

# **Office of the Child Advocate Annual Report Fiscal Year 2018**



The Commonwealth of Massachusetts  
Maria Z. Mossaides  
Child Advocate



# **The Office of the Child Advocate**

The mission of the OCA is to ensure all children in the Commonwealth receive appropriate, timely and quality services with full respect for their human rights. Through collaboration with public and private stakeholders, the OCA examines services to children to identify gaps and trends and makes recommendations to improve the quality of those services. The OCA also serves as a resource for families who are receiving, or eligible to receive, services from the Commonwealth.

## **Office of the Child Advocate Staff**

Maria Z. Mossaides  
Child Advocate

Edie Rathbone  
Director of Policy and Legal Counsel

Christine Palladino-Downs  
Director of Quality Assurance

Melissa Threadgill  
Director of Juvenile Justice Initiatives

Lindsay Morgia  
Research and Policy Analyst

Melissa Williams (Christiano)  
Program Coordinator

Karen Marcarelli  
Program Assistant



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# Letter from the Child Advocate

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March 21, 2019

Dear Governor Baker, Lieutenant Governor Polito, Senate President Spilka, Speaker DeLeo, Members of the General Court and Citizens of the Commonwealth,

I am pleased to submit the Fiscal Year 2018 (FY18) Annual Report for the Office of the Child Advocate (OCA) which documents its activities, findings and recommendations for the period from July 1, 2017 through June 30, 2018.

FY18 marked the tenth anniversary of the establishment of the OCA and the appointment of the Commonwealth's first Child Advocate. Massachusetts was the ninth state to establish an OCA and is currently one of 12 states that operate independent and autonomous child advocate or ombudsman offices. Most of these agencies oversee their state's child protective service agency. Rhode Island, Connecticut and New Hampshire (which became the 12<sup>th</sup> state with a Child Advocate in 2018) oversee both the child welfare and juvenile justice systems, as these are located within one agency. Massachusetts is unique because its OCA oversees services to children<sup>1</sup> across all state agencies. The OCA's broad legislative mandate enables a comprehensive view of children's services in contrast to individual agencies, which are limited to their own statutory mandate.

The OCA was first established by Executive Order 494 in 2007. Under the Executive Order, the Child Advocate was to be appointed by the Governor and would report to the Secretary of the Executive Office of Health and Human Services (EOHHS). In 2008, the Legislature wanted to ensure the OCA had permanent and independent status and created it as a new agency, with the Child Advocate reporting directly to the Governor.

In its initial years, the OCA's work focused on defining its role and implementing core functions. The OCA negotiated a process for receiving critical incident reports from EOHHS agencies, developed a system to track and review substantiated reports of abuse and/or neglect in out-of-home settings and established its Helpline (Complaint Line) to take complaints and requests for information and referrals.

Between 2014 and 2015, the value of the OCA's expertise was recognized as the Governor and Legislature relied on its independence to investigate and review the deaths of state agency involved children. The OCA also conducted two legislatively mandated reviews of the

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<sup>1</sup> Unless otherwise noted, in this FY18 OCA Annual Report "children" refer to any individual under the age of 18.

Department of Children and Families (DCF): *An Evaluation of the DCF Administrative Hearing System and Quality Improvement Review and Analysis of the Office Management of DCF.*<sup>2</sup>

In 2015, the OCA's independence was enhanced by adopting statutory changes consistent with other independent executive agencies, including a fixed term for the Child Advocate and the appointment to be made by agreement of the Governor, the Attorney General and the State Auditor.

Under the 2018 Criminal Justice Reform Law, the OCA's mandate was expanded to include the leadership of the Juvenile Justice Policy and Data Board (JJPAD) and the Childhood Trauma Task Force (CTTF). The JJPAD Board is charged with evaluating juvenile justice system policies and procedures, as well as the implementation and impact of statutory changes to the juvenile justice system and making recommendations to the legislature for further improvements. The CTTF is charged with studying and making recommendations for how the Commonwealth should best identify and provide services to youth who have experienced trauma and are currently involved with the juvenile justice system or are at risk of future juvenile justice system involvement.

The OCA has assumed the role of neutral convener. Not constrained by a limited legislative mandate, the OCA invites both public and private sector stakeholders to develop shared solutions to identified challenges. The OCA supports research into best practices and the presentation of the best available data to inform policy decisions. The OCA's credibility has developed from its expertise and the relationships it has forged.

We are very fortunate that Massachusetts leads in the fields of education, health care and human services. I am fortunate to have the support provided by the Governor and Legislative leadership. In addition, our work is only possible with the collaboration of our public sector colleagues and the advocacy and trade associations who represent the Commonwealth's children, families and child-serving organizations. I also wish to acknowledge the families who have brought their concerns to the OCA. Finally, I am grateful for my staff and their efforts on behalf of the Commonwealth's children.

Sincerely,



Maria Z. Mossaides

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<sup>2</sup> The *Evaluation of the DCF Administrative Hearing System and Quality Improvement Review and Analysis of the Office Management of DCF* reports are available on the OCA website at <https://www.mass.gov/service-details/oca-project-reports>

# Strategic Planning

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In FY18 the OCA chose to undertake a strategic planning process with the goal of establishing clearer criteria for selecting and prioritizing special projects and initiatives. The value of the OCA's independence has increasingly been recognized across all branches of state government, within the provider community and among the general public. Advocacy groups representing parents and children are bringing more issues to the OCA. The OCA serves as a resource to the legislative branch, working to evaluate the impact of proposed legislation and secure the passage of legislation that will increase protections for children.

The strategic planning began with a comprehensive review of our statutorily mandated core functions, historical priorities and current and potential projects and initiatives. The OCA assessed the value and level of effort of its participation on multiple boards, commissions and task forces, many of which are statutorily required. Participation in these groups provides the OCA with relevant information across several domains, which enables the OCA to gain a more complete picture of the gaps and needs in services that serve as barriers to better outcomes for children and families.

The result of the strategic planning is newly established criteria to guide decisions about undertaking or responding to requests for participation in projects and initiatives. The criteria include:

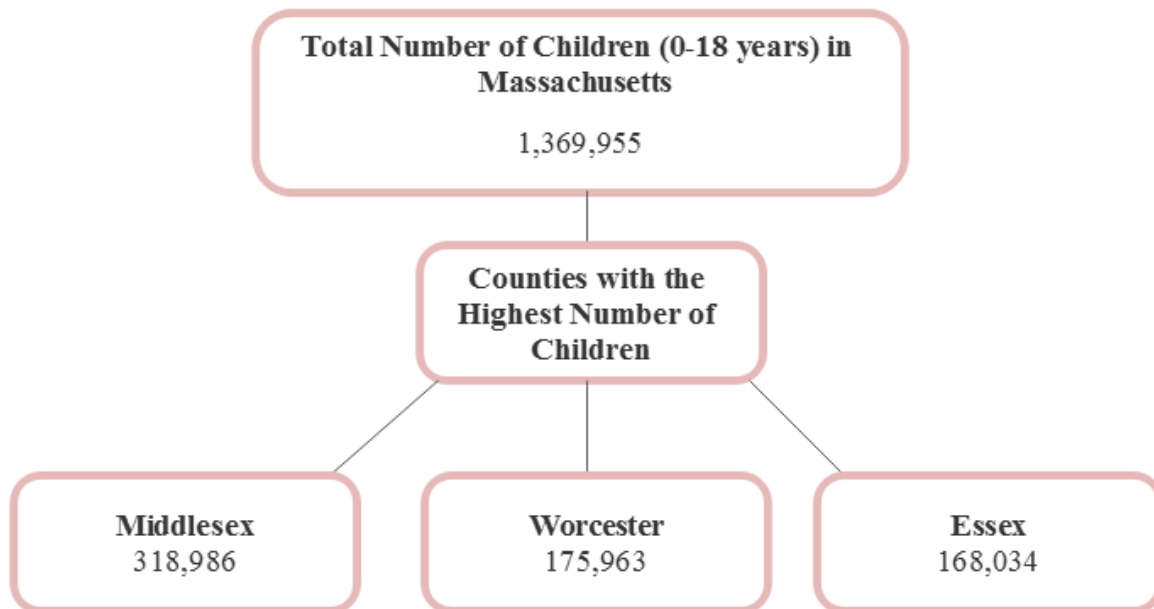
- Whether the work of the OCA will have a significant impact on children, with an emphasis on those determined to be at high risk. These include children who are in the custody of the Commonwealth, in residential or substantially separate education programs, children with disabilities, LGBTQ and transition-age youth.
- Whether another agency or entity is better positioned to take the lead, or whether the OCA is needed to serve as the neutral convener and facilitator.
- Whether the OCA has or can procure the appropriate skill set and can access the information or data required to complete the project.

These criteria are being utilized to assess new initiatives and projects and will be reviewed annually as part of the OCA's budget and operational planning.



# Data Snapshot of Children in Massachusetts

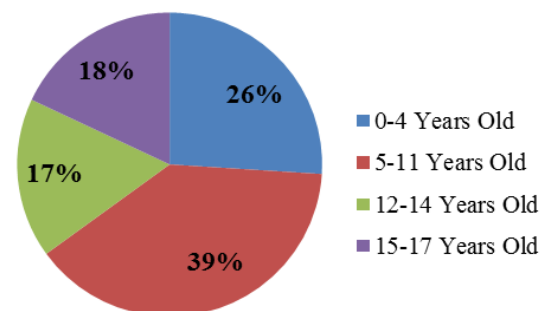
The following are 2017 calendar year **estimates** from the Kids Count Data Center and the US Census Bureau, unless otherwise noted. Kids Count uses a wide variety of sources to collect their data, including census data, the American Community Survey and the National Survey of Children’s Health, among others. For more information regarding data sources, please visit: [kidscount.datacenter.org](http://kidscount.datacenter.org).



## Racial/Ethnic Breakdown of Children in Massachusetts

- 62% of children are white (non-Hispanic)
- 18% of children are Hispanic or Latino
- 9% of children are black (non-Hispanic)
- 7% of children are Asian (non-Hispanic)
- 4% of children are of two or more racial groups (non-Hispanic)
- American Indian/Alaskan Native and Native Hawaiian and Other Pacific Islanders each make up less than 1% of the child population

## Age of Children in Massachusetts



### **Facts on Children in Massachusetts**

- 88.3% of all students graduate from high school in four years, though this varies by race, gender and school district (Department of Elementary and Secondary Education, 2017).
- 23% of children speak a language other than English at home (Kids Count, 2017).
- 14% of children live at or below the poverty line (Kids Count, 2017).
- 286,606 children have special health care needs, including physical, developmental, behavioral or emotional needs (Kids Count, 2015-2016).
- 201,791 children have experienced two or more adverse events in their lifetime (Kids Count, 2015-2016).
- 47,000 children have had a parent incarcerated (Kids Count, 2015-2016).

# Salesforce

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Although established as an independent agency, prior to FY16 the OCA relied on the Office of the Governor to support our administrative functions.<sup>3</sup> The OCA used the Office of the Governor's database to track Complaint Line calls and enter basic data on our core functions. As the OCA has evolved, our data collection and analysis have become more complex. Our legacy database could not adapt to our changing needs and data analysis was too cumbersome.

In March 2018, the OCA hired Salesforce to create a new database for the OCA. With Salesforce, the OCA can create tailored reports of information received through our Complaint Line, review of critical incident reports and review of reports of abuse and/or neglect in out-of-home settings.

All data from our legacy database was uploaded into Salesforce in May-June 2018. In FY19, the OCA will update our existing data policies and procedures to align with Salesforce, use the system to monitor our data quality and create specialized reports to inform our policy and project work.

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<sup>3</sup> The General Appropriations Act of FY16 enhanced the OCA's independence by separating us from the Governor's office.

# Complaint Line

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The OCA is mandated to receive complaints about services provided to children by state agencies. Family members, foster parents, advocates, attorneys and others contact the OCA to express their concern about the services a child is receiving, or eligible to receive, from a state agency. Additionally, anyone who needs help finding resources related to the health, education, safety and well-being of any child in the Commonwealth may contact the OCA.

The OCA has several well-established access points: phone, email, online complaint form and mail. Staff members are available<sup>4</sup> to help identify services or resources, assist with resolving a problem that involves a state agency and provide information and referrals as needed. In more complex matters, staff will meet to discuss the situation and, with the consent of the individual who contacted the OCA, may reach out to the state agency involved.

The OCA maintains a confidential database of information received through the Complaint Line. On October 30, 2017, the OCA shared our FY16 and FY17 Complaint Line data during the annual meeting of the OCA Advisory Council. In response to feedback from the OCA Advisory Council, the OCA reexamined our data tracking methods and implemented immediate changes, retroactive to the beginning of FY17. The most significant change was that we acknowledged not all contacts on our Complaint Line were a complaint or a concern. Rather, some individuals contact the OCA seeking only information and referrals. To distinguish between these two types of contacts, the OCA implemented two categories for the Complaint Line:

1. **Complaint**: An individual expresses dissatisfaction regarding services being provided to children of the Commonwealth.
2. **Information and Referral**: An individual requests information, referrals or education on a specific topic and does not express dissatisfaction with any agency or program that provides services to children of the Commonwealth.

## Overview of FY18 OCA Complaint Line Contacts

In FY18, 358 individuals contacted the OCA Complaint Line. Of these individuals, 86% (308) were Complaint contacts and the remaining 14% (50) were Information and Referral contacts.

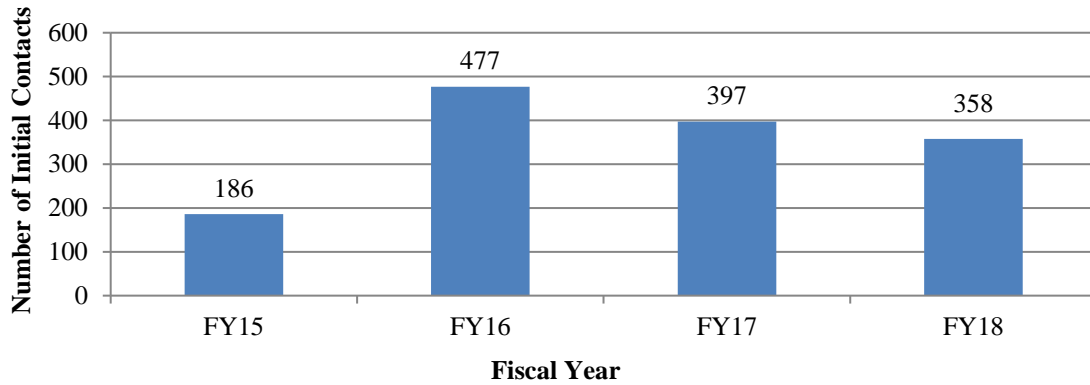
As shown in Figure 1 below, the number of individuals who contacted the OCA is within 10% of the number reported in FY17. These numbers reflect only an individual's initial contact with the OCA; any follow-up contact with the same individual about the same issue is not included in the

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<sup>4</sup> OCA staff are available Monday-Friday, 9:00am – 5:00pm.

chart. Therefore, the actual number of calls, emails, online complaint forms and mail received by the OCA in a fiscal year is considerably higher than what is reflected in the chart.

**Figure 1: Total Complaint Line Initial Contacts  
FY15 - FY18**



The primary method of contacting the OCA continues to be via telephone (69%). The second most common method of contacting the OCA was via email (15%) followed by the online complaint form (13%), mail (2.5%) and in person (.5%).

Of the 358 individuals who contacted the OCA, the greatest number were parents and grandparents. The OCA also received calls and emails from other relatives (e.g. aunts and uncles), other adults in the child’s life (e.g. neighbors), foster parents and professionals who interact with the child (e.g. attorneys, teachers, therapists). It is rare to have children directly contact the OCA. The OCA continuously considers methods of improving outreach to children to let them know about the Complaint Line.

# OCA Analysis of Complaint Line Data

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Complaint Line data serves as a foundation for improving the OCA’s understanding of child-serving agencies, assists in establishing priorities for future projects, guides the OCA staff in identifying additional resources and enhances our ability to respond to individuals who contact our office. To broaden this understanding, during FY18 the OCA revised its Complaint Line data tracking system to better categorize the areas of concern reported by individuals, as well as the requests for information and referrals. This revised tracking system was developed based on a comprehensive review of prior years’ Complaint Line contacts.

Six categories were created for Complaint Line areas of concern, as seen in Table 1.

**Table 1: Categories of Complaint Line Areas of Concern**

Area of Concern	Definition
<b>Abuse and Neglect</b>	Concerns that a child is suffering physical or emotional injury due to abuse and/or neglect at home, in school, in foster care or in any other child-serving program or setting.
<b>Education</b>	Concerns about the actions or inactions of a school. This includes public, private and residential schools.
<b>Legal</b>	Concerns about the actions or inactions of the juvenile court or probate and family court. This includes decisions made by judges and problems with legal representation.
<b>Child Welfare</b>	Concerns about the health, safety or well-being of a child as it relates to DCF case practice, placement, visitation, adoption, permanency or payments/vouchers. A child welfare concern <u>does not</u> have to involve a child or family with an open DCF case.
<b>Healthcare</b>	Concerns the actions or inactions of a medical institution or community provider are impacting a child’s physical, mental, emotional or behavioral health.
<b>Other</b>	Concerns the actions or inactions of other entities that are not related to education, child welfare, healthcare or legal. For example, concerns about non-state agencies and housing.

Complaints and concerns in the Child Welfare category include a wide range of topics, so the OCA created seven subcategories for Child Welfare concerns to develop a clearer understanding of the most common issues brought to the attention of the OCA.

Table 2 lists the Child Welfare subcategories and provides examples.

**Table 2: Complaint Line Child Welfare Subcategories**

<b>Area of Concern</b>	<b>Examples Include</b>
<b>Adoption</b>	<p>Complaint about the length of the adoption process.</p> <p>Complaint that a child has been removed from a pre-adoptive home.</p>
<b>DCF Case Practice</b>	<p>Complaint about the actions or inactions of a DCF employee (e.g. social worker, supervisor, manager).</p> <p>Complaint that DCF removed a child from their biological parents.</p>
<b>DCF Policies and Procedures</b>	<p>Complaint that DCF is not following its policies or procedures.</p> <p>Complaint about the long delay in an individual receiving an outcome decision for a fair hearing.</p>
<b>Payments/Vouchers</b>	<p>Complaint that an individual is not receiving daycare, clothing or other vouchers/payment in a timely fashion or is not receiving them at all.</p>
<b>Permanency Plan</b>	<p>Complaint that there has been a change in the goal of a permanency plan (e.g. adoption to reunification).</p>
<b>Placement</b>	<p>Complaint about being denied placement of a child.</p> <p>Complaint about a child’s removal from a foster home or residential program.</p>
<b>Visitation</b>	<p>Complaint about a visitation schedule between a child and parent.</p> <p>Complaint that an individual is being denied visitation with their child, despite having visitation rights.</p>

During FY18 the OCA also developed six categories to track the different types of information and referrals requested on our Complaint Line. Understanding the different types of information requested allows us to improve our catalog of resources available to individuals who contact our office. Table 3 lists the categories of Information and Referrals.

