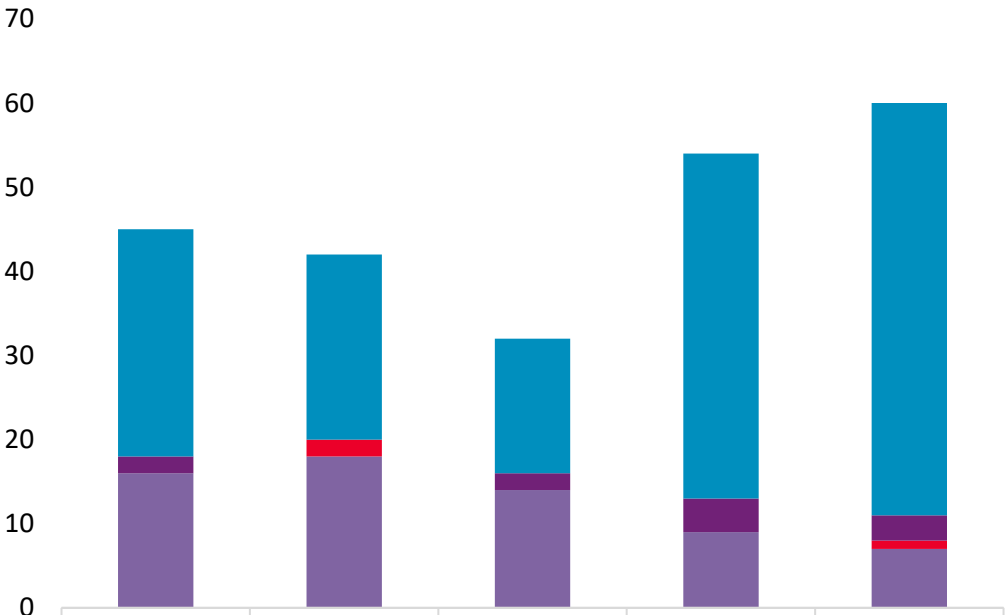
Unexpected Medical Events

Critical incidents reported to the OCA about the fatality or near fatality of a child due to medical causes are most often the result of life-limiting medical conditions or other complex health needs. In FY23, 49 children reported to the OCA died from medical events. The number of critical incident reports about fatalities due to medical events increased in both FY22 and FY23 compared to prior years and is primarily driven by an increase in reports from DPH. Fatalities reported by DPH frequently involve a child receiving care coordination services provided by the DPH's Bureau of Family Health and Nutrition. Care coordination services are for families with a child or youth (up to age 23) who have special health care and/or complex coordination needs. The children reported to the OCA who suffered a fatal medical event ranged from zero to 24-years-old. Thirty-one of the 49 reported medical event fatalities were children 10-years-old or younger, including six infants. Twenty-nine of the children were identified as males, and 20 as females.

Of the seven children who witnessed an unexpected medical event in FY23, three were caused by a parent's medical event, three by a sibling's medical event, and one by another family member. The events were the result of complications from pre-existing medical conditions as well as incidents of cardiac arrest. Children who witness an unexpected or untimely death experience more difficulty in the initial acceptance and in long-term adjustment than children

who witness anticipated/natural deaths.[41] It is estimated that about 10% of bereaved youth experience grief reactions of sufficient severity to produce clinically significant impairment.[42]

Figure 18:
Medical Events in CIRS by Outcome
(FY19-FY23)



	FY19	FY20	FY21	FY22	FY23
Fatality	27	22	16	41	49
Near Fatality	2	0	2	4	3
Serious Bodily Injury	0	2	0	0	1
Emotional Injury	16	18	14	9	7

Violence

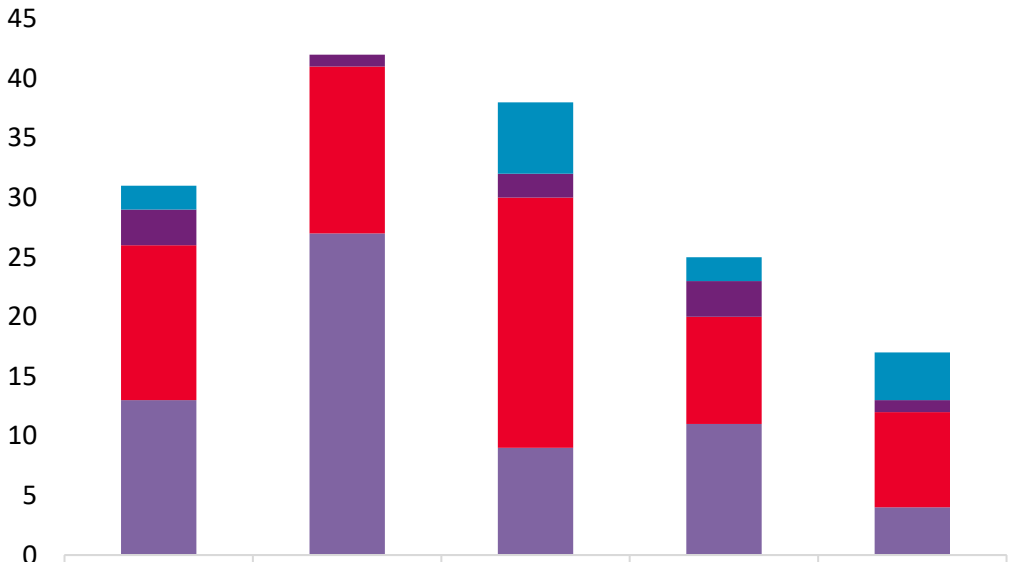
Events in which a child was a victim of community violence increased substantially in FY21 compared to prior years but decreased year-over-year since then. In FY23, 12 youth were physical victims of community violence, and four witnessed violent events. The children physically harmed were between the ages of 13 and 21, except for one five-year-old.

All of the males were victims of gun violence while females experienced three gun-related violent injuries, one assault with bodily force, and two stabbings. Two youth were receiving services from DYS while 11 were involved with DCF. Seven children reportedly witnessed violence; the victim of violence was their parent in three incidents and a sibling in three incidents. One incident was reported by DYS while the other six were reported by DCF. Four of

[41] Lehman, D. R., Lang, E. L., Wortman, C. B., & Sorenson, S. B. (1989). Long-term effects of sudden bereavement: Marital and parent-child relationships and children's reactions. Journal of Family Psychology, 2(3), 344–367.
[42] Kaplow JB, Layne CM, Saltzman WR, Cozza SJ, Pynoos RS. Using multidimensional grief theory to explore the effects of deployment, reintegration, and death on military youth and families. Clin Child Fam Psychol Rev. 2013 Sep;16(3):322-40. doi: 10.1007/s10567-013-0143-1. PMID: 23760905; PMCID: PMC4651441.

the children were in state custody at the time of the incident; one incident occurred in a car while three occurred at a private residence other than the child's home.

Figure 19:
Violence in CIRS by Outcome
(FY19-FY23)



	FY19	FY20	FY21	FY22	FY23
Fatality	2	0	6	2	4
Near Fatality	3	1	2	3	1
Serious Bodily Injury	13	14	21	9	8
Emotional Injury	13	27	9	11	4

Foster Care Review Safety Alerts

Federal and state laws require that DCF implement a Foster Care Review (FCR) process.[43] This process involves only children who are removed from the custody of their parents and occurs at least every six months. The review is a monitoring mechanism to measure progress towards a child's permanency goal.

A Foster Care Review is facilitated by a three-person panel consisting of DCF staff and a community volunteer. When the FCR panel is concerned for the safety of a child in out-of-home care, the panel generates a "safety alert." As part of the OCA's long-term efforts to strengthen the Foster Care Review process, in July 2022 the OCA began receiving Foster Care Review safety alerts. [44] By receiving the FCR safety alert and conducting a review of the related DCF case, the OCA provides an additional layer of oversight to ensure the needs and wellbeing of the child are addressed.

In this first year, the OCA received 36 Foster Care Review safety alerts from the more than 11,000 foster care reviews held that year. The safety alerts received by the OCA often involved

[43] 42 USC 675 Sec 475 (5) (B) ; MGL c. 18B, §6A
[44] To learn more, see the "Strengthening Foster Care Review" section of this report, page 40.

children who were missing or absent from their placement at the time of the review, had unmet or mis-managed needs, were not receiving adequate placement visits from their assigned caseworker, were truant from school, were having unsupervised visits with biological parents experiencing active substance use disorder or other behavioral concerns, and/or inadequate communication between providers when a child resident of Massachusetts was placed out of state.[45]

Supported Reports of Abuse & Neglect in Out-of-Home Settings

A critical part of the OCA's responsibility is to ensure that children are safe and protected from harm across all settings, but particularly in out-of-home settings.[46] As part of that duty, the Massachusetts system of investigating child abuse and/or neglect[47] includes a mandatory report to the OCA when DCF[48] determines that a child was abused and/or neglected in an out-of-home setting. Out-of-home settings include foster care, congregate care, childcare,[49] public schools, private schools, after-school and summer programs, school-funded transportation companies, and hospitals.[50]

OCA staff review and analyze each report to evaluate the safety and wellbeing of the child(ren) involved in the incident, policy and practice concerns with the institution, the quality of the DCF investigation, and trends and patterns about the care of children in out-of-home settings. If the OCA identifies a significant concern in any of these areas, the OCA will immediately follow-up with DCF and/or the licensing, regulatory, or funding agency to gather more information and ensure the concerns are addressed.

In FY23, the OCA received 422 supported reports of abuse and/or neglect in out-of-home settings from DCF involving 621 children and 428 alleged perpetrators. This is the highest volume of reports ever received by the OCA. It was a 41% increase from FY22 and an 80% increase from FY21. Reporting volume increased for all types of settings, except "Other."[51] One third of the reports (35%) came from congregate care, 20% from foster care[52], 20% from childcare, and 18% from public schools. The reason for this increase in supported reports of abuse and/or neglect in out-of-home settings is not yet known. However, as noted below, the increase is driven primarily by supported reports of neglect which suggests that contributing factors may include workforce shortages and burn-out.

[45] For more information about actions taken by the OCA related to these and other concerns, please see Findings and Interventions, page 35.
[46] Out-of-home settings include foster care, congregate care, childcare, public and private schools, after-school and summer programs, school-funded transportation, and hospitals. See Appendix E: Glossary of Terms for definitions.
[47] The Massachusetts system is governed by M.G.L. c. 119 § 51B(l)
[48] Only DCF is mandated to send abuse and/or neglect reports to the OCA. However, the OCA may request reports of abuse and/or neglect from other agencies, such as the Department of Early Education and Care, as necessary.
[49] The Department of Early Education and Care (EEC) licenses approximately 9,000 childcare programs, including about 2,847 center-based and 4,899 family-based programs.
[50] For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.
[51] Other includes hospitals, private schools, transportation companies and more.
[52] See Appendix C for additional data by foster care type.

Table 3: Supported Reports of Abuse and/or Neglect in Out-of-home Settings, FY22 and FY23			
Type of Institution	**FY22 Reports**	**FY23 Reports**	**Percent Increase**
Childcare	54	83	54%
Congregate Care	100	147	47%
Foster Care	63	84	33%
Other[53]	31	31	0%
Public School	52	77	48%
Grand Total	**300**	**422**	**41%**

In FY23 the OCA received **83 supported reports** of abuse and/or neglect in *childcare* settings involving **154 children**. This is a sizable increase compared to FY21 and FY22, when the OCA received 30 and 54 reports. Reports came from center-based (64, 77%), independent home-based (13, 16%), and provider affiliated home-based programs (3, 4%). [54] No information about the type of childcare is available for three reports (4%). Of those 83 supported reports, 99% involved neglect, 32% involved physical abuse, and 7% involved sexual abuse and/or sexual exploitation.[55] There were reported increases across all the neglect categories, however, the increase was largest for improper or inadequate supervision and risk of emotional or psychological harm.

Year-over-year, *congregate care* yields the most supported reports of abuse and/or neglect in out-of-home settings. In FY23, the OCA received **147 supported reports** of abuse and/or neglect in congregate care settings involving **189 children.** This is 47 more reports than the OCA received in FY22, when the OCA received 100 supported reports. This increase breaks a three-year downward trend in the number of supported reports involving congregate care settings.[56] Of the 147 supported reports in FY23, 99% involved neglect, 33% involved physical abuse, and 6% involved sexual abuse.[57] The increase in supported reports of neglect was primarily driven by reports involving improper or inadequate supervision, of which there were 77 in FY23.[58]

In FY23 the OCA received **84 supported reports** of abuse and/or neglect in *foster care* involving **142 children**, which is an increase compared to FY21 and FY22 when the OCA received 58 and 63 supported reports. For context, more than 10,000children and youth receive foster care services through DCF in any given year. Supported reports of abuse and/or neglect occurred in less than 1% of DCF foster care placements in FY23.

[53] In FY23, other includes hospital (6), private schools (5), transportation companies (6), and other (13).
[54] For more information about childcare setting classifications, see glossary of terms and M.G.L. c. 15D § 1A
[55] Some cases involve more than one type of abuse; sums will not equal 100%.
[56] The OCA received 126 supported reports of abuse and/or neglect in congregate care in FY20, 107 in FY21, 100 in FY22, and 147 in FY23.
[57] Some cases involve more than one type of abuse; sums will not equal 100%.
[58] See Appendix E: Glossary of Terms for a definition of improper or inadequate supervision.

Of the 84 supported reports, 93% involved neglect, 20% involved physical abuse, and 14% involved sexual abuse and/or sexual exploitation.[59] Reports came from comprehensive foster care (22), kinship (24), and unrelated (37) foster care.[60] The type of foster care is not available for one case. In prior years, reports from kinship placements were the largest portion of reports; this year, unrelated placements are the highest and account for most of the increase in reporting involving foster care.

Table 4: Total Foster Care Reports, Children Involved and Service Numbers[61]			
Fiscal Year	**FY21**	**FY22**	**FY23**
Supported Reports	58	63	84
Number of Children	92	112	142
Total Number of Children Served in Foster Care	10,796	10,515	10,241

Table 5: Reports from Specific Type of Foster Care Placements[62]			
Type of Foster Care	**FY21**	**FY22**	**FY23**
Comprehensive Foster Care	5	12	22
Kinship Foster Care	34	34	24
Unrelated Foster Care	15	12	37

See Appendix C for additional information about abuse, neglect, and neglect sub-classification by out-of-home setting.

[59] Some reports involve more than one type of abuse; sums will not equal 100%.
[60] See Appendix E: Glossary of Terms for a definition of the various foster care settings.
[61] These figures do not include independent living.
[62] As of 02/27/2023, Kinship and Child Specific are now known as “Kinship” foster care. Unrestricted Foster Care is now known as “Unrelated” foster care. Type of foster care involved is not available for some reports.

