

Office of the Child Advocate  
Annual Report  
Fiscal Year 2020



The Commonwealth of Massachusetts  
Maria Z. Mossaides, Director

## About the Office of the Child Advocate

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

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# Our Executive Agency Partners

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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
DHCD	Department of Housing and Community Development
DMH	Department of Mental Health
DPH	Department of Public Health
DTA	Department of Transitional Assistance
DYS	Department of Youth Services
EOE	Executive Office of Education
EOHHS	Executive Office of Health and Human Services
MassHealth	MassHealth
MCB	Massachusetts Commission for the Blind
MCDHH	Massachusetts Commission for the Deaf and Hard of Hearing



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May 2021

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

I am pleased to present the Fiscal Year 2020 (FY20) report of the activities of the Office of the Child Advocate (OCA). The OCA was created in 2008 to serve both as an ombudsman to ensure that children and their families receive quality, effective, and timely services that meet their needs, and as an independent overseer identifying gaps in needed services and conducting investigations when needed. The OCA performs these core functions while also identifying and working on issues that require deeper review through a project-based approach. Each year the OCA identifies areas for review based on the data collected from both its core functions and the many task forces and committees in which the OCA participates. At times, we have engaged independent consultants to conduct reviews, such as an external assessment of the OCA that provided us with critical feedback from our stakeholders in the state agencies, the Judicial Branch, the Legislature, and the advocacy community.

This fiscal year, the OCA pivoted to meet the unique and pressing issues posed by the COVID-19 pandemic. Recognizing that children and families were under increased personal, economic, and emotional stress, the OCA focused its pandemic response efforts on preventative work that identified targeted interventions and supports for struggling families. This included collecting information about gaps and challenges in providing children with needed services, identifying special populations of particularly at-risk children who need focused attention, and working with the agency's public and private partners to identify creative solutions to both in-the-moment crises and emerging and anticipated challenges.

In February 2020, the OCA began chairing bi-monthly meetings of the Mandated Reporter Commission, which is statutorily charged with reviewing the current mandated reporter law and regulations for child abuse and/or neglect, and to make recommendations to the Legislature on how to improve the response to, and prevention of, child abuse and/or neglect. The Commission's work represents the first comprehensive review of the statute since its inception in 1973. The COVID-19 pandemic and the resulting steep drop in mandated reports to the Department of Children and Families due to school closures and social isolation

underscores the critical need for state attention to the mandated reporter system, and the need to clarify the scope and content of mandated reporter training, which could be designed to meet the complexities of changing circumstances. The Commission has also focused on potential unintended consequences of mandated reporting and the racial and ethnic disparities in mandated reporting. The Commission's work is seeking to review proposals through an equity lens while also seeking to improve the safety net for children who are victims of abuse and neglect.

In FY20, the OCA continued its work chairing the Juvenile Justice Policy and Data (JJPAD) Board, which launched in FY19. The JJPAD Board is charged with studying our juvenile justice system – including the implementation of the various juvenile justice changes enacted as part of the comprehensive criminal justice bill in 2018 – and making annual recommendations for further improvements. The Childhood Trauma Task Force (CTTF), which operates under the umbrella of the JJPAD Board, released a report in December 2020 with a complete Framework for helping child-serving organizations adopt “Trauma Informed and Responsive” practices. In response to concerns about the impact of COVID-19 on children's mental health and well-being, the CTTF also issued a report in June 2020 that identified traumas and stressors children and their families may experience during the pandemic, presented findings based on post-disaster trauma research and interventions, and highlighted child-centered trauma and mental health initiatives throughout Massachusetts.

The OCA is staffed by a small number of subject matter experts in child welfare, juvenile justice and education. We are committed to using the best available data and evidence-based research in developing our recommendations. We have worked tirelessly to ensure that policymakers and the public have the information needed to answer questions regarding how state agencies are performing their functions. We support efforts to improve the quality and quantity of data that is available, including annual improvements to the data the OCA presents in its annual report. We strive to be as transparent as we can while protecting the privacy of the children and families whose information we hold and review.