**Table 3: Categories of Information and Referrals**

<b>Area of Request</b>	<b>Definition</b>
<b>Abuse and Neglect</b>	Requests information about how to file a report of abuse and/or neglect or asks questions about the DCF abuse and/or neglect investigation process.
<b>Child Welfare</b>	Requests information about the child welfare system or requests help navigating the child welfare system. Examples include individuals wanting to know how to become a foster parent or request records from DCF.
<b>Education</b>	Requests information about educational services or resources, such as how to find a special education advocate.
<b>Healthcare</b>	Requests information about healthcare, including physical, mental and behavioral health.
<b>Legal</b>	Requests information about legal representation.
<b>Other</b>	Requests information that does not fall into any of the above categories, such as an individual trying to locate a child in another state.

### **Complaint Areas of Concern Category**

Although there were 358 individuals who contacted the OCA Complaint Line, many individuals expressed more than one concern. As a result, the number of categorized areas of concern is higher than the number of individuals who contacted the OCA. As indicated in Figure 2, in FY18 the two most common Complaint Line areas of concern were Child Welfare and Abuse/Neglect. Complaints categorized as Child Welfare include concerns about the well-being of a child related to placement, visitation, adoption or access to payments/vouchers.

Complaints categorized as Abuse/Neglect include concerns that a child is experiencing abuse and/or neglect at home, at school, in foster care or in any other child-serving setting. In these instances, the OCA directs the individual to contact the DCF Child-At-Risk Hotline<sup>5</sup> and determines whether the OCA, as a mandatory reporter, needs to file a report of abuse and/or neglect with DCF on behalf of the child.

<sup>5</sup> To report suspected child abuse and/or neglect, contact the Child-At-Risk-Hotline at 1-800-792-5200. The Hotline is available 24 hours a day.



Complaints categorized as Legal include concerns that a court appointed attorney was not representing the best interest of a child or parent. Complaints categorized as Education include a public school not providing necessary services to a child with special needs or not following a child’s individualized special education plan.

**Figure 2: FY18 Complaints: Areas of Concern (n=419 categorized contacts)**

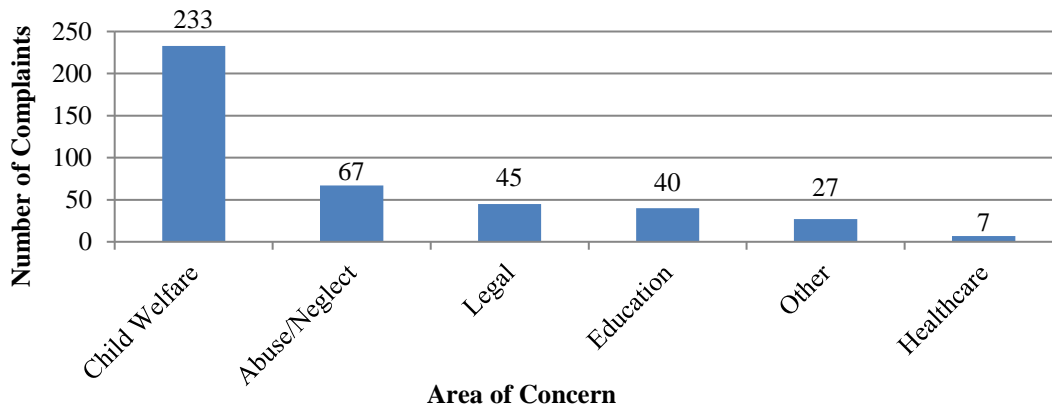
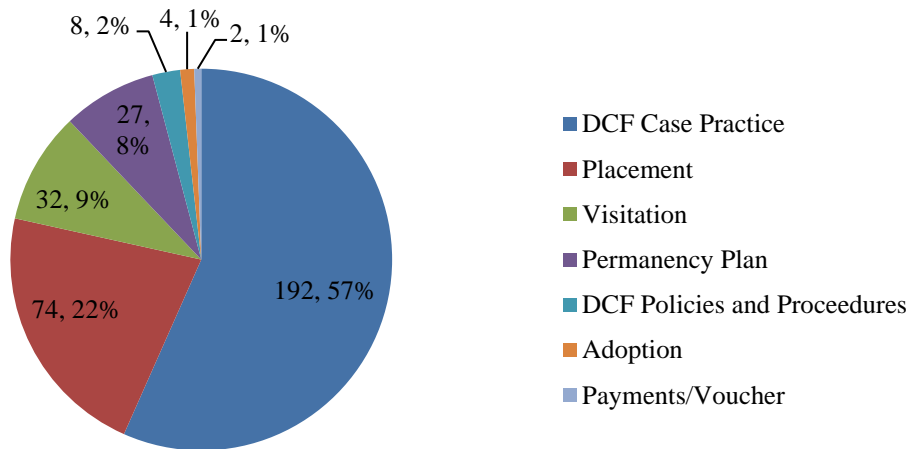


Figure 3 shows that the top two areas of concerns in the Child Welfare subcategories were DCF Case Practice (192) and Placement (74). Complaints about DCF Case Practice include decisions made by DCF on an individual’s case, such as mandating a parent participate in treatment for substance use or individual therapy. Complaints about Placement include DCF moving a child from a pre-adoptive placement or denying an individual the placement of a child in DCF custody.

**Figure 3: FY18 Complaints: Child Welfare Subcategories (n=339 categorized child welfare concerns)**



## Information and Referral Category

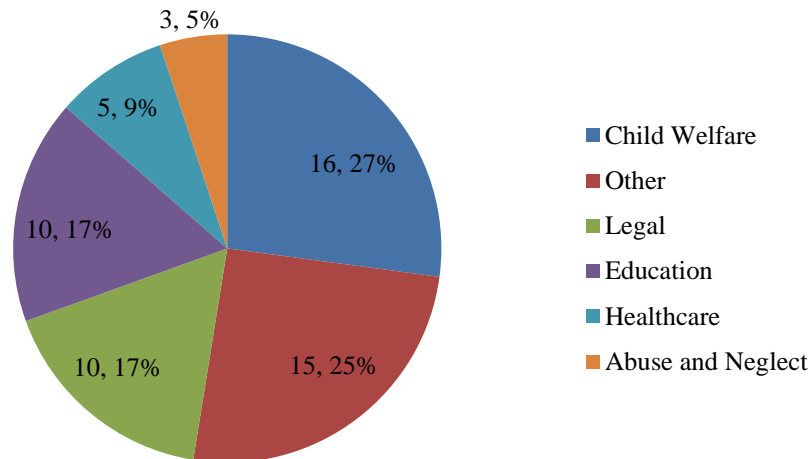
The Information and Referral requests covered a wide variety of topics in FY18. While the most common request for information was related to Child Welfare (16), the second highest number of requests for information fell into the Other (15) category. Included in Other were:

- inquiries regarding what the OCA can and cannot do;
- requests for clarification of information presented in OCA reports; and
- questions regarding media reports relating to child services.

Two other categories, Education (10) and Legal (10), also generated many questions. Education inquiries were related to an individual asking about how to file a special education appeal or find an educational advocate.

Legal inquiries were related to an individual asking about how find legal representation or wanting legal advice. The OCA cannot provide legal advice and with all requests for legal advice, the OCA provides the individual resources to find legal representation.

**Figure 4: FY18 Info and Referral: Subcategories**  
(n=59 categorized info and referral topics)



# Critical Incident Reports

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When a child receiving services from a state agency dies or is seriously injured, that agency is required to send a critical incident report (CIR) to the OCA. A critical incident can happen as a result of any event, such as abuse and/or neglect, an accident, community violence or suicide. A critical incident is defined as:

**Fatality:** When a child receiving services from a state agency dies.

**Near Fatality:** When a child receiving services suffers a near fatal injury which is accidental, or the result of a medical condition or the result of abuse and/or neglect and is dependent on verbal certification by a physician that the child's condition is considered life threatening.

**Serious Bodily Injury:** When a child receiving services suffers an 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, mental faculty or emotional distress.

**Emotional Injury:** When a child receiving services is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act or suicide.

**Other:** Sometimes agencies report incidents they are not required to, but feel the incident is important for the OCA to know about. For example, an altercation between youth placed in a residential setting or incidents of violence in the community that involve children receiving services.

In July 2016, changes to the OCA statute broadened the definition of a critical incident to mandate that all child-serving executive agencies, not just those organized under EOHHS, report critical incidents to the OCA.<sup>6</sup> In FY18, the following EOHHS agencies reported critical incidents concerning the children they serve:

- Department of Children and Families (DCF) reported critical incidents involving children in their custody or receiving services, as well as children whose families had DCF involvement within the preceding six months.
- Department of Developmental Services (DDS) reported critical incidents involving children receiving services in the community.

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<sup>6</sup> In FY19, the OCA intends to develop procedures to receive CIRs from child-serving agencies in secretariats other than EOHHS.

- Department of Mental Health (DMH) reported critical incidents involving children who are their clients in the community, acute care, residential treatment programs and hospital settings.
- Department of Public Health (DPH) reported critical incidents involving children receiving their funded services in the community and in residential treatment programs they license and fund.
- Department of Youth Services (DYS) reported critical incidents involving youth detained or committed by the Juvenile Court to DYS who are receiving services in the community and in group or foster care, residential treatment programs and secure treatment centers.<sup>7</sup>

## Critical Incident Report Definitions Pilot Project

As highlighted in the audit of DCF issued by the Office of the State Auditor on December 7, 2017, one challenge of critical incident reporting is that an agency's definition of a critical incident may be different than the OCA's definition. Recognizing the need for greater clarity between the OCA and the EOHHS reporting agencies about what constitutes a critical incident, in February 2018 the OCA began collaborating with DCF on a pilot project to improve critical incident reporting to the OCA. The OCA chose DCF because it is the agency serving the most children. The goals of the project were to develop clearer definitions of a near fatality, serious bodily injury, emotional injury and to determine which of these incidents need to be reported to the OCA as critical incidents.

The DCF leadership team selected five Area Offices to participate in the pilot: Arlington, Lowell, Park Street (Boston), Pittsfield and South Central (Whitinsville). The Area Offices were instructed to send incidents to Central Office on a weekly basis between February 1<sup>st</sup> and March 30<sup>th</sup> and provided the following guidance:

*Any child or young adult who currently is involved with the DCF, either through a 51A, CRA referral, voluntary services agreement or open case, or was involved with DCF within the **past year** through a 51A, CRA referral, voluntary services agreement or an open case. The types of incidents that should be reported are:*

- *any injury leading to an ICU admission; or*
- *any injury leading to critical condition status and hospitalization as stated by a medical professional; or*
- *a suicide attempt that results in hospital admission for physical injury; or*

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<sup>7</sup> The OCA also received four CIRs from the following EOHHS agencies: Human Service Transportation Office (2), MA Commission for the Blind (1) and the Office of Behavioral Health (1). These incidents did not meet the OCA's definition of a critical incident and therefore are not included in this analysis.

- *being witness to an unexpected fatality or near fatality of an individual related to an overdose, violent act or suicide; or*
- *a suicide attempt, defined as a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.*
- *Serious bodily or emotional injury, an 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. Emotional injury is an impairment to or disorder of the intellectual or psychological capacity of a child as evidenced by observable and substantial reduction in the child's ability to function within a normal range of performance and behavior.*

*Please note that these incidents do not have to be caused by abuse or neglect to be reportable under the OCA Critical Incident guidelines.*

DCF Central Office sent the reported incidents to the OCA on a weekly basis, sorted by type of incident category: *ICU Admission, Critical Condition Hospitalization, Suicide Attempt Non-Fatal, Suicide Attempt Hospitalization, Witness to Fatality/Near Fatality, Serious Bodily/Emotional Injury.*

In total, the OCA received 787 incident reports, with 668 of those reports being in the category of *Serious Bodily Injury/Emotional Injury*. The high volume of reports in the *Serious Bodily Injury/Emotional Injury* category is likely due to the broad definition of emotional injury in the guidance provided to the five Area Office participants.

The OCA analyzed each report to determine if it met two OCA critical incident reporting criteria:

1. the incident was a fatality, near fatality, serious bodily injury or emotional injury; and
2. the incident occurred during the DCF involvement designated timeframe.<sup>8</sup>

The OCA and DCF met frequently over several months to review the OCA incident report analysis and develop clearer definitions for near fatality, serious bodily injury and emotional injury. These discussions included determining what specific types of incidents should be included as a critical incident, including sexual abuse.

Critical incident reporting definitions were finalized in October 2018. The OCA has used these refined definitions to:

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<sup>8</sup> The timeframe for the pilot was current, or within past year, involvement with DCF through a 51A, Child Requiring Assistance referral, voluntary services agreement or open case.

- reexamine all CIRs submitted to the OCA in FY18; and
- establish critical incident reporting criteria for all other child-serving state agencies (beginning in FY19).

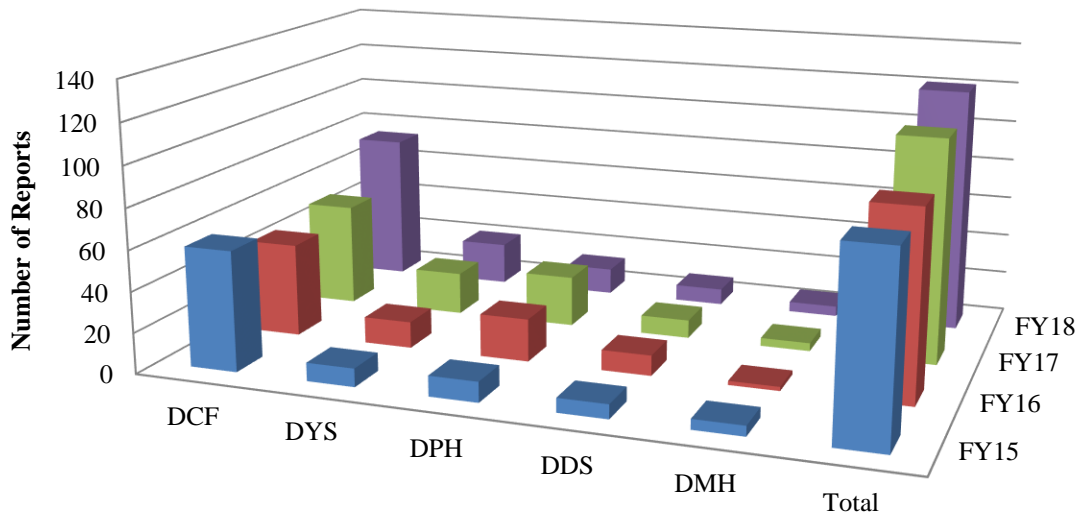
## Overview of Critical Incident Reports (CIRs)

During FY18, the OCA received 121 statutorily required CIRs regarding 115 incidents involving 116 children. The number of reports does not equal the number of incidents or children because:

- two agencies may submit a report on the same child if the child is receiving services from both agencies; or
- one agency can submit multiple reports on one child if the nature of the child’s injury changes (e.g. from near fatality to fatality).

Figure 5 shows the number of CIRs per agency from FY15-FY18. The total number of reports from DCF steadily increased from FY17 to FY18, which is likely the result of the OCA’s collaboration with them on the *Critical Incident Reporting Definitions Pilot Project*.

**Figure 5: Number of CIRs Submitted per Agency  
FY15-FY18**



	DCF	DYS	DPH	DDS	DMH	Total
■ FY15	59	9	10	7	5	90
■ FY16	46	13	21	10	2	92
■ FY17	51	21	25	9	4	110
■ FY18	74	21	13	8	5	121

## Age and Gender

We have gender information for 113 children, 65% (73) were identified as male and 35% (40) were identified as female <sup>9</sup>. The gender distribution is similar to F17.

Historically, children up to the age of three are most impacted by critical incidents. As shown in Figure 6, while the number of children birth-to-three is within the typical range (39-42 per year), the number of youth 16-21 years-old has increased by 64% since FY17.

**Figure 6: Age Range of Children in CIRs  
FY15-FY18**

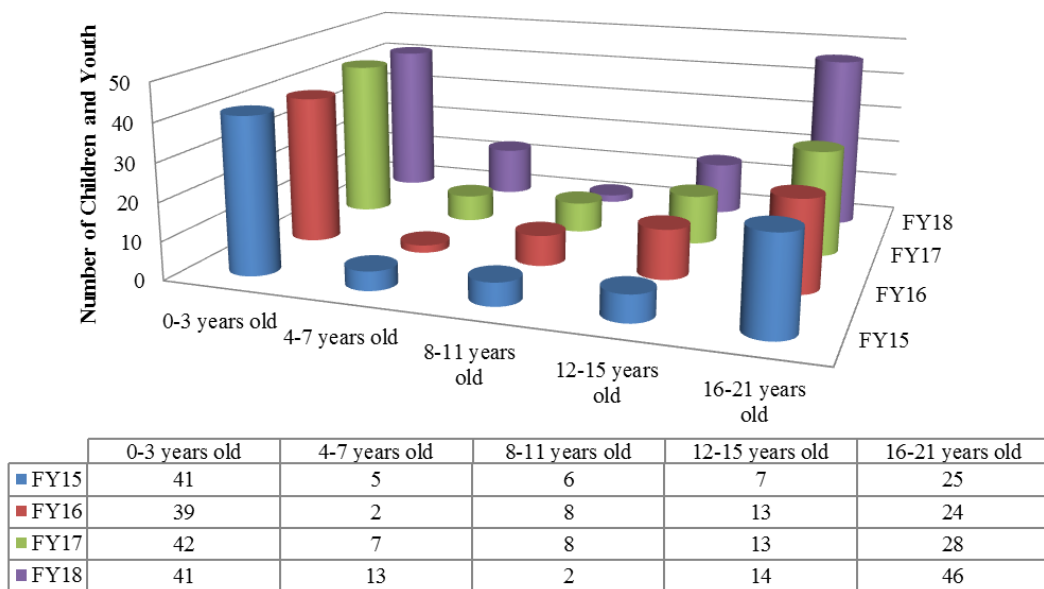


Figure 7 shows the distribution of CIR categories over the previous four fiscal years: fatalities, near fatalities, serious bodily injuries and emotional injuries.<sup>10</sup>

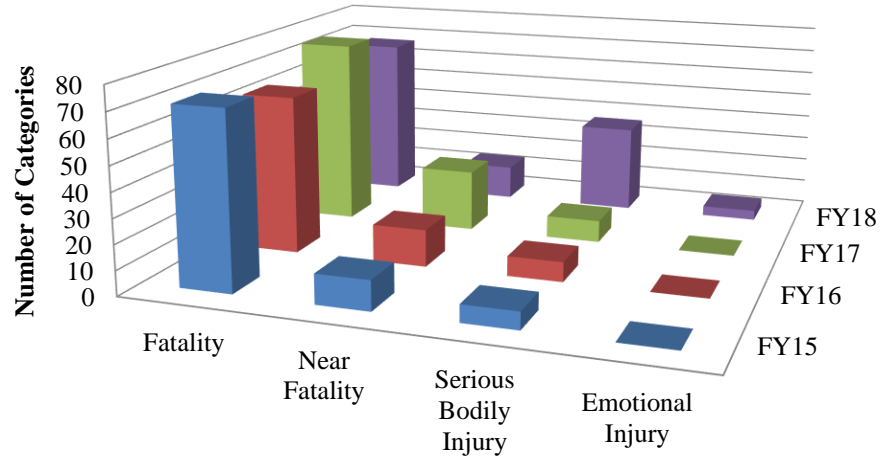
As a result of the OCA applying the refined CIR definitions finalized in October 2018 to the FY18 critical incident reports, some critical incidents were recategorized. For example, an incident that was categorized as a near fatality could have been recategorized as a serious bodily injury. This recategorization has contributed to the decrease in near fatality reports for FY18 and sharp increase in serious bodily injury reports.