Neglect in Childcare, Congregate Care and Foster Care: A Deeper Dive

The majority of supported reports of abuse and/or neglect in out-of-home settings came from foster care, congregate care, and childcare settings; 379 of the 422 reports (90%). In FY23, 369 (97%) of those reports involved **neglect**. Because neglect is such a broad term and is the most frequently occurring allegation, the OCA categorizes the nature of the neglect a child experienced, as identified by OCA staff during report reviews (see the glossary of terms for definitions of these classifications). Based on that assessment, improper or inadequate supervision (152 reports), risk of emotional/psychological harm (92 reports), and improper behavior management (91 reports) most frequently resulted in a supported allegation of neglect in FY23. The nature of neglect varied by setting. Figures 20-22 describe findings in congregate care, foster care, and childcare. In addition to the increase in the number of supported reports of abuse and/or neglect that the OCA received, the OCA also identified more forms of neglect present in each report compared to prior years. The prevalence of each form of neglect compared to the total number of reports received remained relatively stable from FY21 through FY23, despite the increase in reporting. See Appendix C for more information.

Figure 20: *Neglect in Congregate Care*

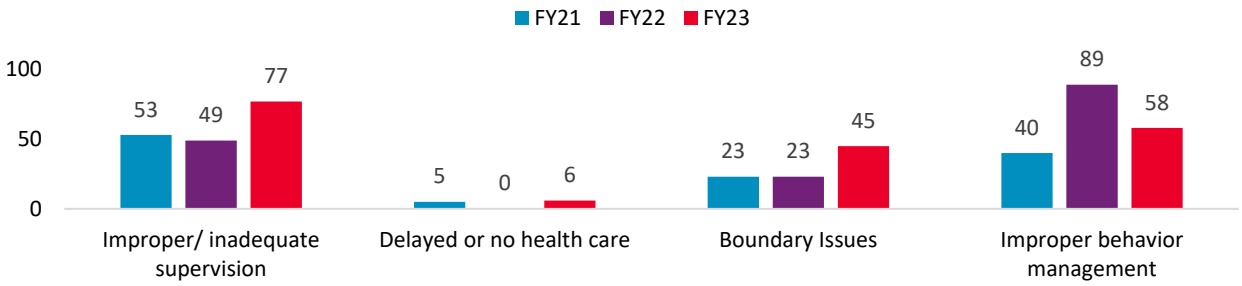


Figure 21: *Neglect in Foster Care*

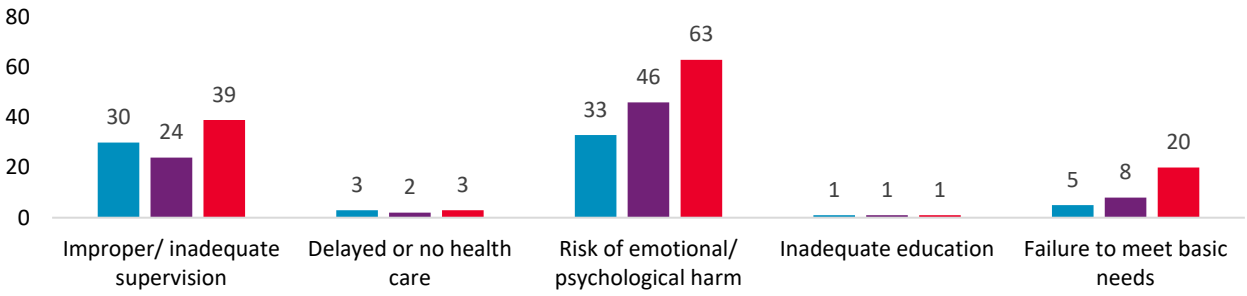
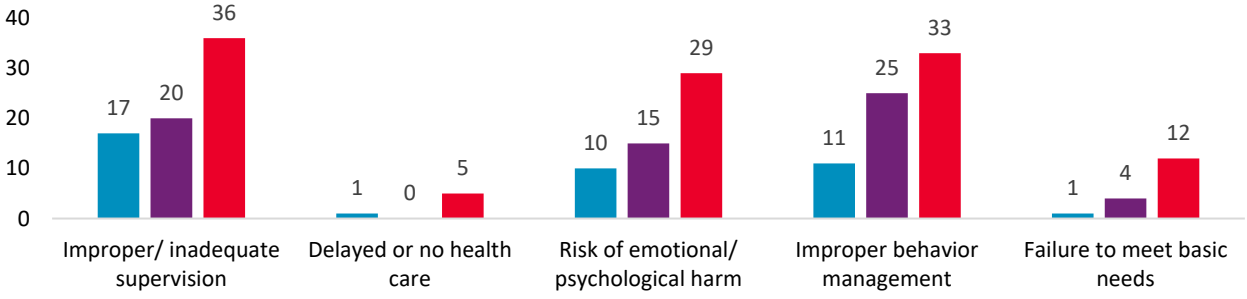


Figure 22: *Neglect in Childcare*



Findings & Interventions

The OCA uses the information reported to our office through our statutory functions to inform our work across the state child-serving systems. The OCA works not only to address situations that have already occurred, but also to identify policy and practice changes that can help the state reduce the incidences of harm to all children and young adults. We also identify trends where the Commonwealth would benefit from greater data gathering and analysis. Our work in this area informs our routine oversight of state agencies, our participation in the Child Fatality Review program and Interagency Safe Sleep Task Force, as well as our various other boards and commissions and related research projects.

The OCA responds to and offers guidance to all individuals who contact our **Complaint Line**. After an in-depth assessment of the situation presented and after the provision of guidance and referrals to support the individual, the OCA may also decide to take action to address an issue. The OCA takes such action when the OCA shares the concerns brought to our attention and/or when we determine that OCA intervention is required to assist in resolving those concerns. Further, the OCA may intervene when the OCA learns of concerns not evident to the Complaint Line individual because of the OCA's access to confidential information. When the OCA decides to act, the OCA continues regular communication with the relevant state agency until the OCA's concerns are alleviated.

The OCA staff conduct an immediate review of all **critical incident reports** to learn more about the circumstance of the incident and the reporting agency's involvement with the child and family. When the OCA determines the actions or inactions of a reporting agency may have contributed to the incident or that the child, young adult, or family, is not receiving quality services to meet their needs, we may obtain additional reports from the agency, speak with staff, and further review case records to learn more about the family's history and involvement with the agency. When the OCA identifies an individual case practice concern or system-wide pattern or trend, we contact the agency involved and take necessary steps to resolve the matter, thereby improving state services to children and families.

OCA staff review and analyze each report of DCF **supported reports of abuse and/or neglect** in out-of-home settings. The purpose of this review is to evaluate the safety and wellbeing of the child(ren) involved and the quality of the DCF investigation. After a review, the OCA may reach out to the reporting agency or a licensing entity to obtain and review investigations and corrective actions plans. The OCA obtains this information to review any challenges the out-of-home setting is experiencing, such as workforce retention, training, or unclear programmatic policy. The OCA may also obtain this information to ensure that proper follow-up has been done to reduce or eliminate the risk to children who remain in the setting or to prevent further harm. When the OCA conducts this follow-up, the OCA does not cease communication with the state agency until the OCA's concerns have been alleviated.

In FY23, the OCA followed up with designated state agency liaisons at DCF, DMH, DPH, DYS, EEC, DESE, DDS, MassHealth, and the Attorney General about service delivery in 368 reports and inquiries. This includes:

- 51 of the 482 complaint line inquiries (49 complaints and two requests for Information or a referral)
- 143 of the 422 DCF supported reports of abuse and/or neglect in out-of-home settings
- 162 of the 319 critical incident reports
- 13 of the 36 Foster Care Review safety alerts

The reasons for follow-up varied by agency, as did the actions taken by an agency to resolve the issues. Table 6 provides an agency-by-agency overview of the number of reports or inquiries about which the OCA followed up and the reason for that follow up.

Table 6. Number of Reports or Inquiries about which the OCA reached out to a State Agency and the Reason for the Follow-up

Agency	Report or Inquiries [63]	Reason for Follow Up
DCF	286	See DCF Related Case Practice Concerns and Response (below)
DMH	5	Complex case resolution Denial of services Hospital boarding
DPH	4	Information regarding a sanitation code investigation Medical treatment
DYS	7	Internet access policies Disciplinary action Employment status or retraining of staff involved with supported reports of abuse and/or neglect in out-of-home settings Treatment of a child in state custody
EEC	68	Appropriateness and quality of care provided in out-of-home placements Clarifications on investigative processes, findings, and documentation Clarification on operations such as intake practices, staff ratios, maximum allowable weekly work time, hiring practices, room check protocols, parent notifications, and incident reporting protocols Questions about disciplinary action and status of staff employment following supported report of abuse and/or neglect in out-of-home setting Staff training and professional development, especially regarding behavior management and mandated reporting
DDS	5	Denial of services Hospital boarding
DESE	9	Employment status of school personnel following supported reports of abuse and/or neglect School corrective action plans Training plans for mandated reporting in specific schools
Other	2	Attorney General regarding legal recourse following abuse and/or neglect in an out-of-home setting MassHealth regarding hospital boarding

[63] Number will not sum to 368 because the OCA occasionally reached out to more than one agency based on a report or inquiry.

Department of Children and Families Related Case Practice Concerns and Response

While the OCA reviews critical incident reports from all EOHHS child-serving state agencies, the OCA's mandate is to focus particularly on critical incidents involving children in the care or custody of DCF and DYS. OCA staff conduct a thorough review of the family's DCF electronic record pursuant to a critical incident report. The purpose of this review is to understand the child and family and their needs, to substantively review DCF's understanding of the family and their needs, and to evaluate DCF's efforts to assist and engage the family and protect the child from harm. In this context, the OCA identifies what worked well in DCF case practice and where there are opportunities for improvement in policy and case practice at the area office level, at the regional level, and across the system or with the specific family. While this review takes place regardless of the method by which the OCA receives information, the OCA's current data collection system captures these data exclusively for critical incident report and Foster Care Review safety alerts.

Regardless of the method by which the OCA receives information, the OCA communicates identified case practice concerns to a designated liaison within DCF senior leadership on an immediate and ongoing basis. This liaison shares the information with the Regional and Area Office management where the family receives services as well as ensures that the senior leadership team is aware of the OCA concerns. The Regional and Area Office responds to the OCA's concerns by providing the OCA with details about the steps they have taken or will take to address the OCA's identified concerns. **The OCA ensures that all the case practice concerns identified through the OCA's review are resolved appropriately and in a timely manner to ensure the safety and well-being of the children involved and to improve services to the family.**

In FY23, the OCA identified case practice concerns in 157 of the 298 (53%) DCF critical incident reports and Foster Care Review safety alerts submitted to the OCA[64]. These concerns were stratified into two categories: Intake/Response and Ongoing Case Practice.[65] Fifty-seven (57) cases had intake or response concerns, 150 had Ongoing Case Practice concerns, and 40 had both Intake/Response and Ongoing Case Practice concerns.[66] Table 7 describes the most frequently identified concerns for Intake/Response and ongoing case practice.

[64] The OCA may reach out to an agency even if there are no identified concerns, or they may not reach out about all cases with an identified concern. Therefore, the number of cases with a concern and the number of cases about which the OCA reached out are not equal.
[65] See Appendix E: Glossary of Terms for definitions.
[66] Numbers will not sum to 157 since any give case may yield more than one concern.

Table 7: Case Practice Concerns Identified in DCF Critical Incident Reports			
Concern Category[67]	**Intake/Response**	**Ongoing Case Practice**	**Combined Concerns**
Collateral Contact	12	68	80
DCF Specialist Consultation	13	64	77
Clinical Formulation	NA	58	58
Father Engagement	8	44	52
Safety Planning	15	17	32
Outcome Decision	27	N/A	27

Of the 161 critical incident report case reviews about which the OCA followed-up with DCF, DCF provided a response in 158 instances.[68] According to DCF, more than half of the OCA-identified concerns resulted from pertinent information not being documented in the DCF electronic record at the time of the OCA review. In total, 90 of the 158 cases with an issue (57%) and of the 262 CIRs received from DCF (34%) were missing pertinent information, which are classified as documentation issues.

Second to documentation issues, DCF responded by acknowledging the OCA-identified concern and addressing them directly with the staff involved for 46 cases, including two instances where DCF Central Office or upper management became involved in the resolution.

DCF also took action to retrain staff using case examples highlighted by the OCA (7), convened an Area or Regional Clinical Review Team (ACRT/RCRT) or specialist consultation to address the case practice concerns within the appropriate area office (7), corrected one administrative issue, and changed one case decision.

The above examples of feedback provided by the OCA to DCF and DCF's response is not a complete picture of the work the OCA does to address the provision of timely, safe, and effective state services, but rather a sample of the types of collaborative work conducted by the OCA and the result of those efforts.

Table 8: DCF's Response to Case Practice Concerns identified by the OCA	
DCF Response	**Number of Cases**
Acknowledgement of Case Practice Concerns - Addressed with Appropriate Staff	44
ACRT/RCRT/Specialist Consultation was Convened to Review Case	7
Addressed by DCF Central Office/Upper Management	2
Administrative Issue - Corrected	1
CIR Case Used as Example for Retraining of Staff	7
Decision Change	1
Documentation Issue	90
No Response to OCA Requested	23
Other[69]	11

[67] See Appendix E: Glossary of Terms for definitions.
[68] Three cases are pending feedback or concerns that are not yet fully addressed as of 3/11/2024.
[69] Other responses include questions that were answered and check-ins on children in DCF care.

Strategic Priorities & Initiatives

The OCA leads and serves on a variety of boards, commissions, and working groups.[70] These initiatives are informed by and build upon the work done via the OCA core functions. The OCA utilizes our work on boards, commissions, and working groups to analyze state service systems and makes recommendations for changes in policy, practice, statute, and/or budgetary allocations while working in partnership with other state agencies to improve service quality.

The OCA's FY23 strategic priorities and initiatives focused on:

- ensuring the safety and wellbeing of children who receive state services
- addressing disparities by meeting the unique needs of traditionally underserved populations
- averting deeper or unnecessary system involvement
- improving state service accessibility and quality, and
- promoting data-informed decision-making

This section of the report describes OCA's specific efforts in FY23 to advance the OCA's mandate. While some projects are described under specific priorities to help organize communication about our efforts, many projects address multiple priorities and are interdependent.

Ensure the Safety & Wellbeing of Children Receiving State Services

There is nothing more critical than the safety of children -- and the Commonwealth has a particular obligation to ensure the safety of children who are receiving state services. This is especially true for any child in the care and/or custody of the Commonwealth, recognizing that children who are in out-of-home settings are often less visible in the community, face increased vulnerabilities, and are especially reliant on caregivers, which poses unique safety risks.

Through the OCA's statutory mandates and collaborations with child serving agencies, the OCA works to identify and raise awareness of necessary steps that will better identify children in need of state services and keep children who are receiving state services safe. Examples in this area include the OCA's work coordinating responses to abuse and/or neglect in out-of-home settings, including residential schools, and improving the DCF Foster Care Review process.

Coordinating Responses to Abuse & Neglect in Residential Schools

Special education residential schools provide a myriad of essential services for children with complex behavioral, developmental, emotional, mental health, and/or medical challenges. These include individualized education, specialized therapies, peer support, and family respite. Residential schools serve some of the most vulnerable children in the state, who often face health vulnerabilities, communication barriers, bullying and stigmatization, impaired executive functioning, and are especially dependent on caregivers to meet their basic needs. Children served in residential schools where housing and educational support are co-located under one

[70] See Appendix B: Boards and Commissions for a complete list.

service provider are not regularly visible in the community, potentially exacerbating their vulnerabilities.