The OCA monitors a broad array of state agencies and services. The issues we explore change over time, but we continue to focus on certain key areas. In FY20, we continued to closely monitor the number of children and youth who are victims of child sexual abuse, commercial sex trafficking and exploitation. We continue to be concerned by the national increase in youth suicide, especially the increase of suicide in young children. During FY20, the OCA researched youth suicide among different cohort groups and released a comprehensive report on youth suicide in Massachusetts across all categories of children and young adults and focused in on our most vulnerable populations including youth involved with the child protection and juvenile justice systems. The OCA continues to be involved with state agencies in improving the provision of the full range of services, including housing, that will engage and support youth who are transitioning to adulthood.

With all that has been accomplished, there is still much more to be done to ensure our children, youth and young adults are able to thrive and grow. The events of this year have also emphasized the need for our work to reflect an antiracism lens. I continue to be grateful to have the support of the Governor and Legislative leadership. In addition, our work is only possible with the collaboration of the leadership and staff of our state agencies, 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 tireless efforts on behalf of the Commonwealth's children.

Sincerely,

A handwritten signature in blue ink, appearing to read "Maria Mossaides", with a long horizontal flourish extending to the right.

Maria Mossaides  
Director, Office of the Child Advocate



# Strategic Review

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The OCA's mission is to ensure the Commonwealth's children receive appropriate, timely, and quality services from state agencies that serve them. To fulfill that mission, the OCA focuses on the processes used by these child-serving state agencies, as well as the outcomes achieved. The OCA believes each agency needs to have a robust continuous quality improvement process to detect and correct errors by constantly linking policies and practices to the desired outcomes. The OCA is also committed to improving its own performance. In FY20, the OCA turned the quality assurance lens inward to determine how we could get better at what we do and how we accomplish our work.

Every year since Director Mossaides was appointed as the Child Advocate, the OCA staff has worked with an external facilitator to assess its current work and projects and to plan for the next fiscal year's initiatives. This year was the fifth anniversary of her appointment and Director Mossaides wanted to conduct a more comprehensive review that included feedback from the OCA's external stakeholders. The strategic review would provide a critical examination of the OCA's working relationships and its reputation for fulfilling its mission. The OCA also wanted to create an operational framework to guide its annual internal assessment process and to create a short-term strategic plan.

The OCA hired with an independent, external consultant to conduct the strategic review. Although the strategic review launched in March 2020, the project was delayed as the OCA responded to emergent issues related to the health and safety of the Commonwealth's children from the COVID-19 pandemic.

The external assessment was completed in July 2020. The external interviewee list included stakeholders from the Executive Office of Health and Human Services (EOHHS), Department of Children and Families (DCF), Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH), Department of Youth Services (DYS), Department of Elementary and Secondary Education (DESE), the Juvenile Court, District Attorneys, the Legislature, and multiple advocacy organizations. These results were shared with the OCA's Advisory Committee at its October 2020 meeting.

## **Broadly, the OCA strengths were identified as:**

- The expansive experience, change management expertise, and credibility of Director Mossaides.
- The responsiveness and accessibility of the OCA staff, and their expertise in listening to consumer and stakeholder concerns.

- The OCA's goal-oriented work ethic, transparency, and collaborative problem-solving.
- The production of data-rich and high-quality reports.
- The ability to convene key players with diverse perspectives.
- The OCA's statutory authority reaches across all branches of government.
- The level of trust state agencies have in the OCA's work and that the OCA's recommendations will be both reasonable and implementable.

**Broadly, the OCA areas of improvement were identified as:**

- Agenda setting and communication of that agenda to others.
- The OCA should share its goals and projects broadly.
- Needed executive branch departmental policy and practice changes should be identified before a change agenda is developed.
- The OCA should report on the implementation of its recommendations.
- The OCA's high-level of attention on DCF limits its ability to focus on other priority issues.

Feedback from external stakeholders also assured the OCA that our reputation as an independent agency working for the good of the children of the Commonwealth remains very strong. The OCA heard that state agencies believe that the OCA challenges them while remaining collaborative and respectful. The OCA heard that legislators trust the OCA's independence. Representatives from advocacy organizations trust the OCA's commitment to change while questioning whether the OCA pushes for change fast enough.

The OCA takes this feedback seriously and will use the information to further strengthen the office and OCA work products. The OCA feels that the feedback does reflect the OCA's culture and priorities to take a critical and data-driven lens to state services and to work alongside state agency partners to create real and actionable change for children in the Commonwealth.