<sup>9</sup> Data on gender is based on what the agency lists as the child's gender in the CIR and/or information in related agency reports, if available. Children and youth do not self-identify in these reports.

<sup>10</sup> In 2016, emotional injury was added to the OCA's statutory definition of critical incidents.

In FY18, there were 36 reports regarding serious bodily injuries, which is approximately four times the amount reported in FY15 to FY17.

**Figure 7: CIR Categories by Fiscal Year**



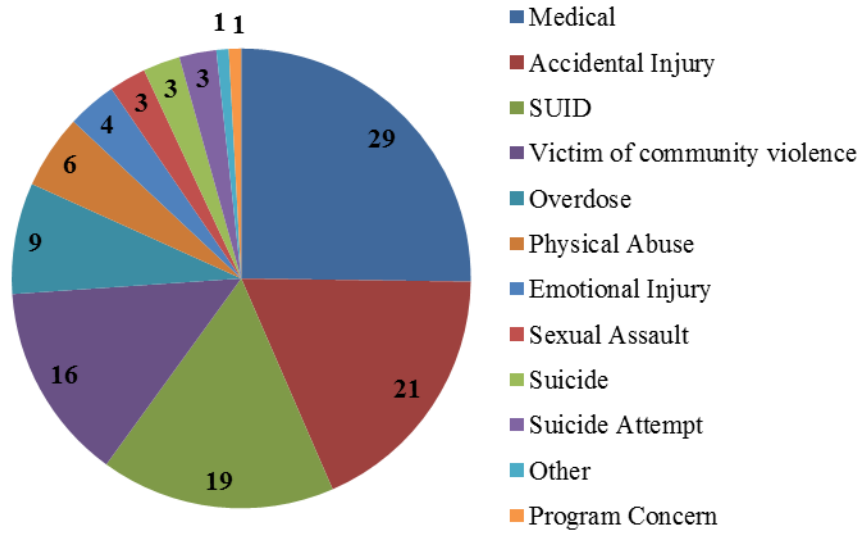
	Fatality	Near Fatality	Serious Bodily Injury	Emotional Injury
■ FY15	71	12	7	0
■ FY16	64	15	8	0
■ FY17	76	25	9	0
■ FY18	67	14	36	4

Figure 8 shows the types of incidents reported in FY18 CIRs across all agencies.<sup>11</sup> In total, 25% of reports were regarding medical conditions, 21% were regarding accidental injuries and 16% were regarding sudden unexpected infant death (SUIDs). Almost all youth who were victims of community violence were injured or died from gunshot wounds (14).

<sup>11</sup> The “other” category includes four emotional injuries, one sexual assault, one self-harm incident and one pending.



**Figure 8: FY18 CIRs by Type of Incident  
(n=115 incidents)**



## Fatalities

Figure 9 shows the number of fatality reports across agencies from the past two fiscal years.

**Figure 9: Number of Fatality Reports  
FY17 and FY18**

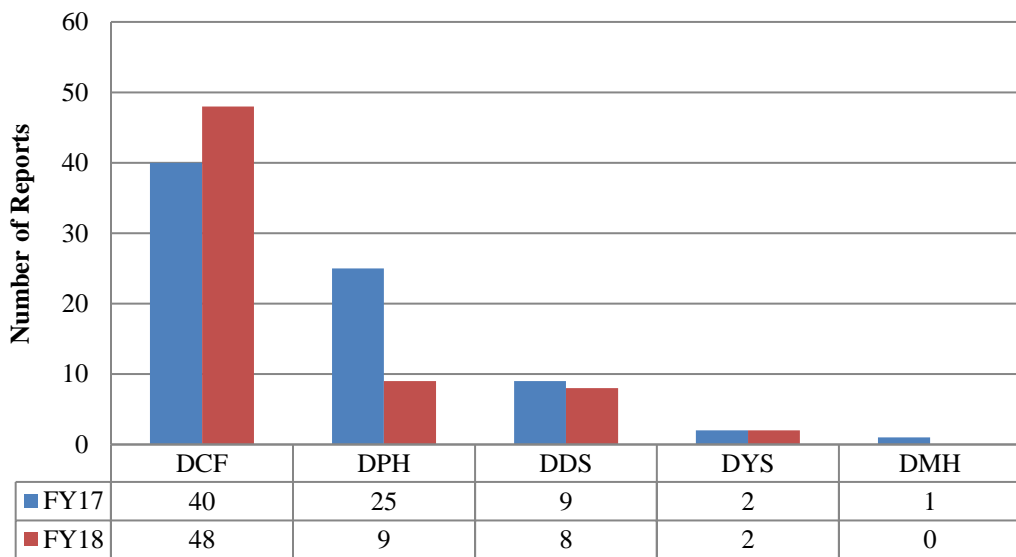


Figure 10 shows the types of fatalities reported in critical incidents. Twenty-nine (29) fatality reports were the result of life-limiting medical conditions or other complex health needs. DCF reported 13 deaths due to medical causes, DDS reported seven and all nine of DPH’s fatality reports were children with complex health needs.

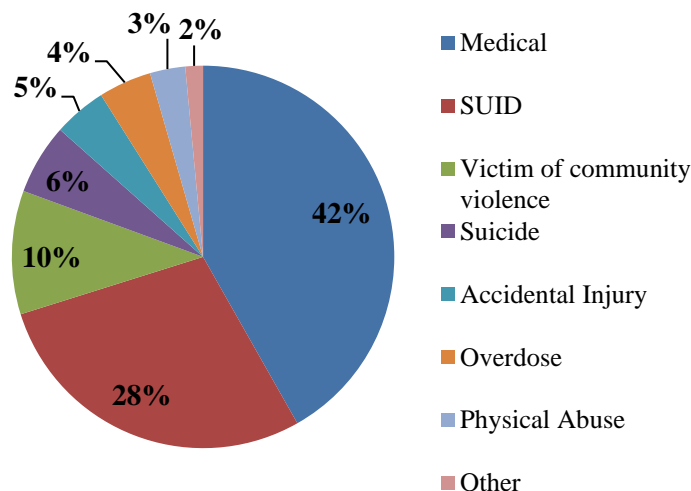
Sudden Unexpected Infant Death (SUID) was the second most common type of fatality reported in critical incidents. Of the reporting agencies, most of the fatality reports about children birth-to-three are from DCF (27). Of those 27 deaths, 17 were SUID. There was no change in the number of SUID deaths over the past two fiscal years.

The relationship between SUID and unsafe sleep environments is well established. In over half of the 17 SUID deaths (14) for FY18, the infant found was in an unsafe sleep environment. Beginning in FY18, the OCA, EOHHS, DCF, DPH, EEC, DHCD and UMass Medical School formed an *Interagency Safe Sleep Task Force* to develop a safe sleep public education awareness campaign and DPH website redesign, both of which launched in October 2018 and aimed at reducing the number of infant unsafe sleep deaths in Massachusetts.

In FY17, DCF reported one fatality of a youth between 16-22 years-old. In FY18, the number of DCF fatality reports in this age category increased to 14. Fatalities in this group include:

- three medical deaths
- three overdoses
- three suicides
- three victims of community violence (gunshot wounds)
- two accidental injuries (car accidents)

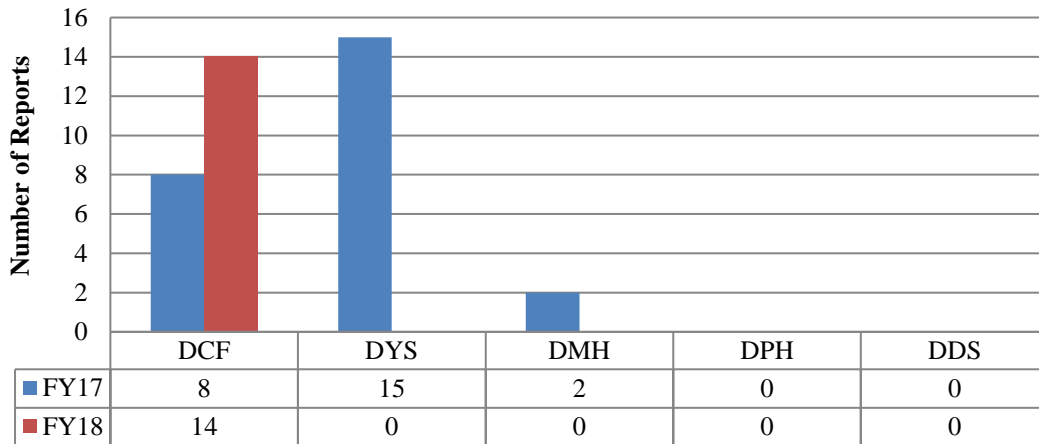
**Figure 10: FY18 Fatality Reports by Type of Incident  
(n=67 incidents)**



## Near Fatalities

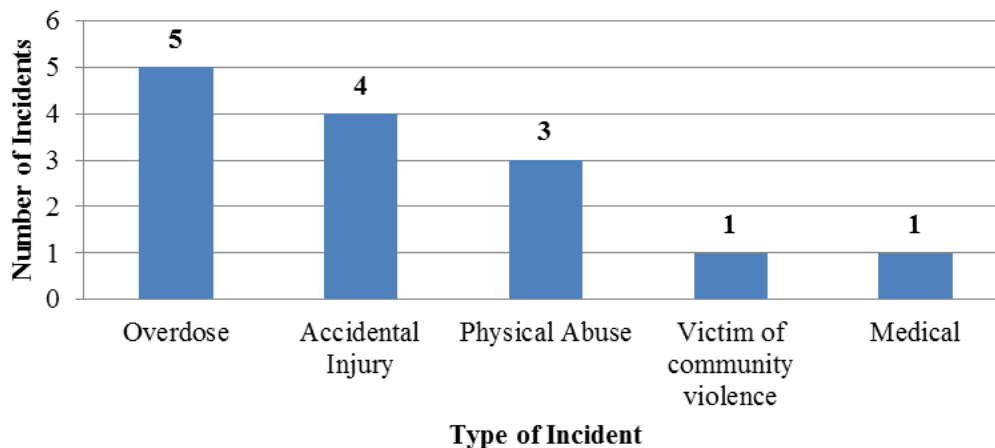
Near fatal injuries are accidental, or the result of a medical condition or the result of abuse and/or neglect and are dependent on verbal certification by a physician that the child’s condition is considered life threatening. Figure 11 shows that DCF was the only agency to report near fatalities in FY18.

**Figure 11: Number of Near Fatality Reports  
FY17 and FY18**



As seen in Figure 12, overdoses were the most common type of near fatality incident, followed closely by accidents and physical abuse. Not only were adolescents and young adults affected by overdoses, but two children under the age of five accidentally overdosed by coming in contact with substances in the home.

**Figure 12: FY18 Near Fatality Reports by Type of Incident  
(n=14 incidents)**



## Serious Bodily Injuries

A serious bodily injury, as defined by the OCA statute, involves one or more of the following:

- a substantial risk of death;
- extreme physical pain;
- protracted or obvious disfigurement;
- protracted or loss or impairment of the function of a bodily member, organ, or mental faculty; or
- emotional injury.

Figure 13 shows that in FY18, the number of serious bodily injury reports from each agency is at least twice the number reported in FY17.

**Figure 13: CIR Serious Bodily Injury Reports by Agency  
FY17 and FY18**

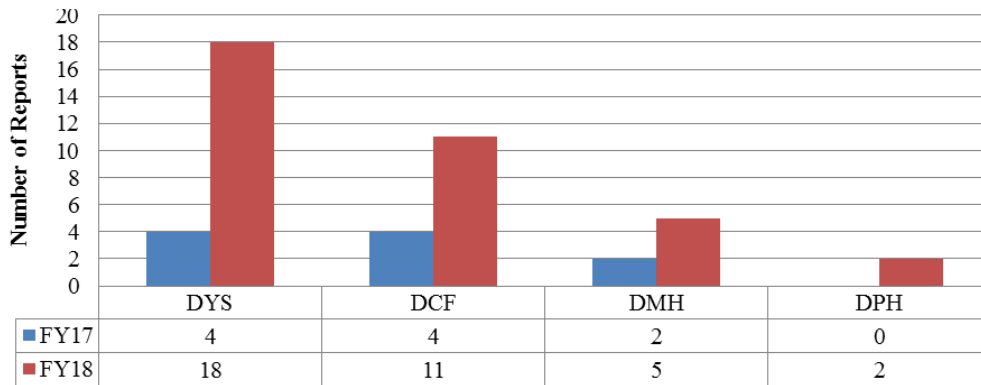
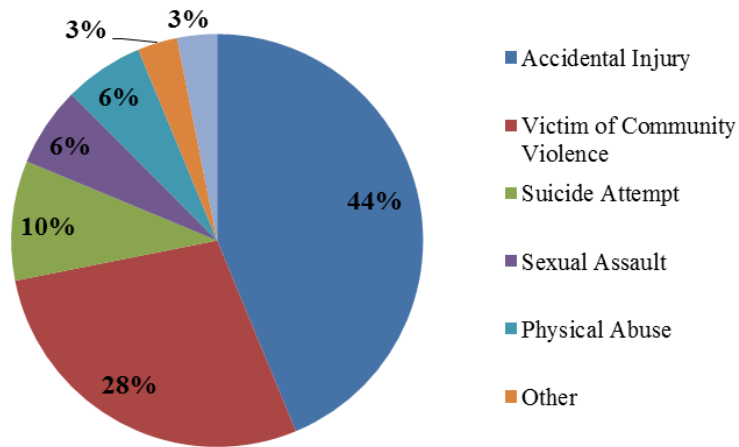


Figure 14 shows the types of incidents that led to serious bodily injuries in FY18. Almost half of these incidents were accidental injuries (14). The majority of these were motor vehicle accidents.<sup>12</sup>

The largest age group in serious bodily injuries is adolescents. DYS reported over four times the number of serious bodily injuries in FY18 compared to FY17. The DYS population is primarily adolescents and young adults, so any increase in DYS reporting will raise the overall number of in this age group.

<sup>12</sup> The reason that the number of SBI incidents (32) is different than the number of reports (36) is because the OCA receives multiple reports about the same incident if the child receives services from more than one agency.

**Figure 14: Serious Bodily Injury Reports by Type of Incident  
(n=32 incidents)**



## Emotional Injuries

In July 2016, emotional injury was added to the OCA’s statutory definition of critical incident. Determining when an emotional injury has occurred is multifaceted and developing a definition of emotional injury for the purposes of critical incident reporting required careful consideration. To develop the definition of emotional injury, the OCA:

- conducted national research on the definition and the impact of an emotional injury;
- examined the types of fatality, near fatality and serious bodily injury critical incidents being reported to the OCA; and
- incorporated developing an emotional injury definition into the *Critical Incident Reporting Definitions Pilot Project*.

The OCA determined that due to the difficulties in determining when an emotional injury has occurred, for the purposes of critical incident reporting it is important to set parameters in the OCA definition of emotional injury. Effective FY18, the OCA defines emotional injury as:

*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.*

This definition is a starting point. We started here because it captures incidents that the OCA believes to be emotionally harmful to a child and would otherwise not be reported to the OCA. Our intention is to continue to review and consider other types of emotional injury, including emotional injury resulting from sexual assault and/or abuse.

In FY18, four emotional injuries were reported to the OCA: two from DPH, one from DCF and one from DYS. In these incidents, children were either witnesses to violence in the home or community or to the overdose of a parent.

The OCA expects the number of reported emotional injuries will sharply increase as the new definition of emotional injury is applied across all EOHHS agencies beginning in FY19.

# OCA Analysis of Critical Incident Reports

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The OCA prioritizes preventable childhood injury and death as one of its focus areas<sup>13</sup>. As such, the OCA analyzes all critical incidents, as the risk of injury or death due to an accident, unsafe sleep environments, suicide and violence can be decreased with proper outreach and prevention.

The OCA is concerned with the increase in the number of adolescents and young adults involved in critical incidents and the rise of serious bodily injury reports. The OCA recognizes that a better understanding of critical incident reporting definitions and criteria has likely contributed to these increases. The OCA also believes that more work needs to be done to protect adolescents and young adults, especially from accidents, substance use and violence in the community. Gun violence resulted in six fatalities, six near fatalities and two serious bodily injuries in FY18. Nearly 80% of these victims were between the ages of 16-22 years old.

Preventing injuries and deaths of all children and youth requires a team approach and the OCA will continue to collaborate with agencies to develop strategies aimed at protecting children's safety.

## Critical Incident Report Agency Follow-Up

In addition to reviewing critical incidents to identify trends, the OCA also conducts an administrative review of every critical incident to learn more about the circumstance of the incident and the agency involvement with the child and family. For children receiving services from DCF, we focus our case review on whether maltreatment may have contributed to the injury or death and whether there was a missed opportunity for DCF to assist the family and protect the child. For youth receiving services from agencies other than DCF, OCA staff request additional information in select cases to review case management practices.

When the OCA is concerned that the actions or inactions of a reporting agency may have contributed to the incident, OCA staff may request investigation reports from the agency, speak with staff, review case records to learn more about the family history and involvement with the agency and promote accountability.

The OCA maintains a database of all critical incident reports, which contains important information about the incident, such as: child-specific and family information, state agency history with the family, past or current allegations of abuse or neglect and any follow-up the OCA has conducted with the agency involved. We use this information to identify case practice

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<sup>13</sup> Only the Office of the Chief Medical Examiner (OCME) can make the final determination regarding the cause and manner of a child's death.

concerns specific to the child and family involved, as well as system-wide patterns and trends about preventable childhood injuries and deaths.

In FY18, the OCA did not have any direct follow-up with DDS, DMH or DPH concerning their submitted CIRs, as most of the incidents were medically related deaths. When a report of alleged abuse and/or neglect was filed with DCF<sup>14</sup> by DDS, DMH or DPH, the OCA reviewed the DCF investigation of the critical incident.

#### *Department of Children and Families (DCF)*

The OCA received 74 CIRs from DCF in FY18 and followed up on 29 of them. Most of the follow-up was concerning case practice issues the OCA identified upon review of the family's involvement with DCF. The identified case practice issues did not necessarily contribute to the critical incident but warranted the attention of DCF according to the OCA.