Oversight and regulation are especially important to ensure children served in residential schools are safe and their needs are adequately met. Currently, oversight and regulation of residential schools are distributed across multiple state agencies, including the Department of Early Education and Care, which licenses the residential aspect of the programs, the Department of Elementary and Secondary Education, which oversees compliance with the special education requirements in the school-day aspect of the programs, the Department of Children and Families, which contracts with and monitors some schools and investigates allegations of child abuse and/or neglect, and the Department of Mental Health, which contracts and monitors some residential schools and can provide individual case management for certain students in residential schools.

Learn More:

Interagency Working Group on Residential Schools: Review and Recommendations to Improve Oversight and Monitoring (2017)

Interagency coordination and ongoing communication between involved Commonwealth agencies are essential to identify challenges and meet children's needs. The OCA began working with the relevant state agencies in 2017 to enhance collaboration and information sharing. The OCA currently works to increase communication and collaboration by facilitating monthly interagency meetings designed to ensure adequate cross-agency communication, to discuss challenges to service provision, to identify trends that need to be addressed through collaborative efforts, and to serve as an early-warning system for potential crises.

In addition to the interagency meetings, the OCA prioritizes and is working on progressing ideas related to systems-redesign, data coordination across providers and agencies, and streamlining and formalizing processes to ensure the Commonwealth has a well-coordinated approach to residential schools and other congregate care settings.

Strengthening Foster Care Review

Federal and state laws require that DCF implement a Foster Care Review (FCR) process.[71] This process involves only children who are removed from the custody of their parents and occurs at least every six months. The review is a monitoring mechanism to measure progress towards a child's permanency goal.

Learn More:

DCF Foster Care Review Policy (2008)

Foster Care Review Report (FY22)

In 2017, the Legislature's Joint Committee on Children, Families, and Persons with Disabilities asked the OCA to review and make recommendations on the effectiveness of the FCR process, specifically looking at whether it would better ensure the safety and wellbeing of children if the process was operated independently from DCF rather than the DCF-run process that currently exists. The OCA engaged a variety of stakeholders, including DCF, attorneys from the Committee for Public Counsel Services, the Children's League of Massachusetts, and legislators to gather

[71] 42 USC 675 Sec 475 (5) (B) ; MGL c. 18B, §6A

varied viewpoints and experiences. That engagement resulted in the OCA identifying concerns with the structure and procedure processes of the FCR process, including meeting planning, logistics, communication, and documentation. Further, the OCA identified concerns with the substance of the FCR process, including recruitment and training of reviewers, meeting planning and facilitation, follow-up on issues identified, and reporting about the process. The OCA worked in collaboration with DCF to address all the OCA-identified issues. The efforts resulted in the successful overhaul of the FCR process, completed between 2019 and 2020, where the OCA and DCF determined the concerns that the OCA identified in our initial review were addressed.

Following the successful completion of the work plan, the OCA monitored individual foster care reviews by attending a total of 101 reviews in FY22 through FY23. This served as a quality-assurance check to confirm the reforms had been implemented. This monitoring revealed that the FCR process had improved substantially compared to prior practice. For example, there was overwhelming improvement in the process of the required community volunteer panel member, all panels began with an introduction that explained the purpose of the review, virtual meetings improved attendance, panelists were well-prepared and knowledgeable about the case, and Family Assessment and Action Plans were consistently used to discuss task completion and progress towards permanency. The multiyear collaboration between DCF and OCA has resulted in an improved Foster Care Review process. It is now functioning as it should, which is reflected in DCF's robust FCR Annual Report. The OCA and DCF's joint efforts ensure that there is no need to upend the successful program by relocating it to a mechanism outside of the DCF structure.

Additionally, beginning in FY23 the OCA began to attend twice monthly mandatory training for community volunteers, with the goal of improving community volunteer engagement. At each training staff explain the role of the OCA, the importance of community volunteers in the FCR, and provide encouragement and gratitude for their participation in the review process.

Address Disparities by Meeting the Unique Needs of Traditionally Underserved Populations

Despite the depth and breadth of services provided in the Commonwealth that make the state a national leader in safeguarding the health and wellbeing of children, substantial disparities in service provision exist. For example, males, children of color, and children and infants living in urban centers are all at higher risk of dying before their 18th birthday,[72] and Black and Latino youth are more likely to be arrested and referred to Juvenile Court than their white peers. [73] There are also disparities in educational outcomes and child protective service system involvement.[74]

[72] FY22 Child Fatality Review Annual Report, https://www.mass.gov/doc/fy22-child-fatality-review-annual-report/download
[73] Juvenile Justice and Policy Board, 2022. https://www.mass.gov/doc/racial-ethnic-disparities-at-the-front-door-of-massachusetts-juvenile-justice-system-understanding-the-factors-leading-to-overrepresentation-of-black-and-latino-youth-entering-the-system/download
[74]Massachusetts Department of Elementary and Secondary Education. (n.d.). Student Opportunity Act. https://www.doe.mass.edu/soa/; Massachusetts Department of Children and Families. (2021, December). Annual Report FY2021. https://www.mass.gov/doc/dcf-annual-reportfy2021/download?_ga=2.47194467.518090395.1672759980-

As part of the OCA's mandate to ensure quality services for children, the OCA recognizes that equity is a fundamental component of quality. Achieving equity and reducing disparities requires a detailed analysis of the systems where marginalized populations may be underserved or overrepresented. In FY23, the OCA explored racial and ethnic disparities at the "front door" of the juvenile justice system, worked alongside the Office of the Child Medical Examiner and DPH to embed equity into the Child Fatality Review program, and began exploring the accessibility of state-funded child services for families for whom English is not a primary language. The OCA also worked to better ensure the specific experiences and needs of underserved or overrepresented populations – including children of color, LGBTQIA+ youth, and immigrant families – were incorporated into the planning, research, and implementation of all our work and projects, including a variety of projects listed in other sections of this report.

Racial & Ethnic Disparities at the "Front Door" of Massachusetts' Juvenile Justice System

Learn More:

Racial and Ethnic Disparities at the Front Door of Massachusetts' Juvenile Justice System (2022)

While Massachusetts has made substantial progress limiting the number of youth coming into contact with the juvenile justice system, this decreased utilization has not affected the racial and ethnic disparities seen across the system. The OCA and Juvenile Justice Policy and Data Board (JJPAD) report "Racial and Ethnic Disparities at the Front Door of Massachusetts' Juvenile Justice System," released in November 2022 found that Black youth were over four times more likely to experience a custodial arrest than their white peers, and Hispanic youth were almost three times more likely to experience a custodial arrest than their white peers.

The report found that disparities are particularly high at the "front door" of the juvenile justice system, meaning when that youth first comes into contact with the juvenile justice system. The report also found that there is no *single* reason for racial and ethnic disparities in the juvenile justice system. Instead, there are a combination of factors stemming from differences in individual behaviors influenced by societal factors, as well as differences in how police departments and/or individual officers respond to Black and Latino youth compared to white youth. The data analysis makes clear that these disparities cannot be fully attributed to the types or severity of offenses youth are alleged to commit, nor the counties in which they reside.

In the report, the JJPAD Board recommends steps the state can take to further address and reverse the disparities seen in the state's juvenile justice system. Those recommendations include:

- Investing in Prevention and Alternatives to Arrest:
    - Increase investments in community-based programs aimed at promoting prosocial activities and reducing system involvement
    - Continue to support and expand the state Diversion Learning Labs
- Gathering and Using Data to Spot Problem Areas and Improve Practice:

1177398998.1621613144; Juvenile Justice Policy and Data Board. (2020, November). Massachusetts Juvenile Justice System: Data and Outcomes for Youth. Office of the Child Advocate. https://www.mass.gov/resource/massachusetts-juvenile-justice-system-data-and-outcomes-for-youth.

    - Police departments should uniformly report the use of summons to the NIBRS data system
    - Police departments should review internal data
    - Police departments should require officers to document why they decided to arrest a youth instead of issuing a summons for arrests and publish their findings
- Practice and Policy Change:
    - Police departments should provide more guidance and limitations on when to use a custodial arrest, when to issue a summons, and when to offer diversion
    - Police departments should re-examine which department policies and practices may be contributing to racial and ethnic disparities in arrests.

Child Fatality Review

Learn More:

Massachusetts Pediatric Injury Equity Review (MassPIER) Project (2022)

Child Fatality Review Annual Report, FY22

The Massachusetts Child Fatality Review (CFR) program is a statutorily based process that includes convening a multidisciplinary group of state agency representatives, health care experts, and law enforcement officials and officers who analyze birth and death records, medical records, social service files, autopsy reports, and police records. The program is comprised of 11 local teams—one in each of the Commonwealth's judicial districts—and the State Team with 16 members. The Local Teams conduct individual fatality reviews of child fatalities in the Commonwealth that aim to understand the circumstances and causes of child deaths with the goal of preventing similar fatalities in the future.

Since 2018, the OCA has collaborated with the Office of the Chief Medical Examiner and DPH to continuously improve the CFR program. As part of that effort, the CFR program began exploring demographic inequities in child fatalities in 2020. The program learned that despite the overall low rate of infant and child fatalities in Massachusetts compared to other states, substantial inequities exist. Males, children of color, and children and infants living in urban centers are all at higher risk of fatality. To understand and address those inequities, the State Team conducted an in-depth examination of social determinants of health through the lens of infant and child fatalities, reviewing broad issues around health equity and dedicating meetings to the intersections of employment, housing, the built environment, and education, relevant to fatalities in FY23. Simultaneously, three local teams worked on a Pediatric Injury Equity Review to identify and refine processes for building equity into local reviews.

Program staff also developed and launched a yearlong community of practice that gathered Local Team leaders and coordinators to explore key topics -- including principals of racial equity, self-care, best practices in record collection, protecting confidentiality, facilitating fatality reviews, and identifying and documenting root causes of fatalities -- in an action-oriented and equitable way.

The Community of Practice culminated in the final draft of the first ever Local CFR Team Guidelines, which was approved by the State Team at the beginning of FY24. The Guidelines are

intended to provide basic operating standards to enhance consistency of local reviews across the Commonwealth. They also provide frameworks and principles that support Local Team members in moving beyond the review of immediate facts of the fatality to a broader review of the societal forces that may affect the risks and opportunities surrounding a fatality. These efforts also resulted in 12 infographics that explore jurisdiction-specific data about social determinants of health and fatalities.

In a substantial change to operations, key staff for the Child Fatality Review program moved from DPH to the OCA in FY23; programmatic operations will now be based within the OCA. The FY24 work plan includes: an in-person meeting of both the Local Team Coordinators and Leaders as well as the State Team and subject matter experts; quarterly meetups of the Local Teams; establishing a dedicated website and resource sharing platform; as well as creating orientation materials for new State and Local Team members.

Promoting Language Access for All Children & Families

One in four Massachusetts residents speak a language other than English.[75] There is a large and growing number of residents with limited English proficiency. Title VI of the Federal Civil Rights Act and various other regulations require language access in some critical systems, such as the justice and health care systems. However, language access is inconsistently available in many government services and creates a major barrier in accessing government-provided services, resources, and information.

To learn more about and address this issue, in FY23 the OCA began interviewing individuals at state-contracted child and family service organizations to better understand the challenges service providers face in serving families for whom English is not a primary language. The OCA is further exploring creative solutions developed by service providers to overcome these challenges. This research is intended to identify both gaps as well as opportunities for improvements, with the goal of developing recommendations for state agencies that fund these services.

Improve the Quality & Accessibility of State Services

Massachusetts funds and operates a large and diverse set of programs designed to support families' needs. However, the most vulnerable children with complex needs may have difficulty navigating the intricate web of services. Barriers to access include difficulty navigating the complex service provider network, limited knowledge of those services, long wait times, a dearth of providers, gaps in specialized programs – both geographic and based on specialization – and inconsistent or confusing eligibility requirements. This challenge is especially acute for children with high and/or complex needs. Caregivers of children with complex medical and behavioral needs spend an exorbitant amount of time and energy locating, applying to, traveling to, and paying for the services their children need.

The OCA's mandate to ensure children receive appropriate, timely and quality state services and its mission to prioritize the most vulnerable and at-risk led the OCA to work on projects related

[75] Governor Maura Healey and Lt. Governor Kim Driscoll. (2023, September 9). Governor Healey Signs Executive Order to Improve Language Access Across State Government [Press release]. https://www.mass.gov/news/governor-healey-signs-executive-order-to-improve-language-access-across-state-government

to a new complex case resolution process, challenges facing children and youth exhibiting problematic sexual behaviors, identifying and responding to childhood trauma, housing stability for youth transitioning out of DCF due to reaching adulthood, facilities improvements at DYS, and Family Resource Centers. Collectively, these and the other initiatives mentioned in this report aim to not only expand available services – especially services that meet the unique needs of children and youth with complex needs – but also improve the quality of those services and streamline access to services.

Complex Case Resolution

On August 10, 2022, the Massachusetts Legislature passed *An Act Addressing Barriers to Care for Mental Health*, Acts of 2022, Chapter 177. This historic legislation aims to transform the Commonwealth's behavioral health system by addressing emergency department boarding, low reimbursement rates for behavioral health providers, gaps in insurance coverage for certain services, and the demand for school-based behavioral health service.

Learn More:

An Act Addressing Barriers to Care for Mental Health, Acts of 2022, Chapter 177

The Act requires the OCA to serve as a member of an interagency review team to collaborate on complex cases where there is a need for urgent action to address the lack of consensus or resolution between state agencies about current service needs or placement of individuals who: are under the age of 24; are disabled or have complex behavioral health or special needs; and who qualify or may qualify for services from one or more state agencies, or special education services through the individual's school district.

This act also mandates that EOHHS submit quarterly reports to the OCA and others about Emergency Department Boarding following the creation of an online data collection portal, requires the OCA to receive complaints from all children, families, and guardians to assist with problems associated with placement, and directs the OCA to file a report, once the online portal is operational and data from the portal is available for analysis, making recommendations for decreasing and eliminating the number of children and adolescents awaiting clinically appropriate behavioral health services. At the end of FY23 EOHHS and the Executive Office of Education were working to finalize regulations related to the statute.

The OCA believes this process can make a substantial difference for a small but important group of children with complex needs, and we look forward to actively participating in the Complex Case Resolution process once regulations are complete.

Child Sexual Abuse Prevention & Addressing Problematic Sexual Behavior

The OCA co-chairs the Child Sexual Abuse Prevention (CSAP) Task Force (in partnership with the Children's Trust), which has developed child sexual abuse prevention guides and toolkits. While executing that work, the CSAP Task Force learned that approximately three quarters of sexual assaults

Learn More:

SAFE KIDS THRIVE

CSAP Task Force report (2020)

Overview of the Research on Children and Adolescents Engaging in Problematic Sexual Behavior (2023)

and sexual abuse experienced by youth are the result of the problematic sexual behavior of other youth.[76]

Based on that finding, the Task Force convened a work group to study the topic of youth with problematic sexual behaviors (PSB). In March 2023, the PSB work group published an "Overview of the Research on Children and Adolescents Engaging in Problematic Sexual Behavior." As part of the work group's long-term goal of creating an in-depth environmental scan of systems' responses to youth with PSB, the report highlights evidence-based interventions the Commonwealth should make more widely available to children and their families. The work group's discussions made it clear that the child-serving system's response to incidents of PSB among children is uncoordinated and inequitable. Too often, the supports children with PSB are offered depends on their age, geographic location, and local authorities' understanding of and response to these behavioral health challenges.