The other components of the strategic planning, the development of a strategic and operational framework and the development of a planning process, are ongoing. The OCA is committed to ensuring that the office leverages our value to ensure that the core competencies and the project work of the OCA is at the highest standards of value.

# COVID-19 Response

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On March 10, 2020, Governor Charles Baker declared a State of Emergency in Massachusetts due to the outbreak of the 2019 Coronavirus (COVID-19). This state of emergency continues in effect at the release of this report. This pandemic has created an unprecedented strain on the Commonwealth's children and families, and on the public and private entities that provide support to them. We recognize the hard work of our essential workers and all Commonwealth residents who continue to keep themselves and their neighbors safe.

Since the state of emergency began in March, ensuring the most vulnerable children and family's welfare and safety has remained the OCA's top priority. The OCA has focused its pandemic response efforts on preventative work that identifies where families can get the help they need. This includes collecting information about gaps and challenges in providing children with needed services, identifying special populations of particularly at-risk children who need focused attention, and working with our public and private partners to identify creative solutions to both in-the-moment crises and emerging and anticipated challenges.

## Targeted Interventions for Vulnerable Populations

Since March 2020, the OCA has kept in constant communication with the leadership of child-serving state agencies and focused on monitoring each state agency's COVID-19 response to the unique challenges posed by the pandemic, particularly for children and youth in the care or custody of DCF, juvenile justice-involved youth, children with behavioral, mental health, and complex medical needs, and transition-age and homeless youth. Examples of the OCA's work include:

- The OCA partnered with EOHHS and the Department of Housing and Community Development (DHCD) to problem-solve issues regarding access to medical and isolation beds for vulnerable populations of youth (youth in group homes, transition-age youth, children in DHCD shelters, children with disabilities).
- The OCA worked with DCF to secure 200 Acer Chromebooks using funding from the Court Improvement Project of the Supreme Judicial Court. These Chromebooks were distributed to facilitate virtual visitation between children in foster care and their families, to assist in virtual access to court hearings, and to provide children in foster care with increased access to virtual education.
- The OCA worked in partnership with the Department of Public Health's Division for Children & Youth with Special Health Needs, MassHealth, and a pediatric nursing

facility, to ensure that children with complex medical needs had emergency care plans if their caregiver became ill with COVID-19. Additionally, this collaboration produced a website dedicated to emergency care planning for COVID-19 and beyond which is accessible here: [Emergency Care Planning for Children & Youth with Special Health Needs during COVID-19 and Beyond](#)

## Child Maltreatment During COVID-19

The OCA recognizes that children and families are under increased personal, economic, health, and emotional stress. Many parents are juggling working from home with providing childcare and in-home education, while others continue to report to work while ensuring that their children are safe at home. It is widely recognized that in times of crisis and economic stress there is an increase in child abuse and/or neglect.

Shortly after the pandemic began in March 2020, nationally and in Massachusetts reports of abuse and/or neglect filed with child protective services dropped by over half. The OCA was concerned that with schools and childcare closed, educators could not provide the extra set of eyes to identify children who are at risk. Educators are the largest source of reports of alleged child maltreatment. The OCA urged DCF and DESE to issue a joint guidance for school personnel to assist them in identifying when to exercise their mandatory reporting responsibilities in their remote and virtual environments. DCF issued a Tip Sheet for Educators available here: [DCF Tip Sheet for Educators](#).

The OCA has also focused on harm prevention by providing families with information and referrals where they could get help. The OCA collaborated with EOHHS to ensure that the Commonwealth's 211 Helpline was prepared to address the unique pandemic-related needs of families. The OCA also asked members of the public to check-in on one another and offer support, especially to families with young children. Other examples of the OCA's work include:

- **“We All Need Help Sometimes” Public Awareness Campaign:** In May 2020, the OCA launched a public campaign to help spread awareness of support services and resources for families. In conjunction with the media outreach described above, the OCA partnered with University of Massachusetts Division of Commonwealth Medicine (Commonwealth Medicine) to launch the “We All Need Help Sometimes” public information campaign. The campaign included:
  - English and Spanish video public service announcements shared on social media featuring appearances by Enes Kantor of the Boston Celtics and Cecy del Carmen, anchor at Telemundo: [Family Resource Centers](#)