Through our review of DCF CIRs, the OCA also requested information from DCF to learn more about their work on specific topics. These topics include:

DCF Fatality Review Reports – Per DCF regulation<sup>15</sup> (110 CMR 13.00), the specialized DCF Case Investigation Unit (CIU), located within DCF Central Office, is required to conduct an internal review of all deaths of a child in a DCF involved family regardless of whether abuse and/or neglect has occurred. A DCF Fatality Report, which includes recommendations, is then written on each death.

The OCA receives all DCF Fatality Reports and reviews each report to be informed of any identified policy or case practice concerns with the agency's work with the family. In FY18 the OCA wanted to better understand how DCF is using the recommendations in their Fatality Reports towards their improvement efforts. The OCA learned that:

- The regional and area office staff review the recommendations and incorporate those into management meetings, meetings with supervisors and general staff updates.
- Recommendations are incorporated into area, regional or statewide trainings, depending on the issue.

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<sup>14</sup> DCF is the state agency statutorily required to receive, screen and, if necessary, investigate all allegations of abuse and/or neglect for children under the age of 18.

<sup>15</sup> DCF regulation<sup>15</sup> (110 CMR 13.00), the specialized DCF Case Investigation Unit (CIU), located within DCF Central Office, is required to conduct an internal review of all deaths of a child in a DCF involved family with an current open case or an open case in the preceding six months of the child's death, a family being investigated for abuse and/or neglect, a family who had a supported 51A report, but the case was not opened for services, in the preceding six months.



- DCF tracks the fatality incidents to identify trends. DCF's internal work on ensuring infant safe sleep and participation in the *Interagency Safe Sleep Task Force* is the result of tracking fatality incidents.

Dual Agency Involved Youth – In FY18, the OCA received six CIRs from DCF concerning youth who were also involved with other EOHHS agencies: two with DDS and four with DYS. The OCA asked DCF about their work with other state agencies concerning dually involved youth. The OCA learned that DCF is involved in several projects and initiatives related to this topic area. DCF also currently has a data sharing agreement with DYS to identify dually involved youth. As a part of this agreement, DCF provides DYS the name of a youth's social worker to collaborate and coordinate services and referrals.

Youth Engagement and Substance Use – The OCA has observed an increase in overdoses with the DCF population. In FY18, there were a total of seven overdoses; three fatal and four near fatal. The OCA is concerned about the impact the opioid epidemic is having on children and youth in Massachusetts and wanted to learn more about DCF's work with youth who are using substances. The OCA learned that DCF has multiple projects and initiatives in this area. A couple highlights are:

- In 2016, DCF began expanding its substance abuse capacity in response to the opioid crisis. DCF's FY16 budget included funding to double the number of substance abuse coordinators from five to 10. Rather than have a specific caseload, substance abuse coordinators consult with social workers, supervisors and managers on individual situations where substance use is impacting families and a parents' capacity to take care of their children.
- In 2018, DCF held its first agency-wide forum on opioids, *The Opioid Epidemic and Child Welfare: Responding with Collaboration and Innovative Practices*. The forum was attended by approximately 200 DCF managers and social workers and included remarks from the Commissioner and presentations from DCF, physicians and substance abuse experts.

#### *Department of Youth Services (DYS)*

The OCA received 32 CIRs from DYS in FY18 and followed up on 21 of them. The goal of the OCA follow-up is to develop a better understanding of the incident, the recovery of the youth and DYS intervention post-incident. DYS has a substantive post-incident response process as part of their continuous quality improvement efforts.

# Abuse and/or Neglect in Out-of-Home Settings

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DCF is the state agency with the statutory mandate to receive, screen and investigate allegations of abuse and/or neglect of a child under the age of 18 in any setting. These settings include a child's home or out-of-home settings such as congregate care, foster care (including kinship care), licensed and unlicensed child care centers, preschools, elementary and secondary schools, hospitals and transportation services.

The OCA receives reports of abuse and/or neglect<sup>16</sup> that were investigated and supported by DCF regarding children in all out-of-home settings. The reports contain the following information:

- demographic information on the child and the alleged perpetrator of the abuse and/or neglect (e.g. foster parents or residential treatment program staff);
- details of the investigation, including summaries of interviews and relevant documents; and
- the basis for the decision to support or unsupport allegations of abuse or neglect.

OCA staff review, analyze and discuss each report. In FY18, the OCA contacted select state agencies to request additional information or discuss the incident that led to a supported allegation of abuse and/or neglect. Examples of these contacts include:

- DCF concerning details and/or decisions about the status of specific foster homes;
- DMH concerning multiple reports of abuse and/or neglect in a DMH licensed inpatient unit;
- DYS concerning staffing and programmatic issues in detention and treatment programs; and
- EEC concerning staffing and programmatic issues in EEC licensed congregate care or child care settings.

In addition to collaborating with agencies, the OCA uses what is learned from these reviews to inform our interagency work, such as through our participation in the *Child Fatality Review Program*, *Restraint and Seclusion Prevention Initiative* and *Interagency Working Group on Residential Schools*.

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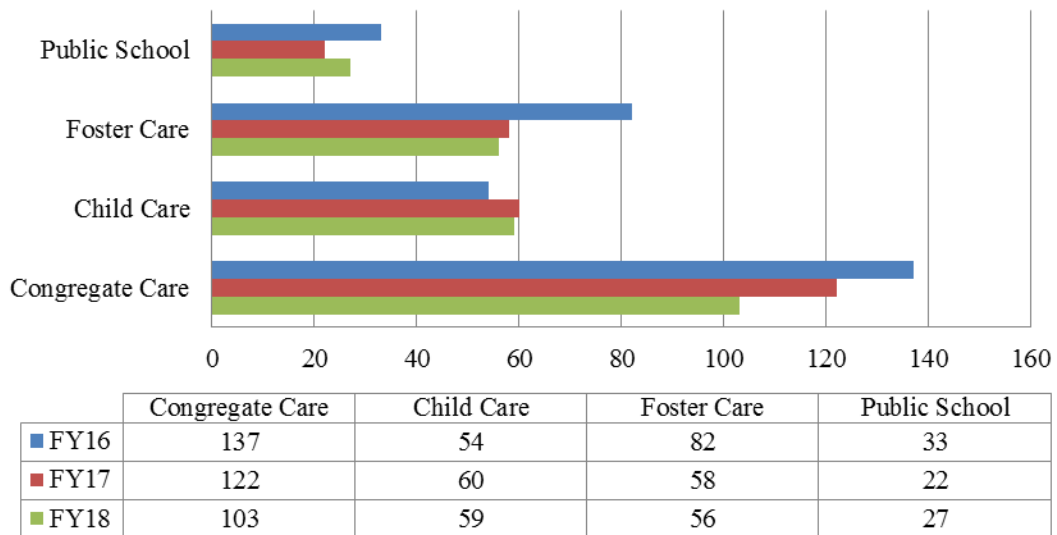
<sup>16</sup> A report of abuse and/or neglect filed with DCF is a "51A" report. The "51B" report is the DCF investigation into the allegations of abuse and/or neglect. (Chapter 119 of Massachusetts General Laws)

## Overview of Abuse or Neglect Reports

In FY18, the OCA reviewed 279 supported reports of abuse and/or neglect that occurred in out-of-home settings, which is almost the same number of reports reviewed in FY17 (276). In these reports, 583 individual allegations of abuse and/or neglect were supported. There are more supported allegations than number of reports because in each report of abuse and/or neglect there could be more than one type of allegation (neglect, physical abuse, sexual abuse, etc.) and/or more than one child or alleged perpetrator involved in the incident.

Figure 15 shows the distribution of supported reports of abuse and/or neglect received across the different types of out-of-home settings.<sup>17</sup>

**Figure 15: Number of Supported Abuse/Neglect Reports by Type of Out-of-Home Setting FY16-FY18**



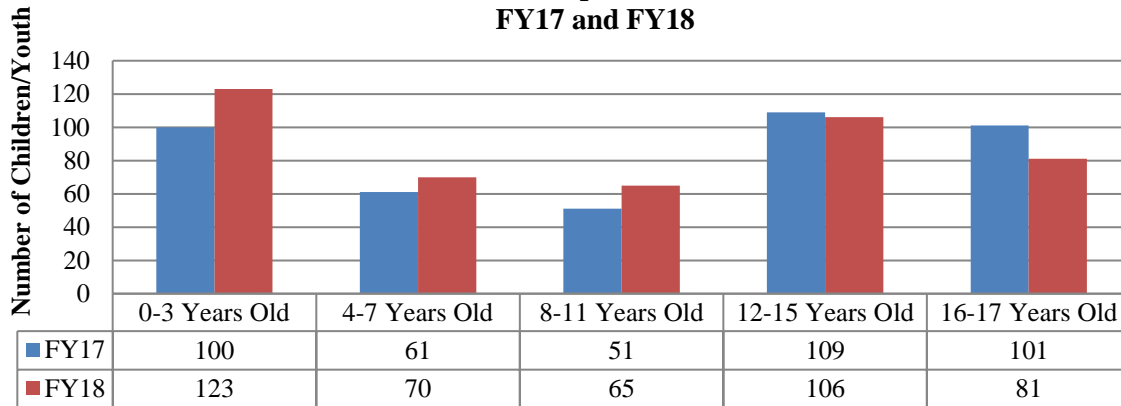
<sup>17</sup> In FY18, the OCA also received eight reports from hospitals, five reports from transportation companies, four reports from private schools, and 16 reports from other settings, such as after-school programs. One report is categorized as “unknown.”

## Age and Gender

At least 445 children were affected by incidents identified in supported 51B investigations. For those children (413) for whom gender information is available, 43% were identified as girls and 56% were identified as boys. One child was identified as transgender/gender non-conforming.

Figure 16 shows the age distribution of children involved in the reports of abuse and/or neglect over the past two fiscal years. In FY17, most of the children involved were 12-15 years-old, but this has shifted in FY18. The number of birth-to-three year-olds increased by 23%. This age group generally appears in reports regarding child care and foster care.

**Figure 16: Age Range of Children Identified in Supported Abuse/Neglect Reports  
FY17 and FY18**

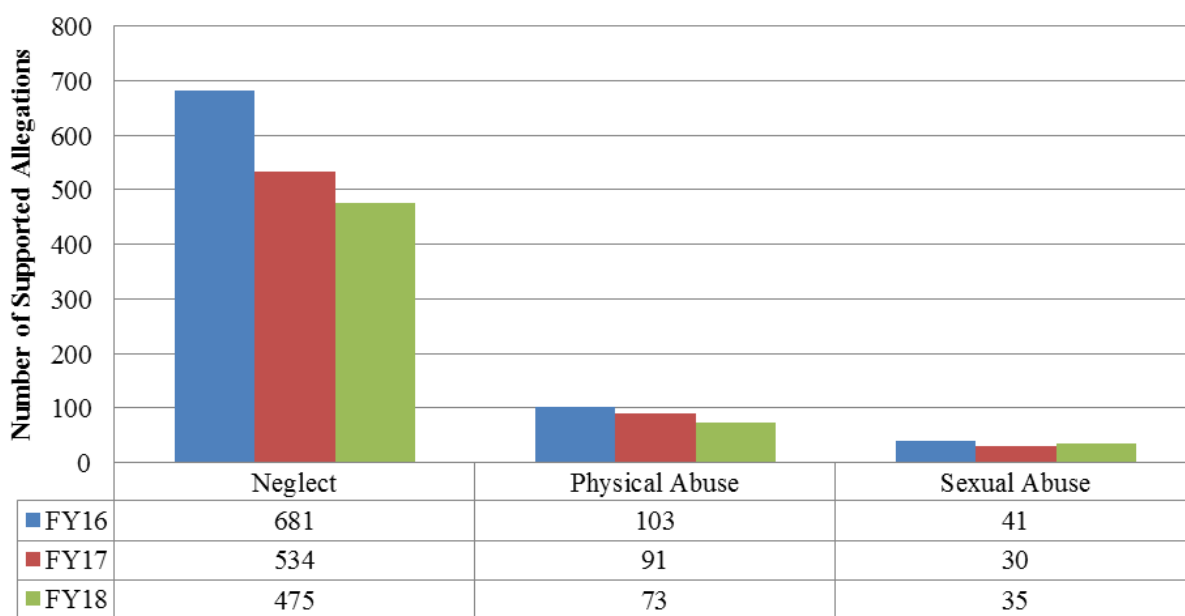


## Supported Allegations by Type of Allegation and Out-of-Home Settings

Figure 17 shows the number of supported neglect, physical abuse and sexual abuse allegations for the past three fiscal years<sup>18</sup>. Historically, and in FY18, the most common type of supported allegation in out-of-home settings is neglect, followed by physical abuse and sexual abuse. For all supported allegations of neglect in Massachusetts, which includes the home setting, neglect is 6.5% more prevalent than physical abuse and 13.5% more prevalent than sexual abuse.

<sup>18</sup> In FY18, there was also one supported death allegation and one supported allegation of human trafficking – sexually exploited child.

**Figure 17: Supported Allegations by Type  
FY16-FY18**



*Child Care*

In FY18, the OCA received 59 supported reports of abuse and/or neglect in child care. At least 104 children were affected by these incidents and most of the children (81) were between the ages of birth-to-three years-old.

Supported physical abuse allegations have increased to almost the same as FY16. Examples include using too much force with a child, grabbing a child’s arm or leg or throwing an object at a child for misbehaving.

Thirteen (13) children in child care suffered injuries due to abuse and/or neglect in FY18. The types of injuries included:

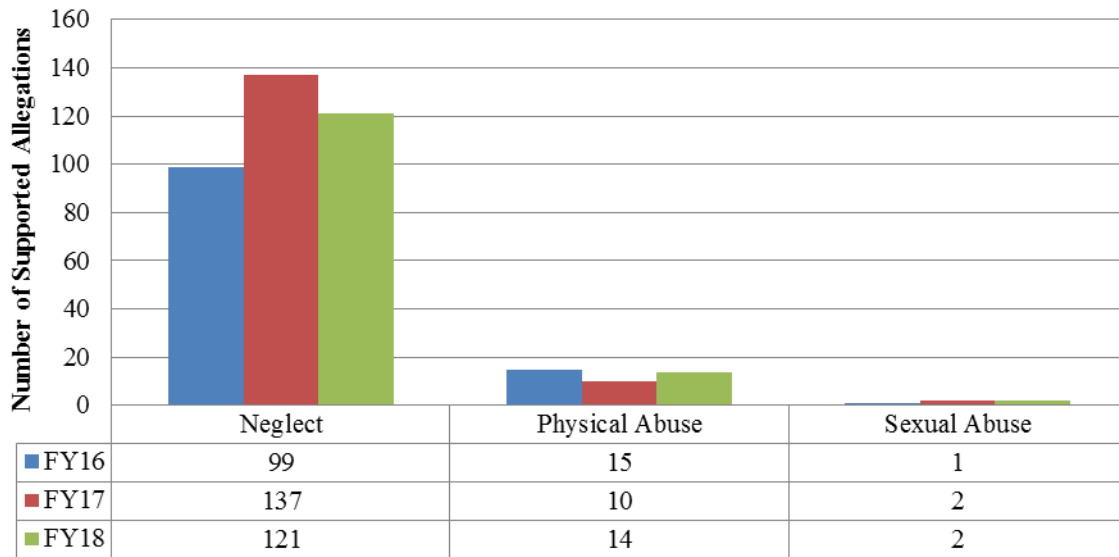
- seven abrasions (cuts, bumps, bruises)
- two deaths resulting from unsafe sleep
- two allergic reactions
- one burn
- one bruised bone

Four of these injuries were determined to be accidents and six were the result of caregiver actions. These actions include use of inappropriate discipline, poor supervision and failure to

provide the child with proper medical care. The causes of the remaining two injuries are unknown.

Figure 18 shows the number and type of supported allegations in child care over the past three fiscal years.

**Figure 18: Supported Allegations in Child Care  
FY16-FY18**

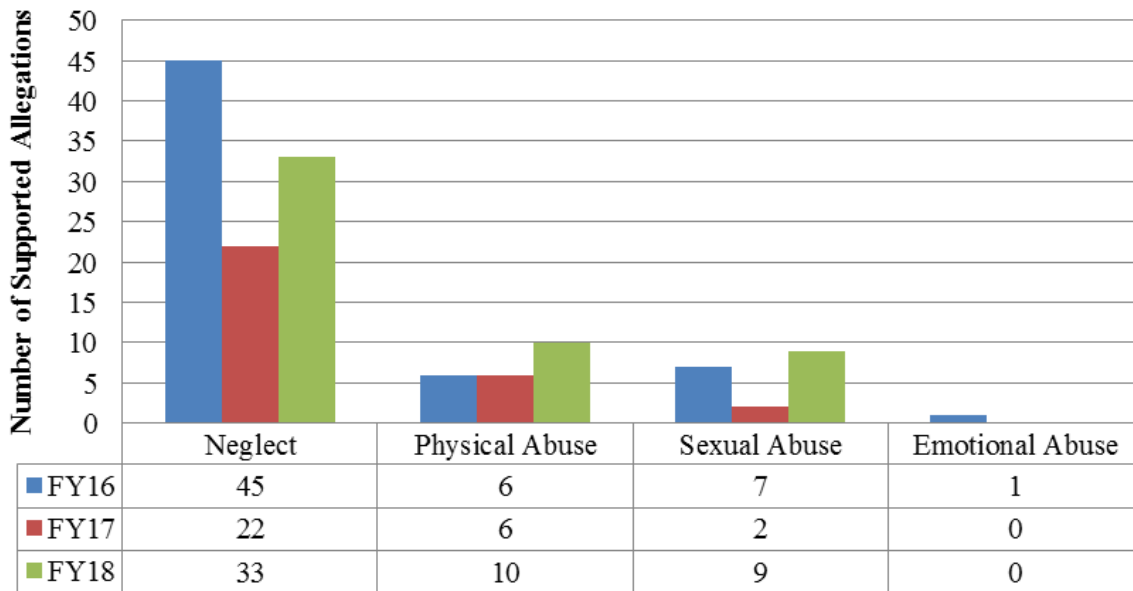


*Public Schools*

The OCA received 27 reports of supported abuse and/or neglect allegations in public schools and 40 children were affected by these incidents. Fourteen (14) children are between the ages of 12-15 years-old, followed very closely by 8-11 years-old (13). For those with gender information (31), 52% were identified as girls (16) and 48% identified as boys (15).

Figure 19 shows the distribution of supported allegations over the past three fiscal years. At this time, the OCA has not developed categories for tracking incidents of neglect in public schools.

**Figure 19: Supported Allegations in Public Schools  
FY16-FY18**



*Foster Care*

When a child is removed from their home by DCF for abuse and/or neglect and the juvenile court grants DCF custody, they may be placed in a foster home. There are several types of foster homes including kinship, child-specific, DCF unrestricted and comprehensive foster care. Table 3 lists the types of foster care and definitions.