Given the breadth and complexity of the systems' issues highlighted by the work group, in the summer and fall of 2023, the OCA invited public and private stakeholders to discuss the strengths and challenges of the state's response to PSB of children. In FY24, the OCA anticipates publishing a report, based on structured interviews with subject matter experts, clinicians, District Attorneys' Offices, Child Advocacy Centers, and state agencies as well as a review of academic and grey literature.[77] The report will present recommendations for improving the process for preventing, intervening, and addressing PSB, and addressing systematic challenges that create barriers for children with PSB to receive services.

While the CSAP Task Force's authorization expired in November 2022, this work continues. Funding for key Task Force projects – including the 2020-launched SAFE KIDS THRIVE website providing modules for youth serving organizations to conduct a self-assessment and then adopt the sexual abuse prevention framework – continued until the end of FY23.

Identifying & Responding to Childhood Trauma

The OCA-chaired Childhood Trauma Task Force (CTTF) released its annual report (for FY23) in November 2022. The report lays out the case for why and how trauma identification should be part of a broad, holistic approach to meeting children's behavioral health needs. The report also spells out the need for a Commonwealth-wide trauma informed and responsive approach to trauma identification and referral processes, for support to organizations that are implementing trauma identification practices, and for increased services and support to help children and youth recover from trauma.

Learn More:

The Center on Child Wellbeing and Trauma

2022 CTTF Annual Report

2023 CTTF Annual Report

https://www.mass.gov/lists/childhood-trauma-task-force-cttf

[76] Gewirtz-Meydan, A. & Finkelhor, D. (2020). Sexual abuse and assault in a large national sample of children and adolescents. Child Maltreatment 25, no. 2: 203-214. https://doi.org/10.1177/1077559519873975

[77] Grey literature is a wide range of publications that are produced outside the traditional peer-reviewed journal process, such as reports, resources guides, and other resources produces by state and federal agencies and non-profits.

The report provides sector-specific information and suggestions for organizations to consider in developing protocols and practices for identifying and responding to trauma. It also describes the support needed from the Commonwealth for the success of these practices, such as training and technical assistance, and resources on trauma identification and referral for both clinical and non-clinical providers.

The Center on Child Wellbeing and Trauma (CCWT), which was established based on a recommendation made by CTTF in 2020 and is funded by the OCA, supported child-serving organizations and systems in becoming trauma-informed and responsive in FY23 through training, technical assistance, professional learning opportunities, and other practice advancement support. See Table 9 for more information.

Table 9: Agency Specific Training and Technical Assistance Provided by CCWT in FY23	
DCF	Technical assistance, training, and coaching for DCF-funded Family Resource Centers and congregate care providers
DHCD/EOHLC	On-going training series and professional learning community for family shelter providers
DTA	Training for DTA supervisors, training team, and SNAP workers on applying trauma-informed and responsive practices. Technical assistance on the development of a trauma responsive toolkit for teen parenting programs
DYS	Technical assistance supporting the hiring and training of new Trauma Response Specialists to work with DYS staff to support trauma responsive practices and responses to incidents (such as assaults) that may occur in group home settings
Schools	Assessment, technical assistance training, and professional learning communities for several schools/districts and education professionals across the state

In addition to ongoing partnerships with state agencies, in FY23 the CCWT maintained and expanded a website with resources and online trainings for professionals on childhood trauma and resilience, including new toolkits on supporting LGBTQ+ youth. The Center also led a Coaching Academy on Resilience and Trauma for six community-based teams across Massachusetts. The Center's services and supports are provided without charge to the participating agencies, organizations, and staff.

Learn More:

Evaluation of a Housing Stabilization and Support Program for Transition Age Youth Policy Brief (2023)

Evaluation of a Housing Stabilization and Support Program for Transition Age Youth Presentation (2023)

Increasing Housing Stability for Transition Age Youth

In the winter of 2020, the OCA partnered with EOHHS to convene an inter-secretariat work group focused on the urgent needs of transition-aged youth[78] at risk of experiencing homelessness, disrupted education, unemployment, behavioral health challenges, and more because of the pandemic. This led to the OCA, EOHHS, and

[78] Transition age youth are between the ages of 18 to 24.

the Unaccompanied Homeless Youth Commission successfully launching the first phase of a Housing Stability and Support Program (HSSP) pilot in Springfield and Worcester that served young people, ages 18-21, who did not seek continued services from DCF post their 18th birthday. This program was expanded statewide in December 2021. The young adults who engage with the HSSP program were connected to housing, education, employment, transitional assistance programs, and other on-going supports as needed.

In June 2023, the OCA released the results from an evaluation of HSSP. The study found that 324 youth were referred to HSSP from February 2021 through April 2023 and that HSSP providers are having a positive impact on the lives of the young people they serve. Youth engaged in HSSP were significantly more likely to have secure housing and employment after participating, proving that HSSP provides an important safety net for DCF-involved youth.

Maintaining & Improving DYS-Run Hardware Secure Facilities

During FY23, members of OCA's Senior Leadership team conducted site visits to several hardware secure DYS facilities.[79,80] Site visits to these facilities had been suspended during the COVID-19 emergency. They met with staff and youth, toured the facilities, and learned about the education, programs, and services provided to the youth held in these programs. The tour highlighted the aging infrastructure of many of these facilities, but also demonstrated creative ways DYS staff had transformed common spaces through furniture, paint, and lighting to create welcoming and comfortable spaces for youth. As a result of the visit, the OCA asked DYS to propose "quick turnaround" infrastructure improvements that the OCA could fund with available FY23 dollars to improve the quality of the physical space for youth in the nine state-operated hardware secure facilities.

DYS brought together a team of fiscal, operations, and program staff to develop a proposal to:

- Improve aesthetics, functionality, and comfort of housing units, classrooms, dining, and community spaces;
- Create wellness spaces for youth; and
- Improve or make available art spaces, recording studios, and indoor recreation spaces.

The OCA was pleased to be able to fund these short-term upgrades. While the OCA hopes this contribution will improve the quality of the facilities for youth who are currently housed there, it is clear to the OCA that longer-term investments, including in some cases construction of more modern facilities, are necessary to ensure detained and committed youth are living in facilities that best support their health and development.

Family Resource Centers

Family Resource Centers were originally established following the 2012 passage of *An Act Relative to Families and Children Engaged in Services* to support families involved in the Child Requiring Assistance (CRA) system.

Learn more:
Family Resource Centers

[79] The Department of Youth Services (DYS) is the juvenile justice agency in Massachusetts.
[80] See Appendix E. Glossary of Terms for a definition of hardware secure facility.

Family Resource Centers, overseen by DCF, are community-based, culturally competent centers that provide a wide array of services to families. FRCs connect families to needed resources and supports; offer parent education classes and support groups; provide school-related educational support; and offer recreational and other activities. Over time, the Centers have come to offer services to any family in need in 32 communities, and they are often activated to provide support in times of community crisis. The OCA – through its role on the Family and Children Requiring Assistance (FACRA) Advisory Board as well as work, described below, on improving the Child Requiring Assistance System – identified opportunities to build upon the existing FRC model and ensure these Centers are properly resourced, staffed, and structured to meet the needs of families today and in the future. Building on work begun in FY23, the FY24 state budget tasks the OCA with reviewing the current capacity of Family Resource Centers including, but not limited to:

- Reach of the current centers
- Activities conducted by the centers
- Needs assessments of the families seeking support from and FRC
- Service gap analysis

The legislation also requires the OCA to issue a report documenting findings and making recommendations regarding improvements for core services, key community partnerships and system navigation services, and closing access gaps to Family Resource Centers.

In the coming year, the OCA will work in collaboration with the Families and Children Requiring Assistance Advisory Board, DCF, FRC consumers, and FRC staff to conduct this review. Findings from the review will be released in a report to the Legislature in April of 2024.

Avert Deeper or Unnecessary System Involvement

Identifying at-risk children, youth, and families and connecting them to evidence-based services before they become involved with systems like DCF and DYS increases overall wellbeing. It also has the potential to reduce the racial and ethnic disparities seen in systems involvement, educational attainment, and health outcome data. While the OCA is most concerned with achieving positive outcomes for children, averting systems involvement has the additional benefit of long-term cost savings for the Commonwealth and alleviating workforce pressures.

In FY23, the OCA worked to improve access to and implementation of evidence-based practices that support children, youth, and their families and avert unnecessary system involvement. The OCA implemented projects aimed at juvenile justice system diversion; increased accuracy in mandated reporting to DCF; improving the Child Requiring Assistance system; and addressing the needs of youth who are involved with DCF and “cross over” into the juvenile justice system.

Increasing Juvenile Justice Diversion

In January 2023, the OCA-chaired Juvenile Justice Policy and Data Board (JJPAD) released its 2022 Annual Report, which identified an increase in the use of the state's juvenile justice system between FY21 and FY22. The report also found that most of the youth entering the system are alleged to have committed a misdemeanor and/or a non-violent offense. Although most youth delinquency cases are dismissed or diverted, the JJPAD Board found that there remain many opportunities to increase the use of youth diversion,[81] particularly for these lower-level offenses. These general findings were reiterated in the JJPAD Board's 2023 Annual Report, issued in January 2024.

Learn More:

2019 JJPAD Report on Diversion

Diversion Learning Lab (2021)

The Massachusetts Youth Diversion Program: Impact Report – Year One of Implementation (2023)

Model Program Guide (2021)

Research shows that youth who are diverted from the traditional juvenile justice system reoffend less when compared to youth who go through the system.[82] Diversion improves public safety, reduces the risk of future justice system involvement, prevents negative outcomes, such as academic failure, that are associated with juvenile justice systems involvement, and is developmentally appropriate for youth.[83]

The JJPAD Board's 2019 report on diversion found that there were no statewide standards or guidelines regarding the use of diversion. To address this, the Board developed a Model Program Guide in 2020, and in 2021 the OCA partnered with the Department of Youth Services (DYS) to launch the Massachusetts Youth Diversion Program (which started as a "Diversion Learning Lab") based on that guide.

The Massachusetts Youth Diversion Program (MYDP) is a state-level youth diversion initiative that provides high-quality, evidence-based youth programming that serves as an alternative to arrest or prosecution through the Juvenile Court. Each diversion site is operated by a community-based provider, contracted through DYS, and funded by the OCA. The core of the program is a Diversion Coordinator at each site, dedicated to accepting referred youth to the program, conducting necessary assessments and intake, developing a diversion agreement, matching services, and providing case management. Additionally, DYS hired a Diversion Manager to act as the central coordinator across all sites.

As further described in the OCA's MYDP Impact Report, in the first year of operation (January 2022 – December 2022), 134 youth were referred to the MYDP across all three sites. By the end of calendar year (CY) 2022 , 45 youth had successfully completed the program, with many more successfully completing in the first few months of CY2023.

[81] See Appendix E. Glossary of Terms for a definition of diversion.
[82] Wilson, H. & Hoge, R. (2013). The effect of Youth Diversion Programs on Recidivism: A meta-Analytic Review. Criminal Justice and Behavior. Vol. 40, No. 5, May 2013, 497-518.http://users.soc.umn.edu/~uggen/Wilson_CJB_13.pdf
[83]Juvenile Justice Policy and Data Board. (2019, November). Improving Access to Diversion and Community- Based Interventions for Justice-Involved Youth. Office of the Child Advocate. https://www.mass.gov/doc/improving-access-to-diversion-and-community-based-interventions-for-justice-involved-youth-0/download

The MYDP began with sites in three counties – Worcester, Essex, and Middlesex – in fall 2021. It expanded to two additional counties – Plymouth and Hampden – in 2023 and will be expanding to two additional counties – Bristol and Cape and Islands – in 2024.

Ultimately, the OCA hopes this model can expand statewide to ensure youth across the Commonwealth have access to high quality diversion services, with the funding and full operational responsibility eventually shifting to DYS. Extensive evaluation of the program is underway as part of the program's commitment to continuous quality improvement.

Improving Mandated Reporting

Learn More:

OCA's Mandated Reporter Training (2023)

For the past several years, the OCA has prioritized improving mandated reporting of child abuse and/or neglect in the Commonwealth. In 2020-2021, the OCA chaired the Mandated Reporter Commission, which was charged with reviewing the mandated reporter law and regulations. The work of the Mandated Reporter Commission highlighted how beneficial training for mandated reporters could be in addressing some of the issues and challenges identified by the Commission. Though the Mandated Reporter Commission completed its mandate in 2021, the OCA determined that it would be beneficial to the Commonwealth for the OCA to pursue creating a profession-specific mandated reporter training. The OCA identified school personnel as an ideal category of reporters for a profession-specific training given that they make the most reports of any mandated reporter profession, and they have unique and prolonged access to children and expertise in children.

The goals of a profession-specific mandated reporter training are to use specialized-sector knowledge to assist mandated reporters in correctly identifying instances of abuse and/or neglect, to differentiate neglect and poverty, to consider the role bias and cultural considerations play in evaluating whether to make a report, and to gain structured decision-making skills that will prevent potential over-reporting of families to the DCF system.

The OCA created both a mandated reporter general training relevant to all mandated reporters in the Commonwealth and an educator-specific module that delves into the issues particularly relevant to Massachusetts' K-12 educators. The training was launched in August 2023, in time for the beginning of the school year. The training is free, online, and on-demand. The training is accompanied by an extensive resource library available online at any time and without the pre-requisite of taking the training. The resource library provides mandated reporters with Massachusetts-specific resources to learn more about relevant topics and services. The resource library also provides valuable tools to assist mandated reporters with connecting families to services when concerns don't rise to the level of abuse and/or neglect as well as a structured worksheet to help think through whether a situation requires a report to DCF. The OCA is monitoring the data available from the training platform and will report that data in our FY24 annual report.

Addressing Concerns Regarding Reporting Substance Exposed Newborns to DCF

Learn More:

Fact Sheet: An Act Relative to Substance Exposed Newborns and An Act Relative to Medication-assisted Treatment (2023)

Mandated Reporter Commission Final Report (2021)

Current law requires that mandated reporters file a report of abuse and/or neglect DCF whenever a child is born with a physical dependence on an "addictive drug," irrespective of whether the mandated reporter believes that the child's safety is at risk. The Mandated Reporter Commission's work explored concerns related to the "automatic filing" of an abuse and/or neglect report in these circumstances. In FY2022, DCF received nearly 1,700 reports on families with newborns who were born substance exposed -- but in approximately half of those reports, DCF did not find reasonable cause to believe that the newborns had been abused or neglected.[84] Oftentimes the "addictive drug" that the newborn is exposed to in utero and that results in physical dependence is a drug knowingly prescribed to the expectant parent by her physician to treat substance use disorder or support ongoing mental health treatment. Therefore, the parents who are following physician's recommendations to stay on stabilizing medications are often reported to DCF at the time of the birth of their child, a particularly vulnerable and critical time for the family. That DCF report can be destabilizing, stigmatizing, and can result in parental avoidance of medical treatment.