- Widespread distribution of fliers and social media graphics encouraging families to seek help from resources such as Family Resource Centers and MA 2-1-1. This information, which was translated into multiple languages, was distributed by a variety of partners including legislators, state agencies, the United Way, food banks, public libraries, the YMCAs, school administrators' associations, children's advocacy organizations, police departments, district attorneys, and labor unions. [We All Need Help Sometimes](#)
- Director Mossaides reached out to media outlets and responded to numerous media inquiries to raise awareness of the heightened risk of child abuse and/or neglect and to emphasize the importance of reporting suspected abuse and/or neglect to DCF.<sup>1</sup> This outreach and response is critical to raise awareness about this issue, but also so that all citizens of the Commonwealth, including mandated reporters, are encouraged, and supported in taking the necessary steps to protect children. Director Mossaides spoke publicly on this issue to many news outlets including, but not limited to, WCVB5 (ABV), WBUR News, Sampan, New England Public Media, Colectivo de Medios Latinos, The Boston Globe, The Eagle-Tribune, NBC10 Boston, and Western Mass News (Fox).

## Family Support and Resources

Each child and family in the Commonwealth are impacted by COVID-19. The pandemic has lasted longer than many anticipated and there is a collective traumatic response for families facing challenging pressures, including those families facing illness, joblessness, isolation, mental health challenges, and substance use disorders. The OCA has focused on identifying areas where increased support and services are needed, and making concrete recommendations and partnering with state agencies to take the necessary first steps. The OCA, in its mission to be a resource for children in the Commonwealth, has produced content for children, families, and service providers to help publicize efforts and strategies to cope with this collective trauma. Examples of the OCA's work include:

- **OCA Complaint Line:** In April 2020, the OCA reached out to legislators, service providers, advocates, and others who work with children and families to provide them with information about the OCA's Complaint Line and ask them to alert the OCA if they had trouble accessing needed services. The OCA serves as a resource connecting people to services, but also compiles data on the information received. The OCA

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<sup>1</sup> Visit these websites for more information: <https://www.mass.gov/lists/we-all-need-help-sometimes>; <https://www.mass.gov/info-details/def-COVID-19COVID-19COVID-19-resources-and-support>

gathered and analyzed COVID-19 related complaints and brought any systemic concerns to the attention of the state agency involved in an expedited fashion.

- **“Protecting our Children’s Well-Being During COVID-19” Report:** In June, the Childhood Trauma Task Force, which is chaired by Director Mossaides and is a subcommittee of the Juvenile Justice Policy and Data Board,<sup>2</sup> published a report “Protecting our Children’s Well-Being During COVID-19.”<sup>3</sup> The report notes that the pandemic compounds the challenges that children in the Commonwealth already face in accessing mental health services and behavioral health services. The recommendations in the report include additional support for mental health first responders, increasing the availability of mental and behavioral support for students in schools, and capacity building in communities to provide culturally competent behavioral health services. The report made specific recommendations for a variety of supports and services to address the mental and behavioral health needs of children.
- **Tip Sheets for Early Educators:** Through a partnership with Commonwealth Medicine, in July the OCA created and launched tip sheets and resources for early childhood educators focused on topics including building children’s resilience, helping children with grief and loss, and discussing the virus with young children. Tip sheets and resources are available here: [COVID-19 Resources for Early Childhood Educators](#)
- **Handhold MA Interactive Website:** The OCA worked with the Department of Mental Health and MassHealth to design and launch the first iteration of an interactive website called “HandholdMA.” This website provides family-friendly information on helping kids build resiliency, tips on managing lower-level behavioral issues, advice on when a child needs a more intense intervention, and a guide to available state and community behavioral health resources. The website is available in multiple languages.