**Table 3: Types of Foster Care**

Foster Care Type	Definition
<b>Kinship</b>	Kinship foster care providers are related to the child by blood, marriage or adoption.
<b>Child Specific</b>	Child specific foster care providers are non-kinship individuals who are a significant adult in the child’s life to whom the parents ascribe the role of family. These foster care providers are licensed for a particular child.
<b>DCF Unrestricted and/or Pre-Adoptive</b>	An unrestricted and/or pre-adoptive foster care provider is an individual who has been licensed by DCF to provide foster/pre-adoptive care for a child usually not previously known to the individual.
<b>Comprehensive Foster Care</b>	Comprehensive foster care programs provide therapeutic services and supports in a family-based placement setting to children for whom a traditional foster care environment will not be sufficiently supportive; are transitioning from a residential/group home level of care and require the intensity of services available through this program; or are discharging from a hospital setting.

The OCA received 56 reports of supported allegations of abuse and/or neglect in foster care and 113 children were affected by these incidents.

**Figure 20: Age Range for Children and Youth in Foster Care (n=113 children)**

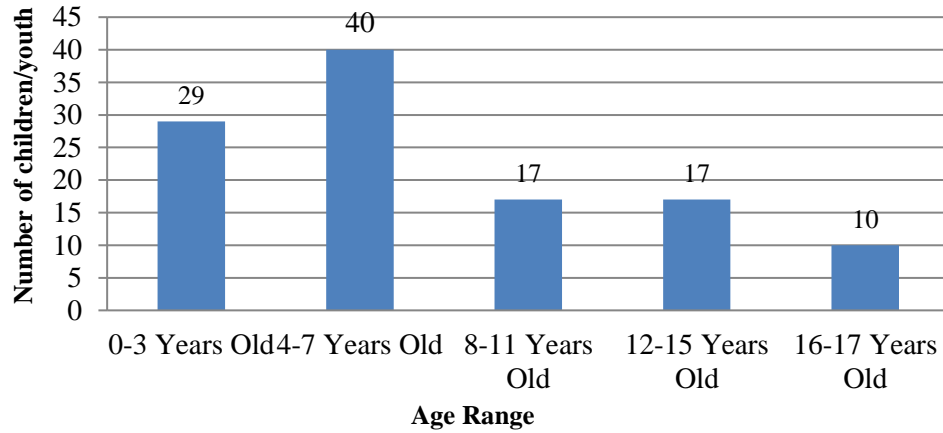
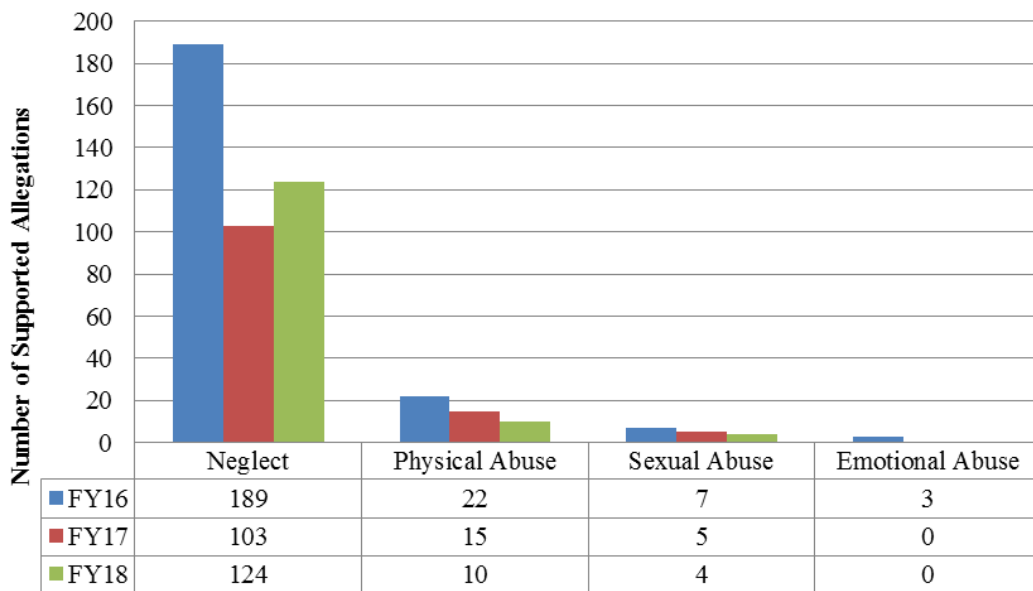


Figure 21 shows the number and type of supported allegations in foster care over the past three fiscal years.

**Figure 21: Supported Allegations in Foster Care FY16-FY18**





## Congregate Care

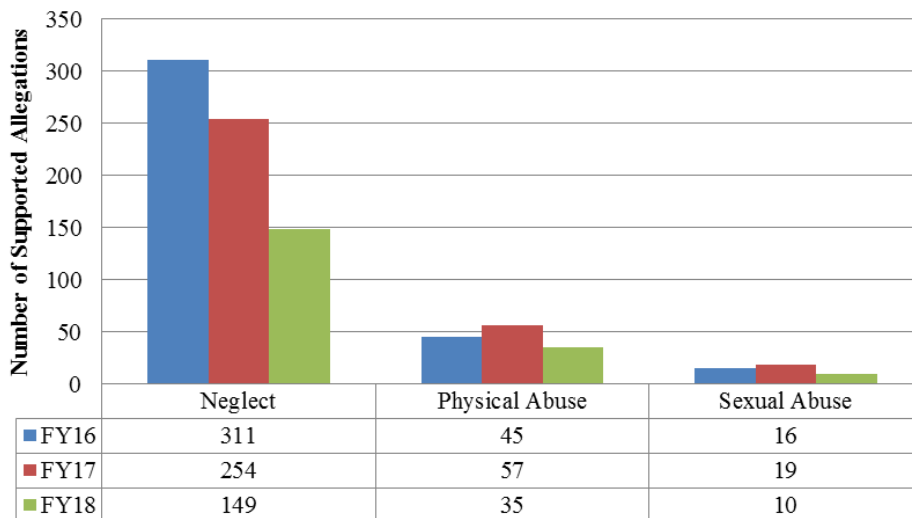
Congregate care programs are for children who need care in a placement setting other than their home or foster care. Congregate care includes short-term stabilization programs as well as long-term group care.

The OCA received 103 reports about congregated care with supported abuse and/or neglect allegations and at least 149 children were affected by these incidents. Sixty-five (65) children were between the ages of 12-15 years-old, followed closely by youth 16-17 years-old (57).

The OCA received gender information for 99 of the children: 50% were identified as boys, 47% were identified as girls and 3% were identified as transgender or gender non-conforming.

Figure 22 shows the number and type of supported allegations in congregated care over the past three fiscal years.

**Figure 22: Supported Allegations in Congregate Care  
FY16-FY18**



Twenty-one (21) children and youth suffered injuries as a result of abuse and/or neglect in congregate care. This is a 52% decrease from the number of children injured in FY17 (51). Over half of the injuries were abrasions (12). Other injuries include:

- two overdoses
- a broken bone
- a concussion
- broken teeth
- head pain
- back pain
- sprain
- poisoning

Over 75% of the injuries were the result of staff actions, including inappropriate restraint techniques and other physical confrontations with youth. Other injuries were the result of children inflicting harm on themselves and in a few incidents, it is not clear whether the injury was accidental.

### **Other Issues and Next Steps**

Since FY17, the OCA has tracked injuries in congregate care programs due to concerns about the improper use of restraints and inappropriate restraint techniques being used in these settings. Injuries occur in all out-of-home settings and it is important to track and analyze this information to ensure the safety of all children. With our new database, the OCA has increased its capacity to easily track injuries and will begin doing so for all out-of-home settings in FY19.

Over the past two fiscal years, the OCA has observed inconsistencies regarding the types of behaviors and actions that result in a DCF supported allegation. In FY19, the OCA will analyze DCF supported reports containing sexual abuse allegations. The analysis will demonstrate what kinds of behaviors result in supported and unsupported sexual abuse allegations and highlight any inconsistencies in DCF investigations. Our goal is to understand how the definitions of sexual abuse is being interpreted in DCF investigations and if further action is needed to improve consistency and accuracy. A similar analysis of physical abuse cases will follow.

# OCA Analysis of Neglect in Out-of-Home Settings

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In FY16, the OCA began developing an internal coding structure to categorize the different types of neglect supported after a DCF investigation in out-of-home settings. The OCA wants to understand the different actions or inactions that lead to supported neglect allegations to determine if there are any trends. With this information, the OCA can identify potential gaps in support services and make recommendations for policy and program changes to lower incidents of neglect in out-of-home settings.

The OCA began developing a coding structure for foster care. The OCA reviewed existing literature about categories of neglect that commonly appear in child welfare investigations. These categories include inadequate supervision, educational neglect, medical neglect and physical neglect.<sup>19</sup> Using this information as a foundation, the OCA engaged in a qualitative review of FY16 supported neglect allegations in foster care. This process led the OCA to develop categories and definitions that are relevant to the types of neglect that occur in the supported reports of abuse and/or neglect the OCA reviews about foster care. In early FY17, the OCA wrote a codebook for foster care neglect that includes categories and definitions.

In FY17, the OCA developed a coding structure for supported neglect allegations in congregate care settings. Following the same coding development process used for foster care, the OCA drafted a list of categories and definitions. Then, the OCA did a qualitative review of supported neglect allegations in congregate care. OCA staff developed a common understanding of each category, definition and applicability to supported neglect allegations. The OCA wrote a codebook for neglect in congregate care that includes categories and definitions.

In FY18, the OCA developed a coding structure for supported neglect allegations in child care settings. Instances of neglect are categorized in family-based and center-based child cares, as well as licensed and unlicensed programs. The OCA reviewed the neglect categories for foster care and congregate care to determine which of them would also be appropriate for child care settings. As we have done in previous years, the OCA conducted a qualitative review of supported neglect allegations in child care to refine these categories and make them applicable to child care programs.

The OCA neglect categories and definitions for foster care, congregate care and child care may be different due to the differences in these types of out-of-home settings.

All OCA neglect codebooks are living documents and subject to further refinement as necessary.

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<sup>19</sup> Child Welfare Information Gateway (2012). *Acts of Omission: An Overview of Child Neglect*. Retrieved from <https://www.childwelfare.gov/pubPDFs/acts.pdf>

## OCA Analysis of Neglect in Child Care

The Department of Early Education and Care (EEC) licenses almost 7,000 child care centers across the Commonwealth. Of these, about 2,400 are center-based programs and over 4,500 are family-based centers, meaning that care is provided in someone’s home and the caretaker is not related to the children.<sup>20</sup>

Neglect is the most commonly DCF supported allegation in child care. While the types of neglect that occur most often in foster care and congregate care are similar to those in child care, there are some important differences. To capture this, the OCA created categories of neglect specifically for child care, as shown in Table 4.

**Table 4: OCA Child Care Neglect Code**

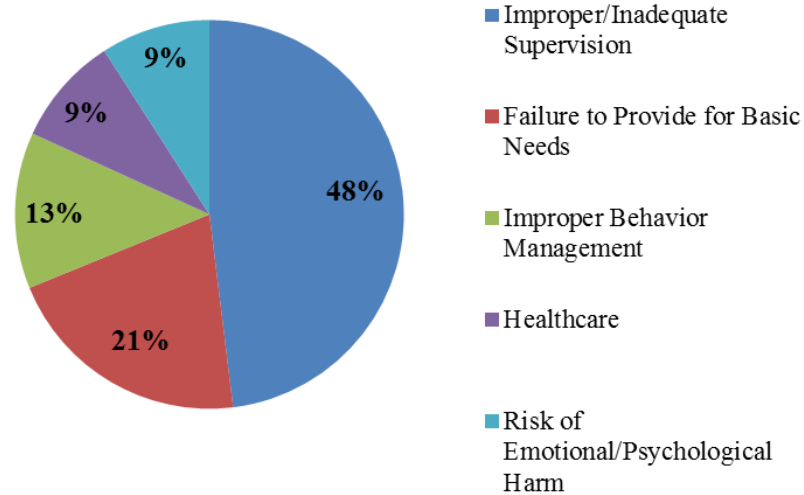
Code	Definition
<b>Improper/Inadequate Supervision</b>	Caretaker engages in activities, actions or inactions that prevent caretaker(s) from being able to properly supervise children.
<b>Risk of Emotional/Psychological Harm</b>	Caretaker exposes child to behaviors, activities, items or actions that pose a risk of harming a child’s emotional or psychological state.
<b>Improper Behavior Management</b>	Caretaker does not respond properly to a child who is exhibiting problematic/concerning behaviors.
<b>Healthcare</b>	Caretaker fails to provide the child with appropriate physical or behavioral health care.
<b>Failure to Provide for Basic Needs</b>	Caretaker does not meet child’s needs for food, shelter, and clothing. This also includes situations where there are safety concerns regarding the center’s physical environment.

Figure 23 shows that in FY18, the most common type of neglect in child care was Improper/Inadequate Supervision (37). Examples of Improper/Inadequate Supervision in these settings include accidentally leaving baby gates and doors unlocked, having more children at the child care than the center’s license allows and hiring caretakers who are not approved by EEC.

<sup>20</sup>These numbers are based off of EEC’s online search tool, EEC Early Education and After School Program Search, <https://eecweb.eec.state.ma.us/childcaresearch/earlyedumap.aspx> Center-based numbers include after school programs, which the OCA does not include in its child care data.

Failure to Provide for Basic Needs is the second most common type (16), followed by Improper Behavior Management (10), Healthcare (7), and Risk of Emotional/Psychological Harm (7).

**Figure 23: FY18 Neglect Categories: Child Care  
(n=77 categorized incidents)**



## OCA Analysis of Neglect in Foster Care

When a child is removed from their home due to abuse and/or neglect, foster care is one placement option. DCF placed 14,363<sup>21</sup> children in foster care throughout FY18. Table 5 lists the types of foster care homes and the number of children placed in each type.

**Table 5: Number of Children in Each Type of Foster Home**

Type of Foster Home	Total Number of Children in Foster Care as of June 30, 2018 <sup>22</sup>
<b>DCF Kinship/Child-Specific</b>	3,469
<b>DCF Unrestricted</b>	2,227
<b>DCF Pre-Adoptive</b>	481
<b>Comprehensive Foster Care</b>	1,465
<b>Total</b>	<b>7,642</b>

<sup>21</sup> All children and youth (any age) placed in Departmental Foster Care or Contracted Foster Care at any time in FY18.

<sup>22</sup> Department of Children and Families Quarterly Profile – FY2018 Q4 (4/1/18-6/30/18), retrieved from <https://www.mass.gov/files/documents/2018/09/18/Quarterly%20Profile%20FY2018-Q4.pdf>

In FY18, reports of supported neglect allegations in foster care affected 101 children in 50 foster homes. This represents less than 1% of the population of children placed in foster care throughout FY18 and approximately 1% of the foster homes in Massachusetts.

Neglect is the most commonly supported allegation in foster care. In FY16, the OCA developed five categories of neglect, as shown in Table 6.

**Table 6: Types of Neglect in Foster Care, as Defined by the OCA**

<b>Code Name</b>	<b>Definition</b>
<b>Education</b>	Failure to assure the child has proper educational opportunities.
<b>Failure to Provide for Basic Needs</b>	Failure to provide the child with proper food, shelter or clothing.
<b>Healthcare</b>	Failure to assure the child has proper and/or timely physical, dental or behavioral health care.
<b>Improper/Inadequate Supervision</b>	Foster parent engages in behaviors, activities, or actions that compromise their ability to properly supervise the child.
<b>Risk of Emotional/Psychological Harm</b>	Foster parent exposes the child to behaviors, activities or actions that pose a risk of harming the child’s emotional or psychological well-being.

OCA staff review each supported report of abuse and/or neglect in foster care and code all types of neglect that are supported in the investigation. For example, if one investigation finds a staff member pushed a child and did not get them medically cleared, these incidents would be counted as two incidents<sup>23</sup> and would be coded as Improper Behavior Management and Healthcare, respectively.

Figure 24 shows that the most common types of neglect are clustered in the same category for the past three fiscal years: Risk of Emotional/Psychological Harm and Improper/Inadequate Supervision. In foster care, Risk of Emotional/Psychological Harm means allowing a child to be exposed to behaviors, activities or actions that may harm the child’s emotional state. This can include using inappropriate discipline techniques, like name-calling, or allowing a child to be exposed to adult situations or content. Improper/Inadequate Supervision includes when foster parents allow a child to have unapproved contact with their biological parents or leave a child with an unapproved caretaker.

<sup>23</sup> The OCA uses the term “incident” to describe the specific behaviors or actions that lead to a supported neglect allegation.

**Figure 24: Supported Neglect Types in Foster Care  
FY16-FY18**

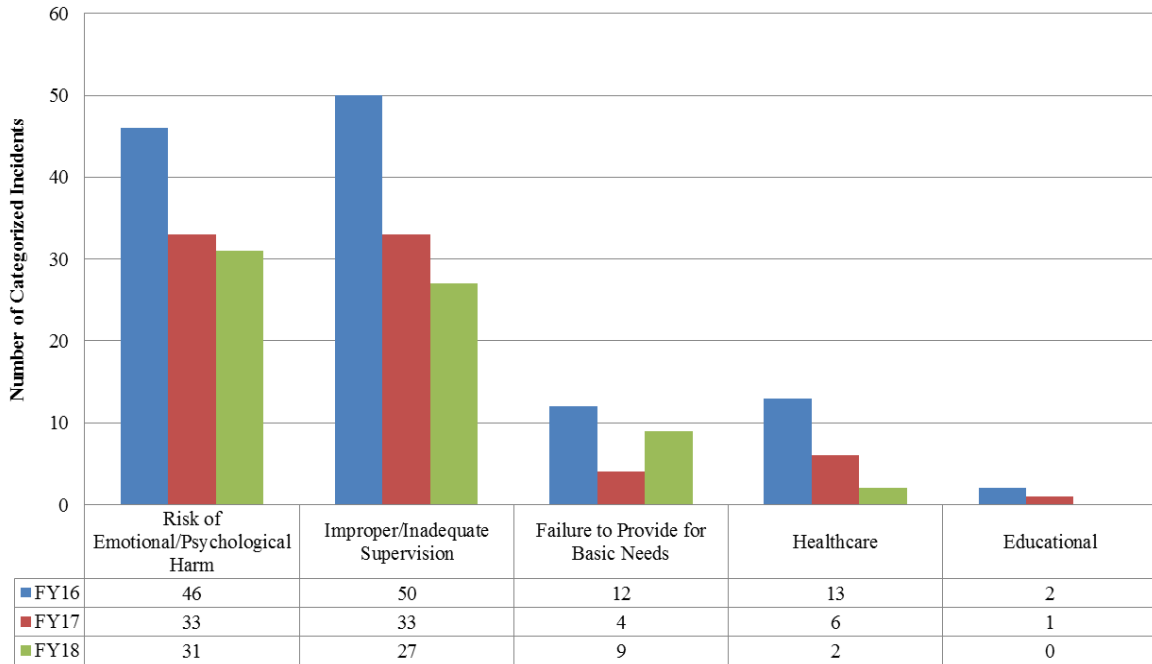
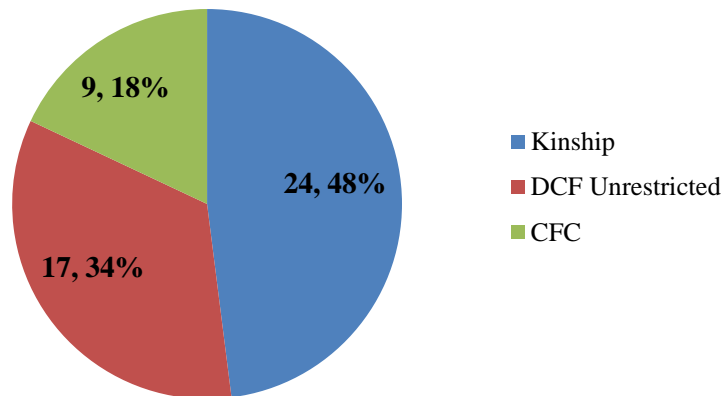


Figure 25 shows the types of foster care placements identified in cases with supported neglect allegations.