In FY23, the OCA collaborated with DCF and DPH to develop a legislative bill establishing an alternative to the automatic reporting of abuse and/or neglect when a child is born substance-exposed by creating a dual notification system that would allow healthcare providers to send notifications of substance-exposed newborns who those healthcare providers deem not at risk of abuse and/or neglect to DPH instead of to DCF. An abuse and/or neglect report is then only filed with DCF if healthcare providers believe the birthing parent poses a safety threat to the child. The legislative bill includes the requirement that there be guidance issued to help mandated reporters make these difficult determinations. The bill is designed to ensure that Massachusetts continues to meet its federal reporting requirements relevant to this discussion while reducing the stigma and unnecessary involvement of DCF in some of these families' lives.

The bill also aims to strengthen the existing support systems for perinatal individuals with substance use challenges, requiring DPH to establish regulations and guidance to ensure every child born exposed to substances has an effective Plan of Safe Care[85] and expand programs for parents with substance use disorders.

Finally, the bill would establish comprehensive data collection and analysis requirements for quality evaluation and reporting on the impacts of legislative changes on child safety, service gaps, and potential disparities, including those related to racial disproportionality.

[84] Massachusetts Department of Children and Families. (2022, December). Annual Report FY2022. https://www.mass.gov/doc/fy-2022/download

[85] See Appendix E. Glossary of Terms for a definition of Plans of Safe Care.

The bill aims to protect substance-exposed newborns from unsafe situations by encouraging parents to maintain their mental health or substance use treatment without fear of child protective services involvement and connecting parents in recovery to supportive services. This approach also reduces DCF involvement in a family's life if no abuse and/or neglect concerns exist. This would ease the DCF workload so they can focus their attention on the children who need it most. For more information, please see Appendix A Legislative Priorities.

Learn More:

Improving Massachusetts Child Requiring Assistance System (2022)

An Act Relative to Families and Children in Need of Assistance

Improving the Child Requiring Assistance System

The Child Requiring Assistance (CRA) system, introduced in 2012 as a replacement for the Child in Need of Services (CHINS) system, allows parents, schools, and, in very limited circumstances, police officers to file a court petition stating that a child needs assistance from the court to help address behavioral concerns. The CRA system represents a critical intervention point: if effective, a child can be connected with services that can address behavioral issues and any underlying causes (e.g., mental health, trauma, ineffective educational supports).

In FY23, the OCA-chaired JJPAD Board released a report titled "Improving Massachusetts' Child Requiring Assistance System." This report is the culmination of a nearly two-year long research process and provides an assessment of the current system as well as recommendations for improvement. The report describes the as-of-yet unmet goals of the 2012 reforms to the CHINS system and that there is no shared understanding of the purpose of the current CRA system. No shared understanding has led to significant operational differences from one part of the state to another, and disparities in how the CRA system is used, and who is referred. The report also describes how barriers to accessing services can push families to the CRA system – despite the potential harm from court involvement and the limited response options available to the Juvenile Court. Finally, the report uncovered limited availability of data about the CRA system, which hampers evaluation of the system and understanding of the needs of the youth involved with the system.

Ultimately, the reports finds that the CRA system can be a helpful "fail safe" for families, including for youth with complex needs. However, improvements are necessary to ensure the system effectively and efficiently meets the needs of youth, without causing undue harm. Recommended improvements include:

- *Shifting Cases from Court to Community*: Increase the number and roles of Family Resource Centers (FRCs) statewide, make shifts to the court process to divert more cases from court to FRCs, educate families about support options, and address bias in referrals.
- *Expanding School and Community-Based Services*: Enhance community-based programs for youth in the CRA system, promote truancy reduction efforts, and address the specific needs of youth in out-of-home placements.

- *Continued Monitoring*: Improve data availability and monitor policy changes and the impact of behavioral health system reforms on youth and families entering the CRA system.

These recommendations aim to reduce reliance on the court process and enhance access to community-based alternatives, aligning with ongoing efforts to improve the child and family support system in Massachusetts. In January 2023, Senator Robyn Kennedy and Representative Natalie Blais introduced legislation to implement the JJPAD report recommendations. See Appendix A Legislative Priorities for more information.

Understanding & Supporting Crossover Youth

In FY22, approximately half of all youth committed to DYS or in pretrial detention had an ongoing abuse and/or neglect investigation or an open DCF case.[86] While both maltreatment and child protective services involvement increase a child's likelihood of juvenile justice system involvement, Massachusetts' data shows that pretrial detention is used differently for youth with DCF involvement compared to youth without DCF involvement.

Youth with DCF involvement were more likely to be held on lower-level offenses than youth without DCF involvement. Youth with DCF involvement were also more likely to have bail set and for that bail to be set at lower amounts than youth without DCF involvement. These differences led the JJPAD Board to launch a project to understand what policies and practices contribute to youth with "dual involvement" in both DYS and DCF.

In FY23, the OCA, as chair of the JJPAD Board, began interviews with stakeholders to better understand how detention and commitments are used across the Commonwealth for youth with child protective services system involvement. These youth are called “crossover youth.” In FY24, the OCA will collaborate with the JJPAD, DYS, and DCF to generate and analyze empirical data about crossover youth’s experiences. The OCA will also conduct national reviews of literature and best practices implemented in other states. The OCA is hoping to learn more about what policies and/or practices --specific to Massachusetts-- may be contributing to crossover. Using this information, the OCA will explore interventions and supports for youth in DCF at risk of crossing over. Recommendations generated from the analysis aim to ensure the needs of youth involved in the state's child protective services system are met while avoiding justice system involvement and DYS admission where possible.

Promote Data-Informed Decision-Making

Learn More:

The 2022 JJPAD Annual Report

Leaders across government, researchers, and policy makers rely on accurate data collection and reporting on key data metrics to inform their decision-making at the case management decisions, program design, and public policy. Unfortunately, all too often, the data needed to make informed decisions is not available. In some cases, gaps are the result of limited resources, data system design, availability of staff to

[86] Juvenile Justice Policy and Data Board. (2023, January). Massachusetts Juvenile Justice System. Office of the Child Advocate. https://www.mass.gov/doc/jjpad-2022-annual-report/download

conduct analysis, or staff capacity to perform data entry. More broadly, however, limited data availability is a result of Massachusetts' decentralized service delivery system: services for children and families are provided by multiple state agencies, and in many cases those services are ultimately provided by hundreds of different non-governmental organizations through state contracts. This can make comparing data across service systems challenging if not impossible, and severely limits our ability to examine data on children, youth and/or families who may be receiving services from multiple agencies or participating in multiple programs. While the OCA works to push long-term, robust solutions forward, the OCA has worked to improve data collection and accessibility through the Child Welfare Data Work Group, the Juvenile Justice Policy and Data Board, and the OCA-administered Juvenile Justice Data Website.

Child Welfare Data Work Group

From FY18 through FY23, the OCA co-chaired the Child Welfare Data Work Group (DWG) in partnership with DCF, following its establishment under Section 128 of Chapter 47 of the Acts of 2017. The DWG was charged with making recommendations to improve and streamline data collection and reporting from DCF.

A final report was submitted to the Legislature in December of 2022, bringing the DWG's work to a close. This critical work resulted in the creation of the DCF Annual Report that provides invaluable insight into the child protective services system in Massachusetts.

In addition to collaborating on the development of the final DWG report and the creation of the DCF Annual Report, the OCA provided financial support to DCF to develop an interactive on-line data dashboard to make its core data more accessible to the public. This dashboard was released to the public in the summer of 2023. The dashboard includes demographic and geographic information for the children and youth who are involved with DCF in the intake and response process as well as children and youth with an open case with DCF. Multiple filters allow users to slice the data in various ways to gain insight about specific populations and demographic groups. In a continuous quality improvement effort, in FY23 the OCA also released a call for public comments regarding DCF's revised annual report. The result of that effort will be available in FY24.

Juvenile Justice Data & Administrative Data Centers

The OCA released the 2022 JJPAD Annual Report in January 2023. This report includes a summary of data on the utilization of the juvenile justice system and provides a

Learn More:

Data Work Group Legislative Report (2022)

Notice of Public Comment Regarding DCF FY22 Annual Report (2023)

Child Protective Services Overview & Dashboard (2023)

Learn More:

Massachusetts' Juvenile Justice Policy and Data Board's Recommended Data Reporting Standards (2020)

JJPAD Improving Access to Massachusetts Juvenile Justice System Data: An Update of the 2019 Report (2022)

Massachusetts Juvenile Justice System JJPAD Annual Report (2022)

Massachusetts Juvenile Justice System JJPAD Annual Report (2023)

Department of Public Health's Public Health Data Warehouse

section on the feasibility of creating an administrative data center to serve as a central coordinator for all child-serving data in Massachusetts.

An Administrative Data Center (ADC) is a central, often third party, organization that links datasets from two or more separate organizations to create a final research data file with each organization's administrative data linked to one individual. ADCs enable a significantly richer analysis of data that, often, can better inform policy, practice, and service delivery than individual agencies' siloed datasets.[87] After an investigation of the benefits and limitations of an ADC, and identification of ADC case studies, the JJPAD Board concluded it is technically feasible for Massachusetts to create an ADC to serve as the central coordinator of record-level state data for child-serving entities and pointed to current efforts in Massachusetts – such as the Department of Public Health's Public Health Data Warehouse – as successful examples of this kind of cross-agency data collaboration.

Juvenile Justice Data Website

The statute creating the JJPAD Board placed a special emphasis on improving the quality and availability of juvenile justice system data. To that end, the OCA created and maintains an interactive data dashboard on the Massachusetts juvenile justice system. In FY23, in addition to adding the most recent year of available data, OCA published a new visualization displaying both geography and demographic data for court and DYS data.

Learn More:

OCA's Juvenile Justice System Interactive Data Website (2023)

Youth Commitments Data: Demographic and Geographic Breakdowns (2023)

Applications for Delinquency Complaint Data: Demographic and Geographic Breakdowns (2023)

Delinquency Filing Data: Demographic and Geographic Breakdowns (2023)

[87] Actionable Intelligence for Social Policy. (n.d.). About Data Sharing. https://aisp.upenn.edu/about-data-sharing/

Next Steps

We know that there is always more work to be done to ensure the safety and wellbeing of children in the Commonwealth, especially those receiving state services.

At the end of FY23, the OCA began a strategic planning process, with the goal of developing a Strategic Framework to guide our work for FY24 to FY26. We started with the question: "What is the OCA's vision for the Commonwealth's children and their families – and what will it take to get there?"

Through that process, the OCA identified eight key goals we believe must be achieved by the Commonwealth to reach a future where all our children – and specifically our children in the care and/or custody of the Commonwealth – can thrive. These goals will serve as a guiding light as we make decisions about new projects to take on, or existing projects to build on, in future years.

- **Safety, High Quality Services & Continuous Quality Improvement:** Children in the care and/or custody of the Commonwealth are safe and receiving the services they need, and the state agencies serving them are continuously improving with well-functioning quality assurance mechanisms in place**.**
- **Prevention & Breaking the Cycle:** There is a comprehensive, coordinated statewide approach to supporting families with the aim of reducing child protective service and juvenile justice system involvement, particularly for those families for whom persistent disparities in supports exist and for families with multi-generational involvement.
- **Transition into Adulthood:** Youth receiving state services transition into adulthood with the support they need to succeed.
- **Addressing the Needs of Diverse Populations:** Our state child-serving systems are addressing the needs of traditionally underserved populations, including racially and ethnically diverse populations, LGBTQIA+ youth, and newcomer families.
- **High/Complex Behavioral Health Needs:** The needs of children and youth with high and/or complex behavioral health needs are met, including their needs for timely delivery of and navigation to appropriate support.
- **Awareness of Services:** Families and youth, and those who serve them, are aware of available supports and services.
- **High Quality Data:** Our state agencies serving children and families use high quality data to inform decision making and continuous quality improvement.
- **OCA Capacity:** The Office of the Child Advocate has the expertise, reputation, relationships, capacity, and operational infrastructure to execute its mission.

In coming years, the OCA will report on the results of the various projects and initiatives the OCA undertakes in services of these eight goals.

References

Actionable Intelligence for Social Policy. (n.d.). About Data Sharing. https://aisp.upenn.edu/about-data-sharing/

Centers for Disease Control and Prevention, Drug Overdose Deaths https://www.cdc.gov/drugoverdose/deaths/index.html Visited 3/11/2024

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control https://www.cdc.gov/injury/features/child-injury/index.html Visited 3/11/2024

Centers for Disease Control and Prevention, Overdose Death and the Involvement of Illicit Drugs https://www.cdc.gov/drugoverdose/featured-topics/VS-overdose-deaths-illicit-drugs.html Visited 3/11/2024

Child Fatality Review FY22 Annual Report, FY22 Child Fatality Review Annual Report, https://www.mass.gov/doc/fy22-child-fatality-review-annual-report/download

Department of Children and Families. (1986, June). *Policy Manual, Chapter 1: Protective Intake Policy*. https://www.mass.gov/doc/dcf-protective-intake-policy-june-2020/download

Department of Public Health. (2023, June). Massachusetts Executive Office of Health and Human Services. https://www.mass.gov/news/massachusetts-opioid-related-overdose-deaths-rose-25-percent-in-2022

Gewirtz-Meydan, A. & Finkelhor, D. (2020). Sexual abuse and assault in a large national sample of children and adolescents. *Child Maltreatment 25*, no. 2: 203-214. https://doi.org/10.1177/1077559519873975

Governor Maura Healey and Lt. Governor Kim Driscoll. (2023, September 9). *Governor Healey Signs Executive Order to Improve Language Access Across State Government* [Press release]. https://www.mass.gov/news/governor-healey-signs-executive-order-to-improve-language-access-across-state-government

Improving Access to Diversion and Community- Based Interventions for Justice-Involved Youth. https://www.mass.gov/doc/improving-access-to-diversion-and-community-based-interventions-for-justice-involved-youth-0/download

Injury Surveillance Program.(2021, Fall). DPH COVID-19 Data Brief 2020 Suicides, Suicide Attempts, and Suicidal Ideation in Massachusetts. Massachusetts Department of Public Health. https://www.mass.gov/doc/covid-19-data-brief-2020-suicides-suicide-attempts-and-suicidal-ideation-in-massachusetts-0/download

Juvenile Justice Policy and Data Board. (2019, November). Improving Access to Diversion and Community- Based Interventions for Justice-Involved Youth. Office of the Child Advocate.

https://www.mass.gov/doc/improving-access-to-diversion-and-community-based-interventions-for-justice-involved-youth-0/download

Juvenile Justice Policy and Data Board. (2020, November). Massachusetts Juvenile Justice System: Data and Outcomes for Youth. Office of the Child Advocate. https://www.mass.gov/resource/massachusetts-juvenile-justice-system-data-and-outcomes-for-youth

Juvenile Justice Policy and Data Board. (2022, November). Racial and Ethnic Disparities at the Front Door of Massachusetts' Juvenile Justice System: Understanding the Factors leading to overrepresentation of black and Latino youth entering the system. https://www.mass.gov/doc/racial-ethnic-disparities-at-the-front-door-of-massachusetts-juvenile-justice-system-understanding-the-factors-leading-to-overrepresentation-of-black-and-latino-youth-entering-the-system/download

Juvenile Justice Policy and Data Board. (2023, January). Massachusetts Juvenile Justice System. Office of the Child Advocate. https://www.mass.gov/doc/jjpad-2022-annual-report/download

Kaplow JB, Layne CM, Saltzman WR, Cozza SJ, Pynoos RS. Using multidimensional grief theory to explore the effects of deployment, reintegration, and death on military youth and families. Clin Child Fam Psychol Rev. 2013 Sep;16(3):322-40. doi: 10.1007/s10567-013-0143-1. PMID: 23760905; PMCID: PMC4651441.