Throughout the pandemic, the OCA has continued its ongoing core work of ensuring equitable access to quality state services for children in the Commonwealth. The OCA has also been able to apply our approach, knowledge, and leverage our relationships to identify consequences of the crisis and recommend actionable next steps for the Commonwealth. The OCA recognizes the pandemic has impacted all the Commonwealth’s children, but

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<sup>2</sup> For more information about the Childhood Trauma Task Force, visit: <https://www.mass.gov/lists/childhood-trauma-task-force-cttf>

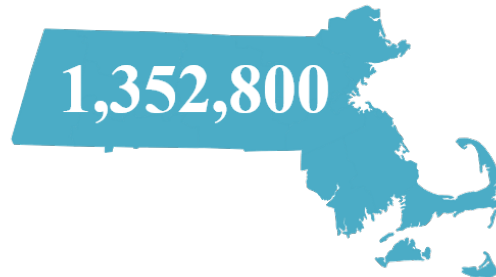
<sup>3</sup> “Protecting our Children’s Well-Being During COVID-19: Recommendations for Supporting Children and Families Who Have Experienced Trauma and Stress During the Pandemic” available at: <https://www.mass.gov/doc/cttf-june-2020-report-protecting-our-childrens-well-being-during-COVID-19/download>

particularly children who were already experiencing trauma, in a vulnerable state, or receiving services from a state agency. The OCA will continue to work actively to protect children and mitigate, to the extent possible, the damage the pandemic has done to our state's children and families.

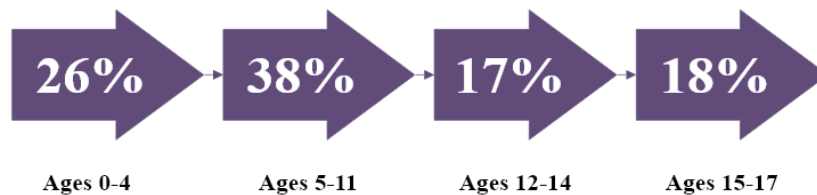
# Data Snapshot of Children in MA

As a framework for the information provided in the OCA’s FY20 Annual Report, the following statistics provide an overall snapshot of the demographics of children residing in Massachusetts.<sup>4</sup> The data below was retrieved from the Massachusetts Kids Count Data Center and is an estimate for calendar year 2019 (January 1, 2019 - December 31, 2019) unless otherwise noted.<sup>5</sup>

**Total Number of Children Under 18 in Massachusetts (2019)**



**Massachusetts Child Population by Age Group (2019)**



## Racial/Ethnic Breakdown of Children in Massachusetts

- White (Non-Hispanic): 60%
- Hispanic or Latino: 19%
- Black (Non-Hispanic): 9%
- Asian (Non-Hispanic): 7%
- Two or More Race Groups (Non-Hispanic): 4%
- American Indian and Alaskan Native/Native Hawaiian and Other Pacific Islander: Less than 1%

## Fast Facts on Children in Massachusetts

- 12% of children under the age of 18 live below the poverty line.
- 15% of children have experienced two or more adverse experiences in their lifetime (Kids Count 2017-2018).
- 24% of children speak a language other than English at home (Kids Count 2018).
- 32% of children are foreign-born or reside with at least one foreign-born parent (Kids Count 2018).

<sup>4</sup> For the purposes of this report, the term “children” refers to any individual between the age of birth to 18, “youth” refers to any individual between the age of 14-18 and “young adult” refers to any individual between the age of 19-22 unless otherwise stated.

<sup>5</sup> Source : <https://datacenter.kidscount.org/data#MA/2/0/char/0>



# Complaint Line

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The Office of the Child Advocate (OCA) operates a Complaint Line Monday through Friday, 9:00am – 5:00pm to receive and respond to complaints and questions regarding state services provided to children, young adults, and families (M.G.L. c. 18C § 5). Family members, foster parents, advocates, attorneys, and other various individuals contact the OCA to express concerns, ask questions, or receive resources and information about a service a child or young adult is receiving, or eligible to receive. For up-to-date Complaint Line contact information, please visit the OCA’s website at: [Office of the Child Advocate](#)

OCA staff members provide support to individuals seeking help in identifying or navigating resources related to the health, education, safety and/or the well-being of any child or young adult in the Commonwealth. OCA staff can assist individuals with resolving a problem that involves a state agency by providing information and referrals as needed. When the OCA deems involvement necessary and appropriate, the OCA will bring a concern to the appropriate state agency and assist in the effort to resolve the concern.

The Complaint Line is accessible through phone, email, online webform, fax, and mail.<sup>6</sup> To ensure that language access is not a barrier, this year the OCA contracted with a telephone interpreting service with translation capacity in over 200 languages.

To better serve individuals who contact the Complaint Line, in January 2020, the OCA launched its first satisfaction survey. The OCA is seeking feedback on the experience of contacting the Complaint Line.