**Figure 25: Types of Foster Homes with Supported Neglect Allegations  
(n=50 foster homes)**



## OCA Analysis of Neglect in Congregate Care

Congregate care programs are for children who have needs that require care in a placement setting other than their home or foster care. Congregate care includes short-term stabilization programs, as well as long-term group care. A child in a congregate care program may be placed by DCF or other entities within or outside of Massachusetts, such as other state agencies, local school districts, and parents.

As of June 30, 2018, 1,678 children and youth receiving services from DCF were placed in congregate care.<sup>24</sup> Table 7 shows number of children receiving services from DCF who are placed in congregate care.

**Table 7: DCF Children Placed in Congregate Care**

Type of Congregate Care	Total Number of DCF Children in Congregate Care as of June 30, 2018
<b>Group Home</b>	817
<b>Continuum</b>	14
<b>Residential</b>	450
<b>STARR (short-term residential)</b>	380
<b>Teen Parenting</b>	17
<b>Total</b>	<b>1,678</b>

Neglect is the most commonly supported allegation in congregate care. While the types of neglect that occur most often in congregate care are similar to those in foster care, there are important differences in the types of behaviors underlying the neglect. The OCA created four categories of neglect specifically for congregate care, as shown in Table 8.

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<sup>24</sup> Department of Children and Families Quarterly Profile – FY2018 Q4 (4/1/18-6/30/18), retrieved from <https://www.mass.gov/files/documents/2018/09/18/Quarterly%20Profile%20FY2018-Q4.pdf>



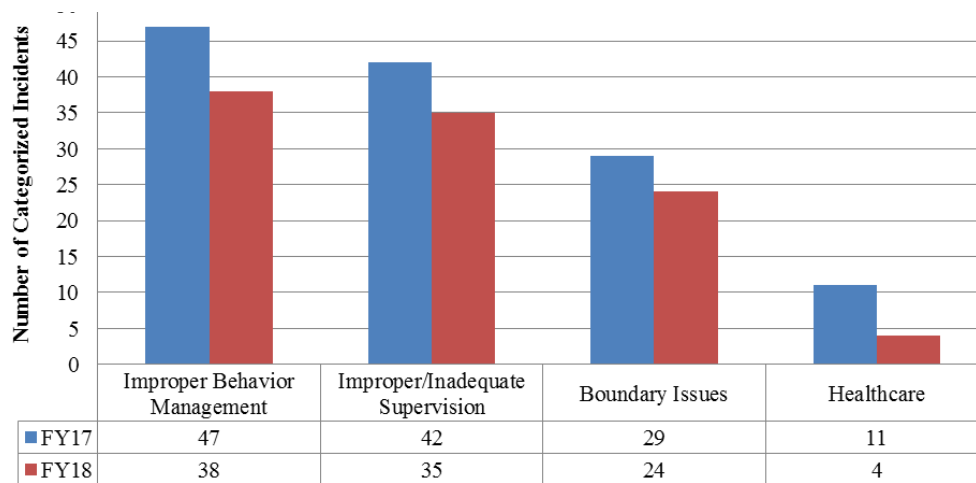
**Table 8: Types of Neglect in Congregate Care, as Defined by the OCA**

<b>Code Name</b>	<b>Definition</b>
<b>Boundary Issues</b>	Congregate care program staff members violate physical and/or emotional boundaries with a child.
<b>Healthcare</b>	Congregate care program staff members fail to ensure the child has proper physical, dental, or behavioral health care.
<b>Improper Behavior Management</b>	Congregate care program staff members do not respond properly to a child who is exhibiting concerning behaviors.
<b>Improper/Inadequate Supervision</b>	Congregate care program staff members engage in behaviors, activities, or actions that prevent them from being able to properly supervise the child.

There are more coded incidents of neglect than there are supported allegations because one allegation may contain multiple kinds of neglect. For instance, if the investigation concludes that a program staff member used social media to contact a child and allowed children to be unsupervised, that would be categorized as both Boundary Issues and Improper/Inadequate Supervision.

As shown in Figure 26, the most common types of neglect that appear in congregate care settings continues to be Improper Behavior Management and Improper/Inadequate Supervision.

**Figure 26: Supported Neglect Types in Congregate Care  
FY17-FY18**



In congregate care settings, the OCA categorizes Improper Behavior Management as failing to de-escalate a situation or using inappropriate physical discipline techniques, including unapproved restraints. Improper/Inadequate Supervision includes staff members failing to conduct 15-minute bed checks during the overnight hours or allowing children to be out-of-sight at the program or in the community.

#### *Workforce and Program Accountability*

Multiple state agencies, including DCF, have responsibilities relating to the licensing of congregate programs as well as the investigation of allegations of abuse and/or neglect in the programs. DCF is unique as it is also responsible for placing children in these programs. Although the OCA has always reviewed DCF’s investigation of allegations of abuse and/or neglect, it is also interested in reviewing investigations of the same allegations by EEC to better understand the implications for congregate programs, and their staff, of these separate investigations.

In 85% (82) of incidents of neglect in congregate care, the OCA found that individual staff members were in fact responsible for their actions. For the remaining 15% (14) of incidents, the OCA felt that program management, including supervisors and program directors, were primarily responsible for the incident. The OCA tracks these incidents, which can include widespread cultural indifference, insufficient staffing and training deficiencies. The OCA then uses what it learns from its review of these reports to inform its other work related to congregate care, including the *Interagency Working Group on Residential Schools*.

# Updates – Building off Fiscal Year 2017

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## Child Sexual Abuse Prevention Task Force

The Child Sexual Abuse Prevention Task Force (Task Force) is a multidisciplinary group that was established in 2014 (Section 34 of Chapter 431 of the Acts of 2014) and is co-chaired by the Child Advocate and the Executive Director of the Children’s Trust. In June 2017, the Task Force delivered to the Legislature its report, *Guidelines and Tools for the Development of Child Sexual Abuse Prevention and Intervention Plans by Youth Serving Organizations in Massachusetts*<sup>25</sup>.

In FY18 the Task Force focused on developing a plan for the implementation of the recommendations in the report. The group also focused on:

- problematic childhood sexual behavior, including child on child sexual abuse, a topic that could not be fully explored in the initial report; and
- developing design specifications for a new interactive website to assist Youth Serving Organizations (YSO) to implement their own prevention program.

Throughout FY18, the Task Force conducted community outreach forums to gather diverse groups of YSO and community representatives from nine regions of the state. The goals of the events were:

- to create awareness of the Task Force;
- to engage in dialogue with community and business leaders and YSO about the recommendations made to the legislature;
- to gather input into training design and technical assistance for YSO; and
- to listen to the community’s response before taking the next steps of implementation.

The forums drew a total of 193 individuals representing 138 individual YSO across the Commonwealth. Themes and highlights from the participant evaluations included an emphasis on the value of the forums for networking, collaboration, learning, hearing what other YSO are doing to protect children, prevent child sexual abuse and to get updated information and resources.

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<sup>25</sup> [http://childrenstrustma.org/uploads/files/PDFs/Child\\_Sexual\\_Abuse\\_Prevention\\_Task\\_Force\\_Report.pdf](http://childrenstrustma.org/uploads/files/PDFs/Child_Sexual_Abuse_Prevention_Task_Force_Report.pdf)

## Child Fatality Review Program

The Massachusetts Child Fatality Review (CFR) program was established in 2000 following the passage of MGL Ch. 38, Section 2A. Pursuant to the statute, the purpose of child fatality review is to “decrease the incidence of preventable child fatalities and near fatalities” in the Commonwealth.<sup>26</sup> The law requires that Massachusetts have two types of CFR teams; local child fatality review teams (CFRTs) and a state child fatality review team (SCFRT).

Local child fatality review teams are county-based and are responsible for collecting and reviewing information on child deaths and near fatalities, developing an understanding of the causes of these incidents and crafting recommendations to change current policies or practices that can reduce these types of incidents in the future. Eleven local child fatality review teams meet under the leadership of the local District Attorneys’ offices to conduct multidisciplinary reviews of individual child deaths. The local teams formulate recommendations for the state team to consider, including changes to statewide policy, practice and/or regulations.

The state child fatality review team is co-chaired by the Office of the Chief Medical Examiner (OCME) and the Department of Public Health (DPH). The Child Advocate is a member of the state team and OCA staff attend the state and local CFRT meetings.

### *Needs Assessment*

At the request of the SCFRT, in FY17 the OCA undertook the first ever comprehensive assessment of the functioning of both the state and local child fatality review teams. The first phase was completed in FY17 and focused on the local teams. <https://www.mass.gov/service-details/oca-project-reports>

In FY18, the OCA completed the second phase of the assessment, which focused on the state team. The goals were to clarify:

- the purpose of the state team;
- the state team goals and objectives; and
- individual team member roles and responsibilities.

As with the local team assessment, the OCA also asked state team members to identify the benefits and challenges of participating on the state team and share ways the team could better meet its goals.

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<sup>26</sup> MGL Ch. 38, Section 2A

In August and September, the OCA interviewed two long-time state team members and the state team leadership from OCME and DPH. In September and November, the OCA asked all state team members and guests to complete a survey about their experiences on the state team. The results from the state team were synthesized with the findings from the local teams to create [a comprehensive report](#) with recommendations for the statewide program. The recommendations are summarized below:

**Figure 27: Summary of OCA Recommendations for Child Fatality Review**

Guidelines	Communications	Capacity Building
<ul style="list-style-type: none"> <li>• Create guidelines for the state and local teams to clarify roles, responsibilities and expectations of its members.</li> <li>• Provide local teams with training on the new guidelines.</li> </ul>	<ul style="list-style-type: none"> <li>• Ask DPH liasons to share updates with local teams about state team activities and vice versa.</li> <li>• Create a schedule so local teams know when to expect feedback on recommendations.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide local teams with informational resources on common issues (e.g. safe sleep, suicide prevention).</li> <li>• Add a public policy component to state team functions.</li> <li>• Develop a budget proposal for CFR and identify strategies to obtain funding.</li> </ul>

The OCA will continue to work closely with OCME and DPH to implement the recommendations. The collective goal is to build a more robust CFR program to work toward preventing child deaths and injuries in Massachusetts.

### *New England Regional Meeting*

Massachusetts hosted its first New England Regional Child Fatality meeting. This annual two-day meeting brings together state coordinators and team members from the New England states, as well as Nova Scotia, to share updates about their teams and common challenges facing their states. Each meeting has a theme and the host state invites regional experts to share information on the selected theme. This year the theme was suicide prevention.

The OCA hosted the meeting at the University of Lowell on June 7<sup>th</sup> and 8<sup>th</sup>. The Chief Medical Examiner, Dr. Mindy Hull, gave a presentation on suicide trends in Massachusetts. Other invited experts from the Rhode Island Department of Health and the Riverside Trauma Center discussed how to use data from child fatality review to inform suicide prevention and postvention work in

schools. Suicide prevention is a priority for all the New England teams and the information shared at the conference was well-received by attendees.

### *National Center for Child Fatality Review and Prevention*

The OCA has built a strong relationship with the *National Center for Fatality Review and Prevention (NCFRP)*<sup>27</sup> over the past two fiscal years:

- In September 2017, the Director of Policy and Legal Counsel was invited by the NCFRP to participate in its National Retreat of Thought Leaders. The retreat was held in Estes Park, Colorado and brought together 25 people from across the country, and the United Kingdom, for three days to develop a better resource to guide the reviews of child maltreatment deaths.
- In February 2018, based on the work done on the CFR needs assessment, the NCFRP asked the OCA to be a member of its Data Dissemination Committee. This committee reviews and provides feedback on proposals from researchers who are requesting access to NCFRP's child fatality review data.
- In May 2018, the OCA presented at the National Child Death Review Conference, hosted by the NCFRP in Denver. The OCA presented on our statewide needs assessment, including the tools for how we collected and analyzed the data. The OCA also shared lessons learned to assist other states interested in conducting an evaluation of their own teams.

## **Restraint and Seclusion Prevention Initiative**

Since 2009, the Interagency Restraint and Seclusion Prevention Initiative has sought to reduce and prevent the use of restraint and seclusion in child treatment and educational settings. The initiative brings together leaders from DCF, DDS, DMH, DYS, EEC, and DESE to work in partnership with parents, youth, service providers, schools and community advocates. The current focus is assessing the implementation and impact of the 2016 regulations.<sup>28</sup> The Child Advocate is an active participant in this initiative.

During this fiscal year, the initiative:

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<sup>27</sup> The NCFRP is a national resource and data center for state and local CFR programs. Funded in part by the U.S. Department of Health and Human Services, the NCFRP focuses on technical assistance, training and resources, reporting systems, data analysis, data quality and dissemination as well as national partnerships to move data to action.

<sup>28</sup> Both EEC and DESE promulgated new regulations intended to prohibit the use of seclusion, minimize and/or prevent the use of restraint and reduce the use of prone restraint.

- received training on the use of occupational therapy to reduce the use of restraint and seclusion; and
- planned a two-day conference on *Preventing Violence, Trauma and the Use of Seclusion in Treatment Settings* that was held in December 2018.

In addition, EEC and DESE conducted surveys of their licensed and approved programs to identify the challenges that providers continue to face in implementing the regulations. Based on the surveys, DESE and EEC are drafting a response to the providers clarifying challenges.

## **Interagency Working Group (IWG) on Residential Schools**

Since early 2016 the OCA has coordinated a review of programs that provide educational services to children whose special education needs require they be served in a residential educational setting. This effort was undertaken at the request of Governor Charlie Baker. The OCA convened a Steering Committee with representatives from EOE, EOHHS and the Office of the Governor. The Steering Committee oversees the work of the Interagency Working Group (IWG). The IWG is comprised of representatives of all state agencies responsible for the oversight of residential schools.

### *Fiscal Year 2016*

The Steering Committee focused its initial work on private residential schools with approved special educational programs because they serve vulnerable children and youth. Residential schools are comprised of both a licensed residential program(s) and an approved special education school. Oversight of these schools is spread across multiple agencies, each with their own specific mandate and areas of focus. These schools serve children and youth with diverse and complex needs in an out-of-home setting. The IWG informed this work and included Steering Committee members, as well as key staff from the following state agencies involved in oversight of residential schools:

- Office of the Child Advocate (OCA)
- Executive Office of Education (EOE)
- Department of Early Education and Care (EEC)
- Department of Elementary and Secondary Education (ESE)
- Executive Office of Health and Human Services (EOHHS)
- Department of Children and Families (DCF)
- Department of Mental Health (DMH)
- Disabled Persons Protection Commission (DPPC)

The IWG reviewed the protocols and practices of all involved agencies to catalog current practice and quickly identify ways to improve the sharing of information for better oversight.

#### *Fiscal Year 2017*

The IWG continued its work and concentrated on improving the Commonwealth's systemic capacity to prevent harm to children by more quickly identifying residential schools at risk of experiencing operational challenges, and how state agencies can provide appropriate support and technical assistance to these schools to ensure their safe operation. The Steering Committee hired Public Consulting Group (PCG) to assist in facilitation, research and analysis for the review. In April 2017, the OCA issued a report, *Interagency Working Group on Residential Schools: Review and Recommendations to Improve Oversight and Monitoring*.

The report documented the complex licensing and approval, contract monitoring and incident investigation processes of all the state agencies responsible for these functions. Included was a research-based list of the safety factors that can assist in the identification of programs with risks of health and safety challenges.

In addition, the report outlined a series of recommendations for improving data collection and shared oversight of residential schools. Lastly, the report included recommendations to improve coordination, data sharing, monitoring of safety factors and reduce the need for providers to submit duplicative documentation between EEC and DESE.

#### *Fiscal Year 2018*

In the fall of 2017, the OCA and EOE again contracted with PCG to focus on the two state agencies with oversight of residential schools:

- EEC, which licenses and monitors residential programs across the state; and
- DESE Office of Approved Special Education Schools (OASES), which approves and monitors special education schools.

The scope of this project was to review data and existing IT systems to create a data taxonomy to support state agencies in identifying residential programs at risk. The data taxonomy focused on the safety factors previously identified and agreed upon by the Steering Committee.

For this phase of the project, leadership from the OCA, EOE, EEC and DESE created a Data Sharing Subcommittee of the IWG. PCG worked with this committee to produce a standard data taxonomy across IT systems for EEC (LEAD) and DESE (WBMS).

In July 2018, PCG issued its final report, which includes:



- recommendations with next steps for sharing and collecting safety factor data between EEC and DESE;
- a data cross walk and taxonomy of safety factors for Approved Special Education Residential School programs; and
- short-term recommendations for EEC and DESE to share and collect data in a coordinated process.

Although this report outlines the gaps of data sharing between EEC and DESE, the agencies are engaged in discussions to improve data collection and sharing as it relates to Approved Special Education Residential School Programs:

### *Looking ahead to Fiscal Year 2019*

The OCA looks forward to continuing this important work. We expect to focus on implementing the recommendations for data sharing systems and protocols among EEC, DESE, and EOHHS agencies, as well as to strengthening professional development offerings for residential school administrators and staff.

## **Mapping of Children’s Services**

In FY16, the OCA started a mapping project to develop a greater understanding of the services available to children and families in Massachusetts, as well as the internal processes for the five primary EOHHS agencies providing services to children (DDS, DCF, DMH, DPH, DYS). The OCA met with senior staff from each agency to collect information on the services available to children, the eligibility criteria for those services, data collection processes and how agencies partner with one another to provide services to children. The OCA uses this information to inform and guide our internal work and as a foundation to collaborate with other child-serving EOHHS agencies.

In FY18, the OCA:

- Met with the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), the Massachusetts Commission for the Blind (MCB) and the Department of Transitional Assistance (DTA) to learn about the services they provide to children and families, as well as their internal processes.
- Finalized an *OCA Resource Guide: Child-Serving State Agencies*. Using the mapping project data as a foundation and conducting additional research, the OCA created this online guide for the general public with information about:
  - the children each agency serves (children with complex medical needs, children who need mental health support, etc.);

- services and programs available to children and young adults within each agency
- how to apply for services (if applicable) and what to expect during the application process; and
- additional community resources for children and families.