Lehman, D. R., Lang, E. L., Wortman, C. B., & Sorenson, S. B. (1989). Long-term effects of sudden bereavement: Marital and parent-child relationships and children's reactions. Journal of Family Psychology, 2(3), 344–367.

M.G.L. c. 15D § 1A, childcare setting classifications

M.G.L. c. 18B, §6A, Foster Care Review

M.G.L. c. 18C § 5 Investigation of critical incidents; coordination with other agencies; complaints; review of program effectiveness; oversight

M.G.L. c. 18C, Office of the Child Advocate

M.G.L. c. 119 § 51B(l), Investigation of report of abuse filed under Sec. 51A; removal of child; transmission and filing of written reports; notice to district attorney; disclosure of information by mandated reporter

Mass.gov, Data about youth arrests https://www.mass.gov/info-details/data-about-youtharrests

Massachusetts Department of Children and Families. (2021, December). *Annual Report FY2021*. https://www.mass.gov/doc/dcf-annual-reportfy2021/download?_ga=2.47194467.518090395.1672759980-1177398998.1621613144

Massachusetts Department of Children and Families. (2022, December). Annual Report FY202*2*. https://www.mass.gov/doc/fy-2022/download

Massachusetts Department of Elementary and Secondary Education. (n.d.). Student Opportunity Act. https://www.doe.mass.edu/soa/

Massachusetts Department of Public Health. (2021) COVID-19 Data Brief 2020 Suicides, Suicide Attempts, and Suicidal Ideation in Massachusetts https://www.mass.gov/doc/covid-19-data-brief-2020-suicides-suicide-attempts-and-suicidal-ideation-in-massachusetts-0/download

Massachusetts Department of Public Health, Data Brief: Opioid-Related Overdose Deaths among Massachusetts Residents, December 2022 https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-december-2022/download

Massachusetts Department of Public Health, Opioid-Related Overdose Deaths, All Intents, MA Residents – Demographic Data Highlights, June 2022 https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2022/download

Massachusetts Registry of Vital Records and Statistics. (n.d.). "Open Death File". https://www.mass.gov/orgs/registry-of-vital-records-and-statistics

Michell, K., Nolte, K., Turner, H., Hamby, S., Jones, L. (2018, January) Exposure to Medication Overdose as an Adversity in Childhood. https://www.sciencedirect.com/science/article/abs/pii/S0882596317304359

Office of Juvenile Justice and Delinquency Prevention. (n.d.) Literature Review: Racial and Ethnic Disparity in Juvenile Justice Processing. https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/racial-and-ethnic-disparity#7

Office of the Child Advocate (June 2021) The Mandated Reporter Commission, Final Report to the Massachusetts Legislature https://www.mass.gov/doc/mandated-reporter-commission-final-report-63021/download

Social Security Administration, 42 USC 675 Sec 475 (5) (B), Definitions

Wilson, H. & Hoge, R. (2013). The effect of Youth Diversion Programs on Recidivism: A meta-Analytic Review. Criminal Justice and Behavior. Vol. 40, No. 5, May 2013, 497-518.http://users.soc.umn.edu/~uggen/Wilson_CJB_13.pdf

Wisdom AC, Govindu M, Liu SJ, Meyers CM, Mellerson JL, Gervin DW, DePadilla L, Holland KM. Adverse Childhood Experiences and Overdose: Lessons From Overdose Data to Action. Am J Prev Med. 2022 Jun;62(6 Suppl 1):S40-S46. doi: 10.1016/j.amepre.2021.11.015. PMID: 35597582; PMCID: PMC9761611.

Woolf SH, Wolf ER, Rivara FP. The New Crisis of Increasing All-Cause Mortality in US Children and Adolescents. *JAMA.* 2023;329(12):975–976. doi:10.1001/jama.2023.3517

Appendices

This Page Intentionally Left Blank

Appendix A: Legislative Priorities for the 2023-2024 Session

The Office of the Child Advocate only recommends legislative changes after thorough study and review. The OCA's legislative priorities listed below will, when taken together, help make children safer in our Commonwealth, strengthen our office, and help connect children and families' access to critical resources they need. All of this is in the pursuit of our mission of helping children thrive. The list below reflects the OCA's legislative priorities going into the 193rd Legislative session.

Protecting Newborns Exposed to Substances and Providing Supports for Families

H166/S129 – An Act Relative to Substance Exposed Newborns / An Act Relative to Medication-Assisted Treatment

As explained earlier in this report, under current law, health care professionals are required to submit a report of abuse and/or neglect to DCF every time an infant is born exposed to a substance that causes physical dependence–regardless of whether they believe the child's health and wellbeing is at continued risk. DCF data demonstrates that about half of these infants are not found to be at substantial risk of abuse and/or neglect that warrants involvement from DCF at the time of the report.

As an alternative to automatically filing a report when a child is born substance-exposed, this legislation supported by the OCA would:

- **Create a dual notification system**, whereby healthcare providers systematically send DPH de-identified notifications of substance exposed newborns, only filing a report to DCF when they believe the birthing parent might continue to use substances in a way that could lead to child abuse and/or neglect.
- **Strengthen our existing systems of support for perinatal individuals with substance use challenges.** The bill charges DPH, in consultation with DCF, with developing regulations and guidance to help health care providers assess family needs, develop a Plan of Safe Care if necessary, and refer families to appropriate services. This bill also requires DPH to increase the availability of programs for parents with substance use disorders.
- **Establish strong data collection and analysis requirements.** Of note, the bill mandates DPH to send DCF de-identified data on cases of substance exposed newborns and DCF to send data to DPH's Public Health Data Warehouse to facilitate ongoing quality evaluation and projects related to this statute and other family service initiatives. Additionally, this bill requires DCF, DPH, and the OCA to report on the impacts of the above-mentioned legislative changes on abuse and/or neglect reporting, child safety, service gaps, and any disparate impact this policy change may have had, including those pertaining to racial disproportionality.

This bill promotes the health, wellbeing, and safety of substance exposed newborns by protecting infants from unsafe situations, all the while encouraging parents struggling with substance use disorders to seek help and be supported in their recovery journey.

A Bill of Rights for Children in Foster Care

H164/S68, An Act Establishing a Bill of Rights for Children in Foster Care

The OCA supports this proposed change to the law as a complement to the foster parents' bill of rights which was passed and became Mass. General Laws c.119 § 23C. Just as the Legislature recently passed a bill of rights for foster parents, the OCA agrees strongly that children in foster care deserve similar statutory protections.

Specifically, this bill would ensure that foster children have the right to receive medical, dental, and behavioral health services, as well as access to gender-affirming care – crucial for LGBTQ+ children. It spells out that each child should have access to healthy food, clothing, personal care products, and items that preserve and promote the child's family's culture or religion.

Critically, the bill makes clear that each child shall have the right to file complaints with the DCF ombudsman's office and the OCA and shall be free from retaliation or punishment for asserting this right.

Strengthening the Office of the Child Advocate and Child Welfare Protections

H165/S124, An Act Enhancing Child Welfare Protections

This piece of legislation would help uphold and enhance the independence of the OCA and help us achieve our mission of protecting the most vulnerable children in Massachusetts. Born out of the tragedies of David Almond and Harmony Montgomery, this bill would help better protect children, families, and foster parents.

An Act Enhancing Child Welfare Protections reinforces the independence of the OCA, enhances the OCA's powers and responsibilities, enacts educational supports for children in foster care, outlines new data collection requirements for DCF, and clarifies the data reporting structure for DCF. These data collection requirements for DCF and the clarification of the data reporting structures stem from the work of the DCF Data Work Group, which the OCA co-chaired.

This bill also includes the above Bill of Rights for Children in Foster Care.

Improving the Children Requiring Assistance System

H134/S101 – An Act Regarding Families and Children in Need of Assistance

This bill would address the findings from over two years of study of the current Child Requiring Assistance system by the JJPAD Board, as well as the Board's collaborative work crafting recommendations for improvement. The Board's 2022 report details the significant shortcomings of the current CRA system, nearly a decade following major reforms made to what was previously called the Children in Need of Services (CHINS) system.

This legislation would:

- **Expand the role and function of Family Resources Centers (FRCs)** to support more children and families outside of the court process. This was the Legislature's initial intent with setting up FRCs in 2012. This bill codifies processes and – subject to appropriation — gives the FRCs the authority to convene multiple agencies and organizations to support a youth's needs with the goal of keeping them out of the juvenile justice system.
- **Change the Juvenile Court CRA filing process to ensure the court is a true "last resort"** option by requiring probation officers to determine that all community-based options were

exhausted by the petitioner prior to filing a CRA petition, and when those options weren't exhausted, connecting the petitioner with community supports, including the local FRC.
- **Raise the lower age of Juvenile Court jurisdiction from six-years-old to 12-years-old** for CRA filings to align with the state's delinquency system and ensure that the state is serving our youngest, and most vulnerable, youth outside of the court process.

For the reforms proposed in this bill to be successful, the OCA strongly emphasizes that statute change must be matched with additional funding to ensure Family Resource Centers can add staff to support the influx of additional cases that may result from this shift in process. Making changes to the court process without bolstering the FRC support system would not result in meaningful change and could even cause harm to children and families this bill seeks to help.

Transfer of Child Fatality Review to Improve this Process

H162/S92, An Act Relative to Child Fatality Review

The OCA is seeking legislation effectuating a transfer of the chairmanship from the Office of the Chief Medical Examiner to a joint chairmanship between the OCA and DPH of the Child Fatality Review program.

This transfer would adequately reflect the role that DPH currently plays in supporting the program as well as the funding, facilitation and policy-setting specialization provided by the OCA. The proposed legislation would also add the Department of Early Education and Care (EEC) to the state CFR team. Legislation to this effect has advanced through the legislative process several times, and was recently included in H.88, *An Act Relative to Accountability for Vulnerable Children and Families*, which passed the Massachusetts House of Representatives in March 2021.

Strengthening the OCA's Ability to Analyze Data from Juvenile Court Records

H1486/S1000, An Act Clarifying the Child Advocate's Authority to Access Juvenile Records.

The OCA currently has statutory authority to access court records as well as criminal offender record information (CORI) reviews. Although the courts have permitted the OCA access to individual files on a case-by-case basis for the purposes of investigations, the OCA has been denied access to data on juvenile court records held by the state Department of Criminal Justice Information Services (DCJIS) because the OCA's statute does not explicitly authorize access to juvenile records from DCJIS. Having access to this data would allow the OCA to better-fulfill requests for information received from the Legislature.

Bail Procedures for Justice-Involved Youth

H1494/S993, An Act updating bail procedures for justice-involved youth

In 2019, the JJPAD Board recommended eliminating the $40 administrative bail fee imposed on justice-involved youth and amending juvenile arrest procedures to require that the Bail Magistrate, rather than the Officer in Charge, makes the decision about whether an arrested youth should be released or held on bail. Under current law, the Officer in Charge at the police station is given the authority to release a youth or call the Bail Magistrate to make a bail determination. This has led to confusion and inconsistent practices across the state.

An Act Updating Bail Procedures for Justice-Involved Youth would enact these recommendations from the JJPAD Board. This legislation also codifies the standing order issued by the Executive Office of the Trial Court during the COVID-19 pandemic, giving Bail Magistrates the authority to administer any oath or required affirmations while taking bail through telephone or virtual options, in addition to the traditional in-person measures. It would also permit bail to be paid through a virtual or mobile payment option.

Appendix B: Boards and Commissions

Juvenile Justice Policy and Data Board (JJPAD): The OCA chairs the Juvenile Justice Policy and Data (JJPAD) Board, which was created as part of *An Act Relative to Criminal Justice Reform* (Chapter 69 of the Acts of 2018). The Board is a permanent entity that is chaired by the Child Advocate and comprised of members representing a broad spectrum of stakeholders involved in the juvenile justice system.

Childhood Trauma Task Force: The OCA chairs the Childhood Trauma Task Force (CTTF), which was created by *An Act Relative to Criminal Justice Refor*m (Chapter 69 of the Acts of 2018). The CTTF is charged with determining how the Commonwealth can better identify and provide services to youth who have experienced trauma, with the goal of preventing future juvenile justice system involvement. Recognizing the complexity and scale of the group's assignment, the Legislature created the CTTF as a permanent entity.

Mandated Reporter Commission: In November 2019, the Child Health and Wellness Bill established the Mandated Reporter Commission ("MR Commission"). The Child Advocate chaired the MR Commission, which was charged with reviewing the mandated reporter law and regulations for reporting child abuse and/or neglect and making recommendations on how to improve the response to, and prevention of, child abuse and/or neglect. The MR Commission was comprised of statutory members who represented a wide range of viewpoints from public entities and groups who have extensive experience with mandated reporting in the Commonwealth. The Commission was sunset on June 30th, 2021, following the release of its final report to the Legislature.

Child Welfare Data Work Group: The Data Work Group (DWG), which the OCA co-chaired with DCF beginning in 2017, was charged by the Legislature (Section 128 of Chapter 47 of the Acts of 2017) with reviewing the current list of DCF's statutorily mandated reports, and recommending which reports could be eliminated, streamlined, and what new reporting was needed. The DWG was sunset in December 2022 following the release of its final report to the Legislature

Child Fatality Review Program: The CFR program was established in 2000 following the passage of M.G.L. c. 38, § 2A and fulfills a federal requirement for Title IVE funding SEC. 470. [42 U.S.C. 670]. The purpose of child fatality review is to decrease the incidence of preventable child fatalities and near fatalities. The law requires Massachusetts to have two types of CFR teams: local child fatality review teams (CFRTs) which are coordinated by the district attorneys and a state child fatality review team (SCFRT). The OCA provides management and coordination of the CFR program, funds related epidemiological work at the Department of Public Health and is a statutorily named member of the State and Local Teams. The OCA, DPH, and OCME currently operate as tri-chairs of the body. See Appendix A, Transfer of Child Fatality Review to the OCA for more information.

Child Sexual Abuse Task Force: The Massachusetts Legislative Task Force for the Prevention of Child Sexual Abuse (CSAP Task Force) was created in 2014 (Section 34 of Chapter 431 of the Acts of 2014) to create a framework for preventing child sexual abuse in the Commonwealth. The

Task Force is chaired by the Director of the OCA and the Executive Director of the Children's Trust and is composed of 30 legislatively named public and private organizations and elected and appointed officials. The Task Force's authorization expired in November 2022, but the group continues to meet on important issues related to child sexual abuse prevention.