## Overview of FY20 OCA Complaint Line Contacts

Not all Complaint Line contacts are 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 has designated two categories for the Complaint Line:

1. **Complaint:** An individual expresses dissatisfaction about services being provided to a child or young adult 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 a child or young adult of the Commonwealth.

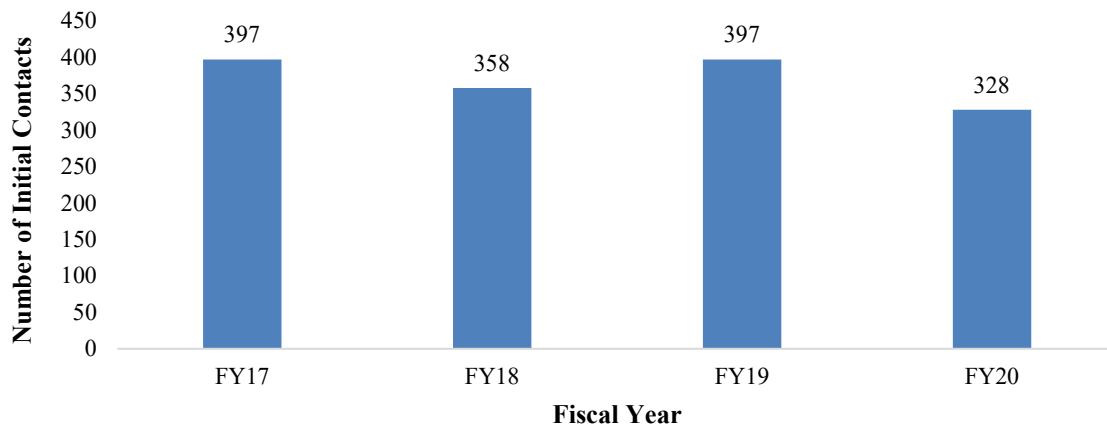
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<sup>6</sup> The Complaint Line operates Monday-Friday, 9:00am – 5:00pm, excluding state holidays. Voicemail messages may be left on the Complaint Line outside of regular business hours.

In FY20, 328 individuals contacted the OCA Complaint Line. Of those 328 individuals, 83% made a **complaint** and the remaining 17% were **information and referral** requests. Parents are the individuals who most commonly contact the Complaint line (53%) followed by grandparents (10%), and other family members such as aunts and cousins (5%). The remaining 32% of individuals had varied roles and included attorneys, foster parents, school and medical personnel, state employees, and concerned neighbors.

Figure 1 represents the total number of initial contacts to the Complaint Line between FY17 and FY20. 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 Figure 1. As a result, the total number of telephone calls, emails, online complaint forms, and letter mail received by the OCA in a fiscal year is considerably higher than what is reflected below.

**Figure 1: Complaint Line Initial Contacts by Fiscal Year (FY17-FY20)**



### **Analysis of FY20 Complaint Line Data**

The OCA maintains Complaint Line information in a secure database. The data collected is used to track issues that impact children, young adults, and their families, to assist in establishing priorities for future research and evaluation projects, and to guide OCA staff in identifying additional resources to enable us to respond to calls. Complaint Line data also provides a complementary perspective on issues and trends that arise through our review of critical incident reports and DCF reports of supported allegations of abuse and/or neglect in out-of-home settings.

### **Analysis of Complaints**

Each distinct concern brought to the OCA is categorized for OCA monitoring and reporting. Consistent with prior fiscal years, many of the individuals who filed a complaint during

FY20 expressed more than one concern. For that reason, the number of categorized concerns (365) in Figure 2 is higher than the number of individuals who filed a complaint (272).

Figure 2 shows that in FY20, the most common Complaint Line area of concern was child welfare. Concerns related to child welfare account for approximately half of the total concerns filed on the Complaint Line, at 48%. The OCA captures detailed subcategories related to child welfare concerns. In FY20, of the 176 child welfare concerns, there were 328 unique subcategories identified. These subcategories include complaints and concerns about the health, safety, or well-being of a child related to their placement/permanency, visitation, a family's child-specific payments/vouchers, or DCF involvement. **A child welfare complaint or concern *does not* have to involve a child or family with current DCF involvement. A child welfare complaint or concern can involve any child-serving state agency.**