The resource guide will be updated twice a year, or as needed, to ensure the most accurate information is available. In FY19, the OCA will add information about services available from MCB.

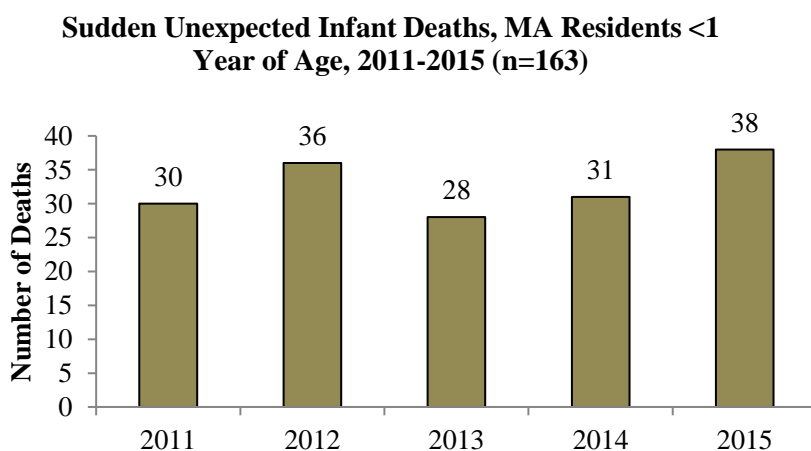
# Fiscal Year 2018 OCA Activities

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## Sudden Unexpected Infant Death (SUID) and Safe Sleep

Newborns are vulnerable to complications arising from pregnancy, fetal development and the birth process, particularly during the first month of life. The Center for Disease and Control and Prevention reports there were 3,607 SUID deaths in the United States in 2016. These deaths occur among infants less than one year old and have no immediate obvious cause.<sup>29</sup>

Sudden Unexpected Infant Death<sup>30</sup> (SUID) is the leading cause of death among infants in Massachusetts ages one to 11 months and the fourth leading cause of death among all children in the Commonwealth from birth to 17 years-old. Approximately 33 infants die suddenly and unexpectedly in Massachusetts each year.<sup>31</sup>



The rate of SUID by Massachusetts district of residence is highest in the Northwest district, which includes Franklin and Hampshire counties. The Cape and Islands district (Barnstable, Dukes, and Nantucket counties) has the second highest SUID rate.

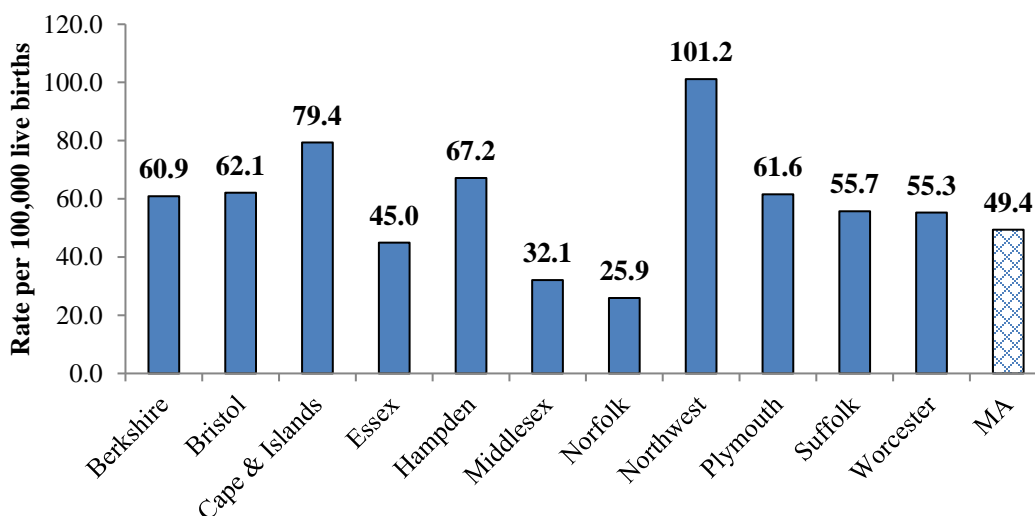
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<sup>29</sup> <https://www.cdc.gov/sids/data.htm>

<sup>30</sup> Sudden unexpected infant death (SUID), also known as sudden unexpected death in infancy (SUIDI), is a term used to describe any sudden and unexpected death, whether explained or unexplained (including sudden infant death syndrome (SIDS) and ill-defined deaths), occurring during infancy. American Academy of Pediatrics Policy Statement, November 2016. Figures and data presented in this section include the following causes of death: SIDS, accidental suffocation & strangulation in bed, and undetermined cause.

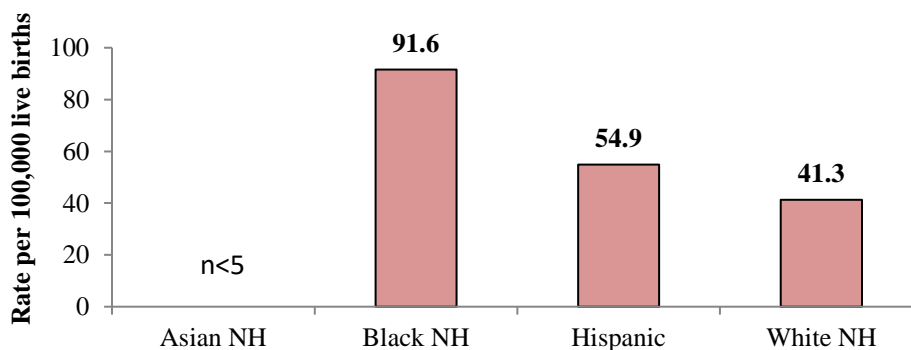
<sup>31</sup> Data in all figures in this section is from the MA linked infant birth-death files, Registry of Vital Records & Statistics, MA Department of Public Health. File dates are: 2006-2011: 7/12/2018; 2012: 7/3/2018; 2013-2015: 6/29/2018. All linked infant birth-death files use the open MA birth and death files at the time of file linkage.

**Average Annual Rate of Sudden Unexpected Infant Death by District of Residence, MA Residents <1 Year, 2006-2015 (n=366)**



In Massachusetts, the SUID rate among Black non-Hispanic infants is more than two times higher than the rate among White non-Hispanic infants. The SUID rate among Hispanic infants is also higher than White non-Hispanic rate.

**Average Annual Rate of Sudden Unexpected Infant Death by Selected Race/Ethnicity, MA Residents <1 Year, 2011-2015 (n=163)**



### *Safe Sleep*

The relationship between SUID and unsafe sleep environments is well established. Review of OCA critical incident data, DPH health data and multidisciplinary reviews conducted by local child fatality review teams have all independently found that many of these deaths are associated with unsafe infant sleep positions (prone or side-lying) and sleep environments, such as bed-sharing or couches.

The understanding of SUID has evolved nationally; in 2016 the American Academy of Pediatrics (AAP) expanded its recommendations concerning safe sleep practices for infants. In 2018, DPH issued “Policy Recommendation: Safe Sleep Infant Practices,” based on the AAP recommendations. These policy recommendations were endorsed by the State Child Fatality Review Team and the OCA.

Beginning in FY18 the OCA, EOHHS, DCF, DPH, EEC, Department of Housing and Community Development and UMass Medical School formed an Interagency Safe Sleep Task Force to develop a public awareness campaign. Additionally, with input from the agencies involved in the Task Force, the OCA is currently reviewing state agency regulations, policies, staff and parent training programs to understand the commonalities and differences. So far, we have found that for those agencies with safe sleep policies and regulations, they emphasize that infants should be put on their backs for every sleep on a firm mattress without any soft items. The OCA is continuing this review and expects to make recommendations to ensure accurate and consistent policies, practices and messaging across the Commonwealth.

## Resources

The Commonwealth now has helpful resources and information available online about what puts a baby at risk and how to protect a baby. <https://www.mass.gov/safesleep>



## **DYS Safety Task Force**

In the fall of 2016, Commissioner Peter Forbes established the DYS Safety Task Force (Task Force). The Task Force included representatives of the Legislature, EOHHS and several state agencies including the OCA, the DYS collective bargaining units and DYS staff. The Task Force was charged with making recommendations for reducing injury to DYS youth and staff as a result of assault by youth, or due to staff intervention during youth-on-youth assaults. The Task Force met nine times over a year and reviewed DYS policies, procedures and practices that informed operations. The Task Force also heard from various subject matter experts.

In February 2018, a report with recommendations was submitted to the Secretary of EOHHS. The recommendations include actions that DYS can implement to supplement and enhance current efforts at DYS to increase safety. The Task Force organized its findings and recommendations into four categories:

### *Staffing*

- Develop and implement more strategies for retaining staff including offering a more realistic preview at time of hire; efforts to improve work/life balance; attention to the adequacy of staffing when unplanned events occur; and a plan for investment in the direct care workforce, including more opportunities for career development and promotion.
- Provide more on the job training, coaching and mentoring with a focus on developing and enhancing situational awareness, defensive disengagement, de-escalation and mediation skills.
- Provide more formal supervisory training for newly hired supervisors, administrators, assistant program directors and program directors.

### *Expectations and Consistent Messaging*

- Improve communications with residential staff to ensure practices in the programs are aligned with DYS policies and expectations as articulated by agency leadership.

### *Residential Programming and Youth Engagement*

- Develop and implement more strategies to enhance programming and youth engagement, particularly during second shift (between 5pm and 9pm) when there are typically more incidents of assaults in the residential programs.
- Strengthen and enhance behavior management and supports used in the residential programs.

## *Incident Responses and Outcomes*

- Establish standards and guidelines for incidents requiring investigations by the DYS investigations unit.
- Educate staff on the requirements of and differences between DCF 51A investigations, EEC investigations, DYS internal reviews and DYS investigations.
- Educate staff on the policies and procedures for reporting, investigating and filing criminal reports when staff are assaulted on the job and the employee support services available to them.

## **Child Welfare Data Work Group**

The OCA is committed to assuring that state agencies present data that is helpful to policymakers and the public by sharing the best available information and putting it into proper context. The OCA's goal is to minimize disagreement about the data, so the focus is on the policy and practice implications of the information.

Over the past decade, the Legislature has increased the number of required reports from DCF. Often these new reports and requests for data are in response to the changing needs and emerging concerns regarding the children served by DCF. As new reports are added, older reports are not always revisited; so reports that were requested in response to a specific event continue to be required, yet the information may no longer be relevant. The OCA identified that a major review of the legislatively required DCF reports was needed and recommended to the Legislature the convening of a multidisciplinary group to review which reports are necessary and which are no longer relevant. In response, the Legislature, in Section 128 of Chapter 47 of the Acts of 2017, created a Task Force on Child Welfare Reporting, which is called the Data Work Group (DWG). Specifically, the Legislature directed the DWG to consider:

- time frames for child welfare data reports (annually, bi-annually, quarterly);
- criteria for measuring service outcomes in child safety, permanency and well-being;
- clearly defined data metrics in the context of historical or comparative data; and
- identification of existing reports that ought to be revised or eliminated.

The Child Advocate and the DCF Commissioner co-chair the DWG<sup>32</sup>. The group met monthly throughout FY18 and continues to meet in FY19. In FY18, the DWG focused on:

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<sup>32</sup> The DWG includes representatives from EOHHS, DCF, OCA, Senate and House Committees on Children, Families and Persons with Disabilities; Committee for Public Council Services, advocacy entities such as the Children's League of Massachusetts, Massachusetts Law Reform Institute, Massachusetts Society for the Prevention of Cruelty to Children and child welfare experts from the Harvard Kennedy School and Purchase of Services providers.

- Developing an understanding of current data collection processes and available data measures, including those required by the federal government. A national expert in child welfare outcomes and data presented on child welfare data reporting nationwide, including what data is required by federal funding sources.
- Developing data measures, progress metrics and key outcomes to provide stakeholders (the public, legislature and advocates) with the status and demographics of the DCF caseload and progress towards achieving its child welfare goals.
- Delineating which types of data would best provide stakeholders with the understanding of how to weigh the quality of data versus its level of detail. Through discussion and analysis, the DWG identified related potential measures and classified them into seven categories.
- Redesigning the DCF Quarterly Profile and Annual Report to include information on transition age youth (18+), to provide more demographic information, information on racial and ethnic disproportionality and more process and outcome measures. A new, expanded Quarterly Profile that provides more comprehensive information, including data for clients over 18 years-of-age was proposed and approved by the DWG in January and is now in use.
- Reviewing federal (AFCARS and NCANDS<sup>33</sup>) data elements that are reported annually and discussing different approaches to presenting data and information to tell a story of services and outcomes. While some outcome measures are defined, more analysis is needed to fine tune components and definitions to assure reports are clear and meaningful to the legislature and the public. Potential annual reports were discussed and will be revised based on stakeholder questions and input.
- Discussing the desirability of distributing and/or publishing Massachusetts data when it is submitted to the federal government (statistical and outcome data is not final until it is accepted and reported by the federal government). This state-federal vetting process results in data being published several years after the close of the federal fiscal year, which reduces the usefulness of information in modifying programs and policy.
- Working with the Legislature to modify mandated reports, some of which are either no longer needed or report information available through other sources such as MMARS, the Commonwealth Information Warehouse and EOHHS systems. The DWG will develop a multi-year reporting plan that reflects planned changes in DCF's electronic database (iFamilyNet) and the availability of improved reporting tools as technology evolves.

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<sup>33</sup> The Adoption and Foster Care Analysis and Reporting System and The National Child Abuse and Neglect Data System.



### *DWG Sub-Committees*

The DWG's monthly meetings led to productive discussion sessions, but the two hour meeting times placed constraints on the group's ability to dig deeply into all topics of interest. Additionally, while the group has a common purpose to disseminate information in a timely manner, stakeholders' needs and priorities are not uniform. For these reasons, smaller group meetings were scheduled to discuss the usefulness and thoroughness of data currently available and its capacity to measure service effectiveness and outcomes. These smaller meetings were designed to:

- examine use of current DCF reports;
- identify differences in data desired by stakeholders;
- determine stakeholder priorities in evaluating quality of services provided;
- consider the importance of longitudinal data in evaluating outcomes; and
- draft recommendations on improving information availability.

Several themes emerged during these Sub-Committee discussions, which will be addressed in FY19. These themes include whether:

- the effectiveness of services and positive outcomes requires qualitative and longitudinal information that is not currently available and is not supported in DCF's current budget;
- DCF requires information/action by other state entities to meet performance standards standard reports need to be published on a predictable schedule;
- reports should distinguish point in time data from operational results;
- DCF should highlight trends and distinguish these from expected annual variations (i.e., seasonal changes that occur every year); and
- visual data, definitions and case vignettes make services more understandable to the public.

### **Foster Care Review (FCR)**

When children are placed in an out-of-home setting by DCF, there is a mandated review required six months after placement and every six months thereafter while placement continues. The purpose of the review is to assess the progress made to address the reason for DCF's involvement with the family and to examine the efforts towards achieving permanency for the child. FCRs are coordinated and run by an independent unit within DCF.

The FCR is conducted by a three person panel whose members are not responsible for case management, oversight or service delivery for the case under review. The panel consists of a member of the Foster Care Review Unit (FCRU), a manager or supervisor from the Area Office

that is not the manager or supervisor assigned to the case under review; and a Volunteer Case Reviewer, a citizen who has been recruited and trained by the FCRU.

In 2017, a bill was filed in the legislature to create a new independent agency to assume responsibility for FCR. The bill is supported by various advocacy organizations who feel that FCR, as currently done by DCF, is not as effective as it could be and is perceived as biased towards DCF.

The OCA believes that FCR should remain with DCF in part because, when done right, it can be a powerful component of the DCF's continuous quality improvement. To support DCF in improving FCR, the OCA worked with DCF to develop a multi-faceted Work Plan to implement changes to FCR. The Work Plan addresses many of the concerns raised by advocates who support an independent agency for FCR. For instance, functions that were not well supported by iFamilyNet, such as record keeping, scheduling and notice, are now supported and improvements are rolling out.

The OCA meets monthly with DCF to review progress on the Work Plan. The OCA also meets frequently with members of the legislature to keep them informed on the progress being made. In FY19, the OCA will convene groups of stakeholders across the state to gather feedback on the implemented improvements.

## **LGBTQ Youth**

Lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) youth face unique challenges at home, in school and in their communities. Compared to heterosexual youth, LGBTQ youth are more likely to experience bullying, report physical and psychological abuse and are at a higher risk for depression and suicide. Unsafe school environments and family rejection contribute to these outcomes.<sup>34</sup>

LGBTQ youth in foster care are more likely to experience discrimination, harassment and violence in their placements as compared to heterosexual youth. These youth are also more likely to experience multiple placements and are less likely to achieve permanency.<sup>35</sup>

To learn more about the issues facing LGBTQ youth involved in the child welfare system, in FY18 the OCA:

- Attended a legislative briefing hosted by Representative Kay Khan and Senator Joan Lovely on LGBTQ youth in foster care. The briefing was about the challenges facing LGBTQ youth and foster parents in the child welfare system.

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<sup>34</sup> The Massachusetts Commission on Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth (2018). FY2018 Annual Policy Recommendations. Retrieved from <https://www.mass.gov/lists/annual-recommendations-commission-on-lgbtq-youth>

<sup>35</sup> Annie E. Casey Foundation (2016). LGBTQ in child welfare: A systematic review of the literature. Retrieved from <https://www.aecf.org/m/resourcedoc/aecf-LGBTQ2inChildWelfare-2016.pdf>

- Met with the Massachusetts Commission on LGBTQ Youth. As a result of this meeting, the OCA:
  - learned about issues with access to healthcare for transgender youth in custody;
  - provided feedback on the commission’s recommendations for FY19; and
  - added LGBTQ resources to our website.

Staying informed and involved in the issues for LGBTQ youth is important and the OCA looks forward to continuing to learn about and work towards solutions to address LGBTQ youths’ needs.

# Legislative Focus

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On June 30, 2018 the two-year legislative session ended. This legislative session was an active one for the OCA, as we continuously reviewed proposed bills and commented on those affecting children's services. In addition, two important pieces of legislation were passed which broadened the mandate of the OCA: *An Act Relative to Criminal Justice Reform* and *Chapter 208 of the Acts of 2018*.

## **An Act Relative to Criminal Justice Reform**

On April 13, 2018, Governor Baker signed *An Act Relative to Criminal Justice Reform* (Chapter 69 of the Acts of 2018) into law. This omnibus legislation impacts the criminal and the juvenile justice systems in a variety of ways, while calling for further study of a number of additional proposed reforms and areas of interest. Of particular relevance to the OCA, the legislation created a Juvenile Justice Policy and Data Board (JJPAD) as well as a Childhood Trauma Task Force (CTTF), both to be chaired by the Child Advocate.

The JJPAD Board is charged with evaluating juvenile justice system policies and procedures, as well as the implementation and impact of statutory changes to the juvenile justice system and making recommendations to the legislature for further improvements. Additionally, the Board is tasked with studying and making recommendations for improving juvenile justice system data collection, reporting and interagency coordination, including developing a plan for the collection of aggregate statistical data on every contact a juvenile has with justice system agencies and service providers.