Appendix C: Additional Core Function Data

Critical Incident

Causes of Injury Appearing in CIRs

Table 10: Number of Children Who Sustained Specific Types of Injuries

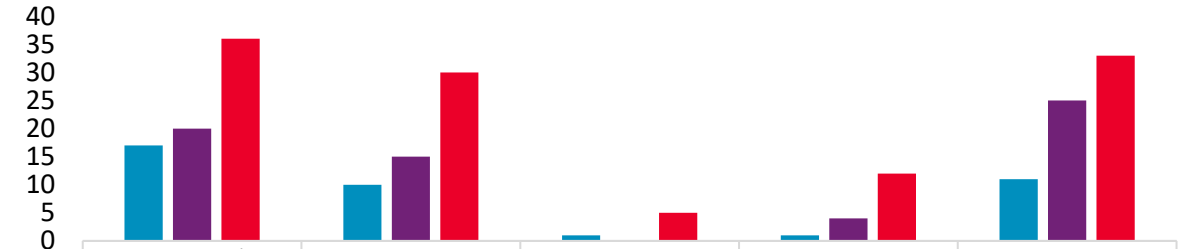
Cause	Emotional Injury	Fatality	Near Fatality	Serious Bodily Injury	Grand Total
Animal Bite/Sting/Attack	0	0	0	1	1
Asphyxia (hanging or strangulation)	0	1	1	0	2
Bodily Force (kick, punch, bite, etc.)	0	0	0	1	1
Car Crash	3	2	4	4	13
Drowning	3	5	3	0	11
Fall	0	1	0	8	9
Fire/Burn	0	1	1	6	8
Gun/Projectile	0	0	0	1	1
Knife/Sharp Object	0	0	0	1	1
Other	0	0	2	0	2
Poison	0	0	0	1	1
Struck by or against (Bat, pushed into wall, etc.)	0	0	0	1	1
Unknown	0	0	0	2	2
Grand Total	6	10	11	26	53

Supported Reports of Abuse and/or Neglect in Specific Out-of-home Settings

Childcare

Of the 83 supported reports, 99% involved neglect, 32% involved physical abuse, and 7% involved sexual abuse and/or sexual exploitation.

Figure 23:
Nature of Supported Reports of Neglect in Childcare



	Improper/ inadequate supervision	Risk of emotional/ psychological harm	Delayed or no health care	Failure to meet basic needs	Improper behavior management
FY21	17	10	1	1	11
FY22	20	15	0	4	25
FY23	36	30	5	12	33

Consistent with prior fiscal years, nearly all supported reports in childcare involved **neglect**. Major themes in FY23 relate to inadequate supervision, emotional abuse, or delaying medical care. Inadequate supervision reports mostly resulted from staff leaving a child or children alone for extended periods, leaving a child with an unapproved caretaker, or not noticing a child left a facility unattended.

Supported **physical abuse** reports relate to the childcare provider or employee's inappropriate response to a child's behaviors or inappropriate attempt to modify a child's behaviors, including corporal punishment. These cases often include grabbing, slapping, hitting, or pushing a child.

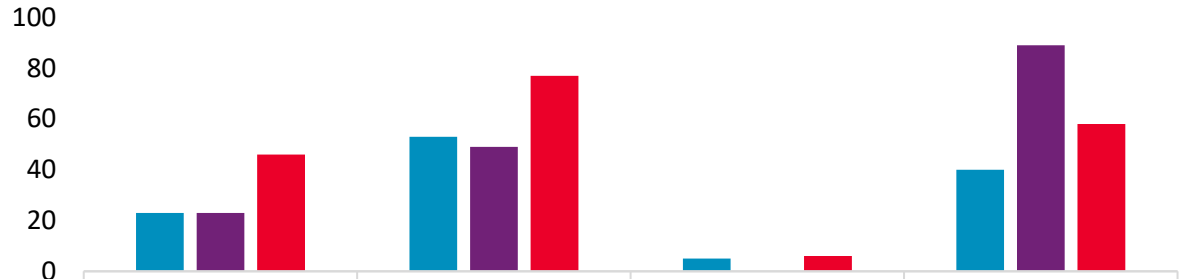
Supported **sexual abuse** reports in FY23 occurred only in home-based childcare settings and involved a child being sexually abused by a household member of the childcare provider.

Congregate Care

Of the 147supported reports in FY23, 99% involved neglect, 33% involved physical abuse, and 6% involved sexual abuse.[88]

[88] Some cases involve more than one type of abuse; sums will not equal 100%.

Figure 24:
Nature of Supported Reports of Neglect in Congregate Care



	Boundary Issues	Improper/ inadequate supervision	Delayed or no health care	Improper behavior management
FY21	23	53	5	40
FY22	23	49	0	89
FY23	46	77	6	58

In FY23, incidents resulting in supported reports of **neglect** mostly involved situations in which youth ran away from the program, engaged in sexual contact with one another, and/or used illicit substances after congregate care staff either fell asleep on the overnight shift or did not properly supervise youth. Incidents resulting in supported reports of neglect also include staff communicating with children on social media, allowing children to use staff's cell phone, providing children illicit substances, and an inappropriate response or attempt to modify a child's behavior such as yelling, demeaning, and/or physically grabbing, shoving, or improperly restraining a child (when such contact does not rise to the level of abuse).

Supported reports of **physical abuse** include injuries to the child due to a staff person's negligent behavior or inappropriate response to the child's behavior.

Incidents resulting in supported reports of **sexual abuse** related to staff engaging in sexually explicit conversation and/or an emotional or physical relationship with a youth in the program.

Foster Care

Of the 84 supported reports of abuse and/or neglect in foster care received in FY23, 93% involved neglect, 20% involved physical abuse, and 14% involved sexual abuse and/or sexual exploitation.[89]

The number and type of neglect varied by foster care setting.[90] For each foster care category detailed below, no more than 3% of the total children in each care setting experienced a supported report of abuse and/or neglect. There was a substantial increase in the number of supported reports of abuse and/or neglect in unrelated pre-adoptive homes in FY23 compared to prior years. [91]

[89] Some cases involve more than one type of abuse and/or neglect; sums will not equal 84.
[90] For definitions of the types of foster care settings, see Appendix E. Glossary of Terms
[91] For definitions of the types of foster care settings, see Appendix E. Glossary of Terms

Comprehensive Foster Care

In FY23, the 22 supported reports from comprehensive foster care involved supported allegations of neglect in 96% of the cases, physical abuse in 23% of the cases, and sexual abuse in 18% of the cases.

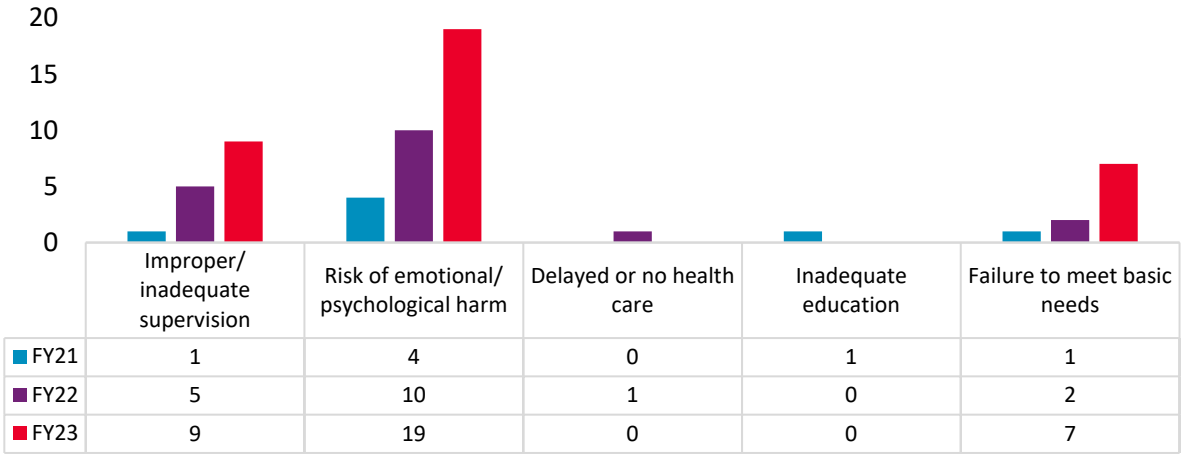
Table 11: Supported Report of Abuse and/or Neglect in Comprehensive Foster Care, FY21-FY23

Fiscal Year	FY21	FY22	FY23
Supported Reports	5	12	22
Number of Children	6	20	40
Total Number of Children Served in CFC	1,190	1,081	962

Incidents of **neglect** included concerns about domestic violence/intimate partner violence, the mental health of a caregiver, inadequate supervision, inappropriate contact with biological parents, access to food, and a foster parent's failure to seek necessary mental health treatment for a child. Supported reports of **physical abuse** were the result of the foster parent's use of inappropriate physical discipline. Supported reports of **sexual abuse** related to inappropriate touch, language, and sexual coercion by a foster father.

Figure 25:

Nature of Supported Reports of Neglect in Comprehensive Foster Care



	Improper/ inadequate supervision	Risk of emotional/ psychological harm	Delayed or no health care	Inadequate education	Failure to meet basic needs
FY21	1	4	0	1	1
FY22	5	10	1	0	2
FY23	9	19	0	0	7

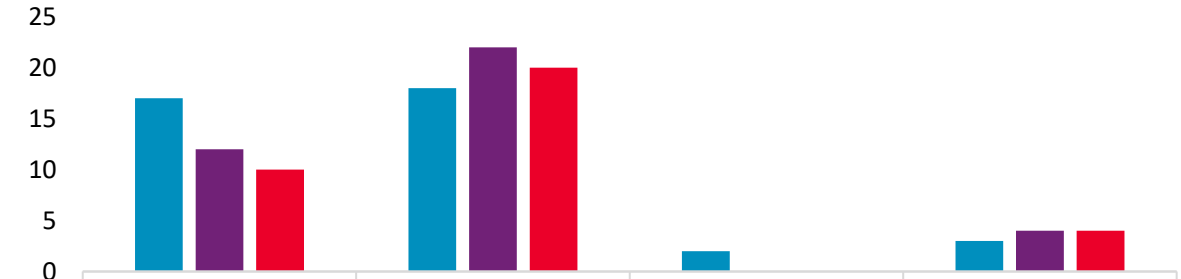
Kinship Foster Care

In FY23, the 24 supported reports from kinship foster care involved supported allegations of neglect in 96% of cases, and physical abuse in 29% of cases. There were no supported reports of sexual abuse. It is important to note that though the raw counts appear to be going down year-over-year, this is because the total number of children in placement is also going down year-over-year. The actual rate of kin placement as a percent of all placement utilization by type continues to stay the same or improve year-over-year.

Table 12: Supported Report of Abuse and/or Neglect in Kinship Foster Care, FY21-FY23			
Fiscal Year	**FY21**	**FY22**	**FY23**
Supported Reports	34	34	24
Number of Children	62	67	37
Total Number of Children Served in Kinship Foster Care	3,232	3,169	3,001

Incidents of **neglect** were the most frequently occurring supported reports and included concerns for delay in needed medical or mental health treatment for a child(ren), yelling and/or threatening a child(ren), domestic violence/intimate partner violence, substance use by the kinship foster parent(s), unapproved individuals living in the home, the use of unapproved caretakers for the child(ren), and allowing unapproved and/or unsupervised contact with the child(ren)'s biological parent. Supported reports of **physical abuse** were the result of the foster parent's use of inappropriate physical discipline.

Figure 26:
Nature of Supported Reports of Neglect in Kinship Foster Care



	Improper/ inadequate supervision	Risk of emotional/ psychological harm	Delayed or no health care	Failure to meet basic needs
FY21	17	18	2	3
FY22	12	22	0	4
FY23	10	20	0	4

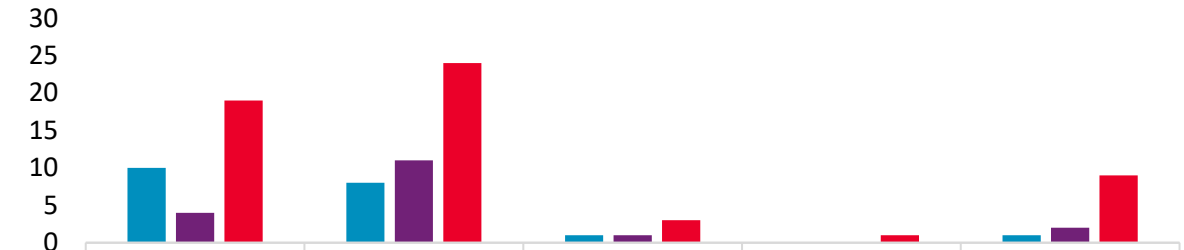
Unrelated or Pre-adoptive Foster Care

In FY23, the 37 supported reports from unrelated foster care involved supported allegations of neglect in 91% of cases, physical abuse in 14%, and sexual abuse or human trafficking in 16% of cases.

Table 13: Supported Report of Abuse and/or Neglect in Unrelated or Pre-adoptive Foster Care, FY21-FY23			
Fiscal Year	**FY21**	**FY22**	**FY23**
Supported Reports	15	12	37
Number of Children	27	23	64
Total Number of Children Served in Foster Care	2,401	2,387	2,204

Incidents of **neglect** included concerns for domestic violence/intimate partner violence, foster parent substance use, allowance of alcohol use by foster parents, use of unapproved or inappropriate caretakers for the child(ren), a lack of supervision resulting in injuries to a child, and a child running away. **Physical abuse** reports related to foster parent inappropriate discipline practices, and coercion to fight with siblings. **Sexual abuse** reports related to inappropriate physical touch and sexual contact.

Figure 27:
Nature of Supported Reports of Neglect in DCF Unrelated Foster Care



	Improper/ inadequate supervision	Risk of emotional/ psychological harm	Delayed or no health care	Inadequate education	Failure to meet basic needs
FY21	10	8	1	0	1
FY22	4	11	1	0	2
FY23	19	24	3	1	9

Appendix D: Acronyms

State Agencies

DCF Department of Children and Families

DDS Department of Developmental Services

DESE Department of Elementary and Secondary Education

DHCD Department of Housing and Community Development

DMH Department of Mental Health

DPH Department of Public Health

DTA Department of Transitional Assistance

DYS Department of Youth Services

EEC Department of Early Education and Care

EOE Executive Office of Education

EOHHS Executive Office of Health and Human Services

EOPSS Executive Office of Public Safety and Security

MassHealth Massachusetts Medicaid program

OCA Office of the Child Advocate

Other Acronyms Appearing in the Report

ACRT/RCRT: Area or Regional Clinical Review Team

ADC Administrative data center

ASERPS Approved Special Education Residential Schools Programs

CAPTA Child Abuse Prevention and Treatment Act

CCWT Center on Child Wellbeing and Trauma

CFC Comprehensive Foster Care

CFR Child Fatality Review

CfJJ Citizens for Juvenile Justice

CIR Critical Incident Report

CHINS Child in Need of Services

CJRA Criminal Justice Reform Act

CSAP Child Sexual Abuse Prevention

CTTF Childhood Trauma Task Force

CY Calendar Year

DWG Child Welfare Data Work Group

EI Emotional Injury

IEP Individualized Education Program

F Fatality

FCR Foster Care Reviews

FRCs Family Resource Centers

FY Fiscal Year

HSSP Housing Stability and Support Program

JJPAD Juvenile Justice Policy and Data

LEP Limited English Proficiency

MR Mandated Reporter Commission

NF Near Fatality

NIBRS National Incident-Based Reporting System

POSC Plans of Safe Care

PIER Pediatric Injury Equity Review

PSB Problematic Sexual Behaviors

RFR Request for Responses

SCFRT State Child Fatality Review Team

SBI Serious Bodily Injury

SUD Substance Use Disorder

SUID Sudden Unexpected Infant Death

Appendix E: Glossary of Terms

Abuse and/or Neglect: In relation to the Complaint Line, this refers to DCF's response to a report of abuse and/or neglect; maltreatment of a child at home or in an out-of-home setting.

Boundary Issues: Relates to a supported report of neglect in an out-of-home setting. The provider violates physical and/or emotional boundaries with a child.

Care and Custody of Child: In relation to OCA case review findings, this refers to a concern that DCF left the child in the care and/or custody of a parent or caregiver or removed the children from the care and/or custody of a parent or caregiver.

Childcare: For the purposes of this report, childcare references either center-based, independent home-based, and provider affiliated home-based programs.

Child-Specific Foster Care: Foster care placements where a non-kinship individual(s) is identified and licensed as a placement for a particular child (e.g., teacher or parent(s) of the placed child's friend). This is a person who the family or child has a strong bond with and is significant in their life. This was incorporated by DCF into Kinship foster care in FY23.

Child Welfare: In relation to the Complaint Line, this refers to a lack of responsiveness from DCF staff; placement of a child in DCF care and custody; parent or grandparent visitation rights; adoption or guardianship process.

Clinical Formulation: In relation to case review findings DCF not holistically assessing the family based on all information available to them to create a realistic plan of required changes to promote a child's safety, permanency, and wellbeing within their family. Clinical formulation requires a thorough review of DCF's history with the family.

Collateral Contact: In relation to OCA case review findings, this refers to a determination that the risk posed to the child was not fully assessed because the DCF case management team did not contact professionals and/or natural supports or did not ask questions that elicited information necessary to inform clinical formulation. Cases are not identified for this concern if the barrier to obtaining information is the result of parent/caregiver refusal to provide releases of information.

Comprehensive Foster Care: Foster homes that offer more intense therapeutic care and supports setting for children with more complex needs. This service is only provided by licensed foster care agencies in accordance with the licensing requirements of the Department of Early Education and Care (EEC) and DCF.

Congregate Care: A wide range of out-of-home group placements for children that provide 24-hour supervision in a variety of structured settings. This includes group homes, residential treatment programs, and secure facilities for those involved in the juvenile justice system. These placements offer both short-term stabilization as well as longer-term group care. Parents and caregivers can place their child in select congregate care programs though children are

commonly placed in congregate care through DCF, DMH, DYS or other state agencies within or outside of Massachusetts.

COVID-19: In relation to the Complaint Line, this refers to concerns arising from a lack of adherence to COVID-19 protocols.

Critical Incident Report: State agencies providing services to children or young adults must notify the OCA if a child suffers a fatality, near fatality, serious bodily injury, or emotional injury. These notifications are referred to as Critical Incident Reports (CIR).

Crossover Youth: Youth who are involved with the child protection system who also become involved with the juvenile justice system.

DCF Case Management: In relation to the Complaint Line, this refers to DCF's response to a report of abuse and/or neglect; removal of a child; service coordination or case oversight; frequent changes in social workers.

DCF Personnel: In relation to the Complaint Line, this refers to delay or lack of response to a parent or caregiver's questions or concerns; unprofessional communication; non-adherence to home visiting requirements as outlined in the DCF Ongoing Casework and Documentation Policy

DCF Specialist Consultation: In relation to case review findings, this refers to a determination that a DCF specialist consultation was not completed during the response although there were identified complex or high-risk factors that warranted one.

Delayed or no Health Care: Relates to a supported report of neglect in an out-of-home setting. The provider failed to ensure the child has proper and timely physical, dental, or behavioral health care.

Diversion: Any program that allows a youth who commits an offense to be directed away from more formal juvenile justice system involvement. Diversion is considered an alternative response to arrest and/or prosecution in Juvenile Court.

Education: The OCA uses this term in two ways:

- In relation to an allegation of neglect, this refers to a failure to provide the child with proper educational opportunities.
- In relation to the Complaint Line, this refers to concerns or requests for information related to bullying, an Individualized Education Plan (IEP) for a child and/or special education.

Emotional Injury: An emotional injury occurs when a child is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.

Experiences: In terms of a critical incident, this is used to capture the multitude of outcomes and characteristics that can occur from one single event, leading to a critical incident report. For example: one critical incident report can involve two children, one who died, and one who

experienced a serious bodily injury and witnessed the death of the other child. This would be captured as one report involving two children and three experiences.

Failure to Meet Basic Needs: Relates to a supported report of neglect in an out-of-home setting. The provider did not meet the child's needs for food, shelter, and clothing. This also includes situations where there are safety concerns regarding the physical environment where services are provided.

Fatality: In terms of a critical incident, a fatality occurs when a child between the age of birth to 24 dies.

Foster Care Review Safety Alert: Safety alerts are generated by Foster Care Reviewers at the end of a Foster Care Review if an immediate safety concern is identified for the child/youth. The safety alert is immediately sent to the DCF area office responsible for the case. The Area Director must document a response to the safety alert within one working day.

Foster Care Review: A Foster Care Review panel convenes every six months for every child in out-of-home placement to provide oversight and ensure that every child, youth, under the state's custody has a permanency plan, which defines a safe and permanent home. Implementation of a Foster Care Review process is a federal requirement.[92]

Foster Care: When a child is removed from their home due to abuse and/or neglect, foster care is one type of setting in which they may be placed. As the Commonwealth's designated child protective services agency and the one that serves more children and families than any other EOHHS agency, most children are placed in foster care by DCF, however DYS can also place children in foster care.

Hardware Secure Facility: A DYS or provider facility characterized by locked entrances and exits, and other physically restrictive construction that typically include locked bedrooms as well as procedures that are intended to prevent a client from departing with out the approval of the Department.

Healthcare: The OCA uses this term in two ways:

- In relation to an allegation of neglect, this refers to a caregiver and/or staff failing to provide the child with appropriate physical or behavioral health care.
- In relation to the Complaint Line, this refers to MassHealth coverage; extended stays in emergency rooms for behavioral health reasons; children not receiving services and support for their healthcare needs.

Improper Behavior Management: In relation to an allegation of neglect, this refers to a caregiver and/or staff do not respond properly to a child who is exhibiting problematic and/or concerning behaviors.

[92] 42 USC 675 Sec 475 (5) (B)

Improper/Inadequate Supervision: In relation an allegation of neglect, this refers to a caregiver and/or staff engage in behaviors, activities, or actions that prevent them from being able to properly supervise the child, such as not conducting bed check properly, sleeping while working etc.

Inadequate Education: Relates to a supported report of neglect in an out-of-home setting. Failure to assure the child has proper educational opportunities.

Inconsistent Home Visits: In relation to case review findings, this refers to a determination that family participants in an open DCF case have not been visited by the DCF social worker monthly and there is a lack of documentation regarding attempts to visit the family if such attempts were made.

Inconsistent Placement Visits: In relation to case review findings, this refers to no documentation in the record that a child in DCF custody is being visited monthly in their placement, such as foster care or congregate care.

Independent Living: A wide range of residential options that afford adolescents and young adults to live on their own, and still access resources.

Injury: In terms of a critical incident, injury relates to non-medical physical harm that is not the result of malintent. Injuries can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Interagency Collaboration: In relation to case review findings, this refers to a child having additional agency involvement (DDS, DMH, DYS) and no documentation in the record that DCF is collaborating on an ongoing basis with the agency.

Interviewing/Engaging Children: In relation to case review findings, this refers to a determination that the social worker is not performing full, protective, developmentally appropriate interviews with the child as part of their ongoing case management responsibilities.

Kinship Foster Care: Foster care placements provided by persons related by either blood, marriage, or adoption (e.g., adult sibling, grandparent, aunt, uncle, first cousin) or other adult to whom the child and/or parent(s) ascribe the role of the family based on cultural and affectional ties or individual family values.

Lack of Father Engagement: In relation to case review findings, this refers to a determination that one or more of the following occurred: the father was not assessed as part of a family assessment and action plan; not contacted as part of ongoing case management; or not visited or contacted monthly and a reasonable explanation is not documented in the case record to support why these actions did not occur.

Language Access: Services that agencies use to bridge the communication barrier with individuals who cannot speak, understand, read, or write English fluently to provide Limited English Proficient (LEP) individuals with the same services as English speaking individuals.

Legal: In relation to the Complaint Line, this refers to concerns about a court appointed attorney; delays in court proceedings.

Limited English Proficiency: Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English have limited English proficiency.

Medical: In terms of a critical incident, a medical event relates to a non-injury health event, such as a heart attack. Medical events can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Nature: The characteristic of the events involved in a critical incident. These can be related to an unintentional injury, suicide or attempt, overdose, sudden unexpected infant death, physical abuse, violence, a medical event, or something else not otherwise classifiable.

Near Fatality: Near fatalities are accidental, the result of a medical condition, or the result of abuse and/or neglect. A near fatality designation is dependent on verbal certification by a physician that the child or young adult's condition is considered life-threatening.

Other Concern: In relation to case review findings, this refers to the OCA's identification of errors in the electronic record and/or poor-quality case activity notes including electronic records that should have been, but were not uploaded (i.e., education records, medical records).

Other: In relation to the Complaint Line, this refers to child support and other concerns not elsewhere classifiable

Outcome Decision: In relation to case review findings, this refers to an OCA disagreement with an intake or response decision either regarding the critical incident or a prior DCF intake and response involving the same family. This could mean a disagreement with a screening decision, with a finding of abuse and/or neglect, with a finding on the alleged perpetrator, or with a categorization of a case as either emergency or non-emergency.

Outcome: Whether or not a child died, nearly died, was seriously physically injured, or suffered an emotional injury. Used to describe critical incident reports.

Out-of-Home Setting: A facility that provides care to children when they are removed from their home due to abuse and/or neglect, juvenile justice involvement, mental/physical health needs, or for childcare. Settings include congregate care like residential schools and group homes, childcare facilities, detention centers, foster care, hospitals and more.

Overdose: In terms of a critical incident, overdose relates to an excessive and dangerous dose of a drug. Overdoses can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Payments/Voucher: In relation to the complaint line, this refers to assistance with childcare tuition and eligibility for guardianship subsidy.

Permanency Planning: A formalized strategy or set of actions designed to ensure the long-term stability, well-being, and security of a child who is involved in the child welfare protection system, typically due to circumstances such as abuse, neglect, or family disruption. The primary goal of a permanency plan is to provide a safe and permanent living arrangement for the child, focusing on their best interests and overall welfare.

In relation to case review findings, this refers to at least one of the following areas: there was not a permanency planning conference for a child in DCF custody in conjunction with DCF's Permanency Planning Policy and/or when it was clinically appropriate; a child in DCF custody was not progressing toward their permanency goal; the current permanency goal for the child was not appropriate.

Physical Abuse: In terms of a critical incident, physical abuse relates to an intentional act that causes injury or physical suffering and is perpetrated by a caregiver. Physical abuse can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

Placement/Permanency: In relation to the Complaint Line, this refers to length of stay in out-of-home placement; delays in reunification; foster care placement and/or denial of placement with kin; concern for the wellbeing of a child in foster care or congregate care.

Plans of Safe Care: A document created jointly by a pregnant or parenting person, and their provider. This document helps pregnant people with active substance use disorder or in recovery think about what services or supports they might find useful, to record their preparations to parent and organize the care and services they are receiving. A Plan of Safe Care can be any family service plan that covers both the parents' behavioral health/recovery services (including addiction and mental health supports) and family or child-focused services (such as referral to Early Intervention and prenatal care appointments).

Premature Case Closing: In relation to case review findings, this refers to a determination that a DCF case was closed without one or more of the following occurring: the protective concerns that led to the family's involvement being addressed; the case closed with protective concerns due to lack of family cooperation; collateral contacts were not performed prior to case closure; the case closed post critical incident without appropriate services/supports in place.

Public Schools: Schools that are funded and supported by the Department of Elementary and Secondary Education.

Record Review: In relation to case review findings, this refers to no documentation in the case record that the response worker reviewed the family's prior DCF history, if any, as part of their response.

Risk of Emotional/Psychological Harm: In relation to an allegation of neglect, this refers to a caregiver and/or staff allow children to be exposed to behaviors, activities or actions that pose a risk of harming a child's emotional or psychological state.

Safety Planning: In relation to case review findings, this refers to a concern that DCF approved an individual(s) responsible for ensuring a child's safety and that individual was not an appropriate caregiver and/or was not aware of the safety plan and DCF's concern for the child.

Serious Bodily Injury: Serious bodily injuries are accidental, the result of an underlying medical condition, or the result of abuse and/or neglect and lead to bodily injury "which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress."[93]

Sexual Assault: In terms of a critical incident, sexual assault that results in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

State Custody: A state agency, such as DCF or DYS, has obtained temporary or permanent legal custody of a child. Children in State Custody may stay in their home or be placed out-of-home.

Suicide: In terms of a critical incident, suicide relates to someone taking or attempting to take their own life. Suicide and suicide attempt can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

SUID: Sudden Unexpected Infant Death is the unanticipated death of an infant under the age of one year that occurs without warning where a cause is not immediately known before investigation. These deaths occur primarily during sleep.

Summons: A formal notification issued by the court to a youth outlining the alleged offense and ordering them to appear in court.

Supported Report and/or Allegation of Abuse and/or Neglect: When DCF receives a report of abuse and/or neglect (51A), DCF gathers information to determine whether the allegations meet DCF criteria for suspected abuse and/or neglect, if there is immediate danger to the safety of a child, whether DCF involvement is warranted and how to best respond. DCF begins its screening process (intake) immediately upon receipt of a 51A report. If a 51A is "screened in," it is assigned for a child protective response to determine whether there is reasonable cause to believe that a child has been abused and/or neglected. "Screened-in" are categorized as requiring either an immediate emergency response or a non-emergency response. For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.

[93] M.G.L. c. 18C § 5

Unrelated Foster Care: An individual(s) who has been licensed by DCF as a partnership resource to provide foster/pre-adoptive care for a child usually not previously known to the individual(s). Formerly called unrestricted foster care.

Violence: In terms of a critical incident, violence relates to an intentional act that causes injury or physical suffering that is not sexual in nature and is not perpetrated by a caregiver. Violence can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

Visitation: In relation to the Complaint Line, this refers to concerns about the frequency of visits with children in DCF custody; concerns about interactions between a child and parent during DCF supervised visits.

Commonwealth of Massachusetts
Office of the Child Advocate

Phone
Main Office: (617) 979-8374
Complaint Line: (617) 979-8360

Address
One Ashburton Place, 11th Floor
Boston, MA 02102

Website
https://www.mass.gov/orgs/office-of-the-child-advocate

Contact
Childadvocate@mass.gov