The CTTF is charged with studying and making recommendations for how the Commonwealth should best identify and provide services to youth who have experienced trauma and are currently involved with the juvenile justice system or at risk of future juvenile justice system involvement.

At the beginning of FY19, the OCA hired a Director of Juvenile Justice Initiatives to manage the office's work to foster and sustain juvenile justice reform, including providing support to the JJPAD Board and the CTTF.

## **Chapter 208 of the Acts of 2018**

The Act for the Prevention and Access to Appropriate Care and Treatment of Addiction (Section 2 of Chapter 208 of the Acts of 2018) included a provision authorizing the OCA to impose binding temporary cost sharing agreements between state agencies and local educational

agencies. The OCA can exercise this authority when the interagency teams established under MGL C. 6A Section 16R cannot reach agreement on the responsibility for payment, which prevents a child from accessing needed services.

In addition to the two new OCA mandates, the Child Advocate and OCA staff met frequently with legislators and advocates to discuss issues in pending bills, particularly about residential school programs and the Commonwealth's mandated reporter law.

## **Residential School Programs**

In February, the Child Advocate testified before the Joint Committee on Children, Families and Persons with Disabilities' oversight hearing on residential programs. The Commissioners of DCF and EEC also testified on the improvements to the licensing and oversight of residential programs undertaken as part of the IWG on residential schools. The Child Advocate also responded to questions regarding a recent federal audit of these programs.

## **Mandated Reporter Law (Chapter 119, Section 51A)**

In the OCA FY17 Annual Report, the OCA made a recommendation to update the Commonwealth's child abuse and mandated reporting law to:

- clarify reporting in institutional settings;
- include coaches and recreational program staff as mandated reporters; and
- consider mandatory training for all mandated reporters.

The House Post-Audit Committee issued a report in May that contained two recommendations:

- Legislation should be enacted to add coaches, administrators and other staff employed by or volunteering with private athletic organizations as mandated reporters.
- There should be a standardized online mandatory reporter training in which a free EOHHS approved curriculum would be offered and the state licensing entities should develop a certification for professionals.

In addition, the Joint Committee on Children and Families convened a Working Group, which included representatives from DCF, EEC, DESE, Committee for Public Counsel Services, the Attorney General's Office, District Attorneys and the Children's League to consider updates to the statute. As this work began late in the formal legislative session, the Working Group agreed to limit its recommendations to a few technical changes. These included the addition of coaches and recreational program staff and volunteers to the list of mandated reporters, clarification regarding the reporting of child abuse and/or neglect in out-of-home settings and the addition of

a requirement for maintaining records of filed child abuse and/or neglect reports. The Working Group also recommended the creation of a task force, to be chaired by the OCA, to consider a total revision of the statute and to review training of mandatory reporters.

The bill, *An Act relative to mandated reporters (H4852)*, passed the House, but was not taken up in the Senate before the July 31 deadline.

## **Updates from Fiscal Year 2017**

During both legislative sessions, the Child Advocate worked extensively on two pieces of legislation that primarily involved protecting girls and young women; *An Act to end child marriage (S 785/H 2310)* and *An Act to protect girls from genital mutilation (S788/H2333)*.

The *Act to end child marriage* would have raised the age to marry to 18 and eliminated the ability for parents to give minors permission to marry. The *Act to protect girls from genital mutilation* would have established civil and criminal penalties for female genital mutilation. This bill had the strong support of the Attorney General and the DA's Association. Unfortunately, neither of these bills was reported favorably out of Committee.

# OCA Recommendations

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## **Update and Improve the Child Abuse and Neglect Mandatory Reporting Law**

One of the three recommendations the OCA made in the Fiscal Year 2017 Annual Report was for the creation of a task force to update and improve the child abuse mandated reporting law (MGL C 118, Section 51A). The OCA's recommendation focused on updating the list of mandated reporters to include coaches and others involved in recreational sports and activities, to clarify the reporting roles in institutional settings and to address the provision of training for mandated reporters. The Joint Committee on Children, Families and Persons with Disabilities convened a Working Group that proposed some immediate legislative changes to ensure that coaches and organized recreational program staff were included as mandated reporters, while a permanent task force be established to comprehensively review the statute. The proposed changes were outlined in a bill which passed the House in the waning days of the legislative session, but there was not time for the Senate to respond.

Although this bill was not enacted, the OCA is committed to establishing a task force to review the existing mandated reporter statutes and regulations; to examine the responsibility for, the quality and frequency of, and best practices for the training of mandated reporters; and to evaluate how mandated reporting should be completed in institutional settings, such as schools, hospitals and human service programs.

## **Examine the Current Statutory Framework for the Licensing and Investigation of Child Serving Entities**

For the past two years, the OCA has chaired an Interagency Working Group on Residential Schools. This work focuses on making improvements to the systematic oversight of these programs to ensure safe, secure and positive learning environments. Oversight of the residential schools is shared across several secretariats and multiple state agencies. Licensure of child care, foster care, adoption and residential programs is the responsibility of EEC, while the approval of the educational programs is the responsibility of DESE. DCF is responsible for investigating allegations of abuse and/or neglect if the child is 18 and under and DPPC is responsible for individuals over between 18-59. DCF, DMH and DYS place children and youth in these licensed programs. School districts in Massachusetts and from other states and countries may also place children. Contract monitoring and individual case management is the responsibility of case managers in each placing agency.

EEC, DESE and DCF are making progress towards more effective and timely collaboration of oversight and monitoring in residential schools. The Interagency Working Group continues to

work on improving the data and information sharing and on addressing the recommendations from the two PCG reports. As current processes are improved, it is time to also review the underlying statutory framework. Questions include:

- Should responsibility be spread across so many agencies, each focused on its own statutory mandates?
- Would it be more effective to have cross functional teams composed of all the required skills now spread-out among several agencies?
- Would a more unified approach result in a better response to programs experiencing stress and quicker identification of problems?

The OCA believes that addressing allegations of maltreatment in licensed programs is different than addressing abuse and/or neglect in family settings. If a child is injured in a program because of inadequate staffing or overtired staff who have worked multiple shifts, is it the management or the staff of the program who should be held responsible?

The child abuse and/or neglect statute mandates DCF to investigate “caretakers.” The law also requires notice to EEC if the alleged abuse and/or neglect occurs in a licensed entity. DCF and EEC try to coordinate their investigations, especially in egregious cases. However, circumstances do not always permit this to occur. The child abuse and/or neglect statutory framework does not distinguish between a family caretaker and an institutional one. DCF’s focus is on identifying the caretaker who is a perpetrator. Staff in any setting that serve children are considered caretakers by DCF. If DCF supports an allegation of abuse and/or neglect against a staff member, that staff member’s name may be added to the DCF Central Registry of alleged perpetrators and referrals will be made to the district attorney as appropriate. EEC will address any licensing violations that result from its own investigation of the incident. DCF and EEC approach the investigation and its resolution from their unique statutory responsibilities.

The OCA believes that we need to establish protocols and standards that reflect the differences between these categories of caretakers to ensure that the response is appropriate and uniform.

## **Support Workforce Development**

In last year’s Annual Report, the OCA recommended there be a coordinated effort among state agencies, human service and educational providers to address the recruitment and retention challenges facing the child-serving workforce. This continues to be a challenge. State agencies and providers identify high turnover as a problem. This causes instability in programs and prevents staff from properly engaging with the children they serve. The Commonwealth must analyze the trends to determine where turnover is highest and to ascertain what is crucial to recruiting and retaining staff. The experience of staff and stability of the management team are



critical safety factors in residential programs. Yet, no state agency currently collects this information.

State agencies must understand the reasons for the high turnover in order to design supports and should begin by collecting information on the workforce.

## **Improve Demographic Data Collection**

Agencies need accurate information about identity to assess whether there are disproportionate impacts based on any status. Almost every agency collects identity information on race, ethnicity, gender and gender identity to monitor for any disproportionate impact. However, there is no uniform taxonomy used across the child-serving agencies and programs. This is due in part to the different requirements for data collection that are unique to the agencies statutory requirements including applicable federal requirements. In order to monitor how children are treated across the human services system, uniform taxonomy must be adopted, as well as a shared protocol for how this information will be collected. The OCA, through the JJPAD, is charged with making recommendations for the uniform collection of Juvenile Justice data. We expect that the examination in this specific area could be used to review data collection on identity across all children's programs.

## **Child Fatality Review Statutory Changes**

After completing its assessment of both the local and state child fatality teams, the OCA has concluded that the statute authorizing Child Fatality Review must be reviewed and potentially rewritten to reflect current practice and to optimize the work of the teams going forward. Specifically, the OCA believes that the state team should be chaired by DPH and/or the OCA, rather than the OCME as currently specified in the statute. Although participation of the OCME continues to be critical to the success of the teams and it should certainly be a key member of both state and local teams, DPH and OCA are better positioned to access the necessary data to make informed policy recommendations, as well as provide necessary support to the local teams. Further, there should be consideration given to how best to review child deaths resulting from maltreatment, which are very rarely reviewed currently.

# Committees, Boards and Councils

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In addition to the OCA's committee work discussed within this report, The Child Advocate participates as an *ex officio* member on many boards and councils. OCA staff also attend meetings of selected working groups and initiatives. Involvement with these groups helps to inform and educate staff about work being done across the state on issues involving children and provides an opportunity for us to share information and help synchronize policy.

## **Access to Mental Health Advisory Board**

The Massachusetts Children's Alliance (MACA) is the statewide coalition of the state's 12 Children's Advocacy Centers (CACs). Because the CACs work so closely with the District Attorneys, there are concerns that the CACs may be subject to discovery rules in criminal proceedings. As a result, the CACs have requested that MACA take an active role in ensuring that child victims of sexual assault and physical abuse have access to specialized and evidence-based mental health interventions. To that end, one area of strategic focus for MACA is its *Access to Mental Health for Child Victims of Abuse Initiative* (AMHI). The Advisory Board, comprised of mental health experts and partner agency representatives from throughout the Commonwealth, helps identify, advise and prioritize the projects for MACA's AMHI. A recent project of the MACA AMHI was a 12-month statewide Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Learning Collaborative in which 65 child therapists were trained. The Office of the Child Advocate lends a unique statewide multi-systemic perspective to the Advisory Board.

## **Children's Behavioral Health Initiative Advisory Council**

The Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008, is comprised of representatives from professional guilds, trade organizations, state agencies, family and young adult leaders, and other stakeholders. The Council works to ensure that children's behavioral health issues are brought to the forefront in policy discussions on healthcare reform by advising the Governor, the legislature and the secretary of EOHHS. Between October 2017 and September 2018, the Council held six meetings and focused on the challenges of recruiting and retaining a high-quality and well-educated workforce and identifying promising initiatives to address these workforce challenges. The Council also explored the following additional priorities:

- Growing and sustaining the peer workforce, defined to include family partners, young adult peer mentors, community outreach workers, and recovery coaches.

- Streamlining the licensing and credentialing process, improving the processes for health plan enrollment, and exploring the use of telemedicine to improve access.

For further information visit: <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-advisory-council.html>

### **The Children’s League of Massachusetts**

CLM is a non-profit association of private organizations and individuals who collectively advocate for policies and quality services in the best interests of the Commonwealth’s children and youth and their families. Child serving organizations and the OCA are special members who attend the monthly meetings and contribute to the collaboration. The OCA worked with the CLM on the Mandated Reporter Task Force, the DCF Data Working Group and planning for a research study of Transitional Age Youth in conjunction with University of Massachusetts Medical School. <http://www.childrensleague.org/>

### **Children’s Trust**

The Massachusetts Children’s Trust is a leader in efforts to stop child abuse in Massachusetts. The Child Advocate is a statutory member of the Children’s Trust Board. The Child Advocate co-chairs the Child Sexual Abuse Prevention Task Force with the Executive Director of the Children’s Trust. In FY18, the Children’s Trust:

- Through Healthy Families Massachusetts, offered home visiting programming to young parents in every city and state across Massachusetts. A longitudinal study found that the program reduces child abuse and has long-term positive impacts on families.
- Partnered with UMass Amherst to create a unique pathway to college for para-professionals through an innovative course that brings together home visitors and UMass students to apply a research-based framework to topics critical to working with young parents.
- Through seven Family Centers, served over 40 communities with a wide-range of center-based programs and events. This year, all center staff were trained on the Standards of Quality for Family Strengthening and Support, the only standards in the country that integrate the Principles of Family Support Practice with the Strengthening Families Framework and Protective Factors.
- Hosted the 25<sup>th</sup> Annual View from All Sides conference for family support professionals, which had 500 attendees and offered 25 workshops on a range of topics.
- Served hundreds of communities across the Commonwealth through the Fathers and Family Network for professionals who work with fathers, parenting education and support groups, parent training on keeping children safe from sexual abuse, and a

parenting website and local resource finder that lets parents search for local resources by zip code.

For information visit: <http://childrenstrustma.org/>

### **The Children’s Mental Health Campaign**

The Children’s Mental Health Campaign (CMCH) is a coalition of families, advocates, health care providers, educators and consumers from across Massachusetts dedicated to comprehensive reform of the children’s mental health system. In FY18, the CMHC continued to focus on the issue of children “boarding” in emergency departments (ED). Boarding is when a child in crisis requires inpatient psychiatric care, but there is no available inpatient program, resulting in a prolonged stay in an ED or on medical units. OCA staff attend the CMHC to stay informed on this issue. For information visit: <http://www.childrensmentalhealthcampaign.org/>

### **Families and Children Requiring Assistance Advisory Board**

An Act Relative to Families and Children Engaged in Services went into effect in November 2012. This law created a new service system, replacing the Child in Need of Services system, to better serve children who are runaways, truants, have serious problems at home or in school, or who are the victims of commercial sexual exploitation. The new law encourages families to seek services prior to going to court and requires EOHHS to develop a network of child and family service programs throughout the Commonwealth to assist these children and families. The law also created the Families and Children Requiring Assistance Advisory Board to advise EOHHS on the development and implementation of the community-based service network and to monitor its progress. While prior years have focused on program design and start up, the primary focus this year was on expanding the number of children and families served, training staff to deliver evidence-based programs and developing a comprehensive information technology. The Child Advocate is a member of the Advisory Board.

### **Governor’s Council to Address Sexual and Domestic Violence**

In 2007 Governor Patrick signed an executive order creating the Governor’s Council to Address Sexual and Domestic Violence (GCSDV). In April 2015 Governor Baker and Lieutenant Governor Polito relaunched the GCSDV, established through Executive Order 563. The Council’s charge is to advise the Governor on how to help residents of the Commonwealth live a life free of sexual assault and domestic violence by improving prevention for all, enhancing support for individuals and families affected by sexual assault and domestic violence and insisting on accountability for perpetrators. Though not a member of the Governor’s Council, the

OCA's Director of Quality Assurance participates in a working group. For information visit: <http://www.mass.gov/governor/administration/groups/sexualassaultanddomesticviolencecouncil/>

### **Leadership Advisory Board of the Massachusetts Child Welfare Trafficking Grant**

Three years ago, Massachusetts received a five-year federal grant from the Administration for Children and Families to increase the capacity of the child welfare system to address child trafficking. The grant supports efforts to build greater interagency collaboration, enhanced infrastructure and new policies and practices to improve the prevention, identification and response to trafficked youth across the Commonwealth. The Leadership Advisory Board meets quarterly to guide and inform the work of the grant. This Advisory Board represents a cross-section of top leadership in the agencies and departments involved in supporting and protecting at-risk and trafficked youth. The Child Advocate is a member of the Advisory Board and OCA staff attends the quarterly meetings.

### **Professional Advisory Committee for Child and Adolescent Mental Health (PAC)**

PAC was founded in 1978 as a statewide group with representatives from professional, advocacy, trade, and family organizations. The goal of PAC is to ensure universal access to quality mental health services for all children and adolescents in Massachusetts. PAC makes recommendations to DMH, other child-serving agencies, and the Legislature regarding service quality, best practices, access, system change and design and public policies that will promote quality behavioral health services for children and adolescents. OCA staff attends these meetings to discuss the concerns and ideas of this committee.

### **Psychotropic Medication Task Force**

The DCF Psychotropic Steering Committee is a multidisciplinary, interagency team that meets regularly to ensure appropriate oversight of psychotic medication use for youth in state custody. Along with the OCA, the DCF led Committee consists of representatives from many of the state's child serving partners including the MassHealth Office of Clinical Affairs, MassHealth Pharmacy, DMH and Massachusetts Behavioral Health Partnership. This year, the Committee continued to tackle the issue of informed consent of psychotropic medications for youth in state custody. Currently DCF provides consent for psychotropic medications (outside of antipsychotics) for youth in state custody which is a population at risk for inappropriate psychotropic prescribing. The consent given by DCF for psychotropic medications is variable with regard to how it is obtained and communicated across the state, which places these children at risk for inappropriate medications. To address this issue, the psychotropic consent pilot project was developed with the support and expertise of the DCF Psychotropic Steering Committee. This pilot project aims to provide an informed consent process for children in the custody of DCF that

promotes appropriate psychotropic use through additional psychiatric review, in a timely and consistent way throughout the state. The pilot project launched in October of 2018 and the Committee will continue to work on assessing the effectiveness and feasibility of expanding this pilot across the state next year.

### **Young Children's Council**

The Young Children's Council (YCC) was formed in March 2010 to advise EOHHS, DPH and the Boston Public Health Commission as they implemented two federal grants, MYCHILD and Project LAUNCH. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration funded the grants to expand early childhood mental health services in Boston, with an emphasis on children and families who have experienced toxic stress related to child abuse, neglect, domestic violence or homelessness. The Child Advocate is a member of the YCC and values the opportunity to share information pertaining to mental health intervention for children younger than five years of age. For information visit:

<http://www.ecmhatters.org/Pages/ECMHMatters.aspx>.

## **Appendix A: Our Partners in the Executive Agencies**

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CBHI	Children’s Behavioral Health Initiative
DCF	Department of Children and Families
DDS	Department of Developmental Services
DEEC	Department of Early Education and Care
DESE	Department of Elementary and Secondary Education
DMH	Department of Mental Health
DPH	Department of Public Health
DPPC	Disabled Persons Protection Commission
DYS	Department of Youth Services
EOEA	Executive Office of Elder Affairs
EOE	Executive Office of Education
EOHHS	Executive Office of Health and Human Services
MCB	Massachusetts Commission for the Blind
MCDHH	Massachusetts Commission for the Deaf and Hard of Hearing





# Commonwealth of Massachusetts Office of the Child Advocate

## Address

One Ashburton Place, 5<sup>th</sup> Floor  
Boston, MA 02108

## Website

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

## Email

[childadvocate@mass.gov](mailto:childadvocate@mass.gov)

## Twitter

@MAChildAdvocate

## Phone Numbers

Main: (617) 979-8374  
Complaint Line: (617) 979-8360  
Toll Free: (866) 790-3690  
Fax: (617) 979 8379