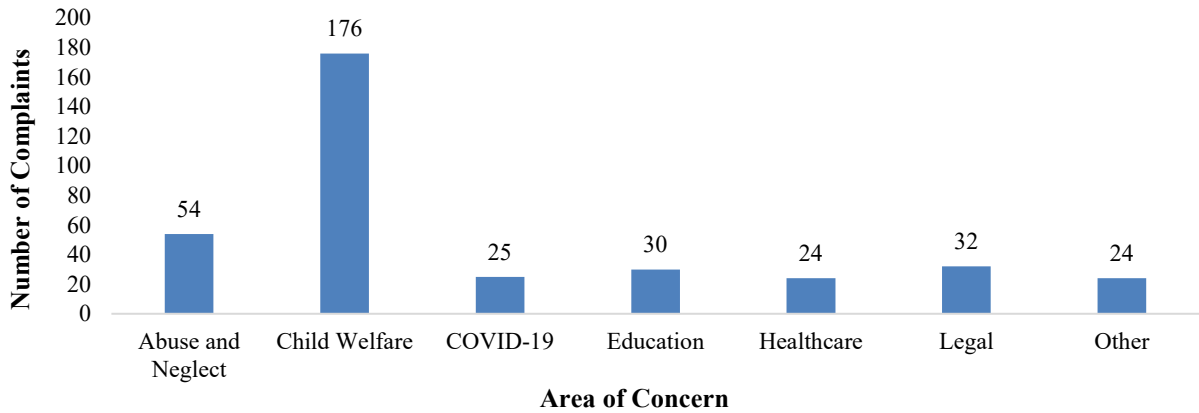
Abuse and/or neglect were the second highest category of complaint. In many of these complaints, individuals were reporting a concern that a child was being abused or neglected. In these instances, the OCA directed the individual to the **Child-at-Risk Hotline**<sup>7</sup> to file a report of abuse and/or neglect with DCF, pursuant to MGL 119 §51A.

In March 2020, the OCA added a new category, "COVID-19," to track concerns that were specifically related to the pandemic. The most common COVID-19 concerns were about access to technology for remote education, restrictions on in-person visitation for children and families involved with DCF, barriers to placement for children and youth in need of out-of-home care, congregate care programs not following COVID-19 emergency guidelines, and parental and child stress management. The OCA took the information received and brought the concerns to the appropriate state agencies for resolution.

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

**Figure 2: Areas of Concern Identified within FY20 Complaints (n=365)**

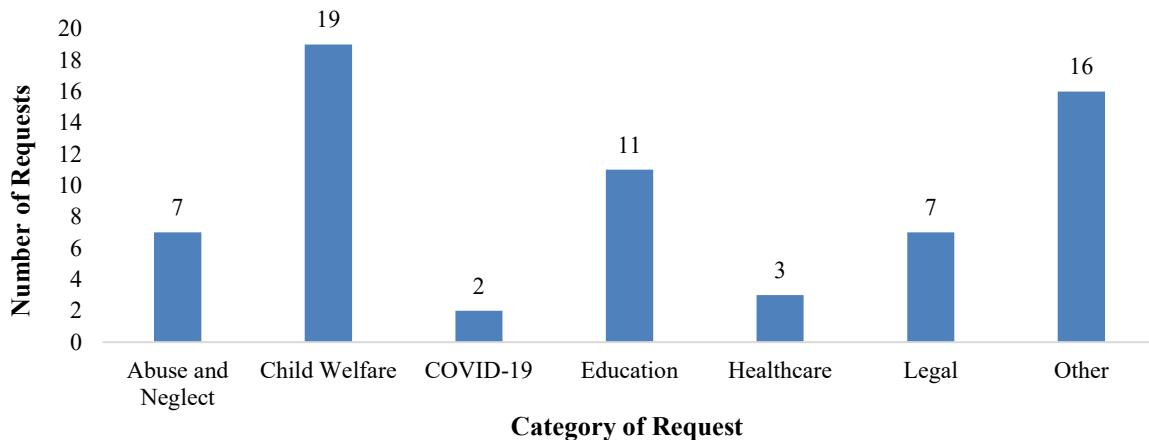


***Analysis of Information and Referral***

Of the 56 individuals who contacted the OCA with an **information and referral** request in FY20, some raised questions about more than one matter. Each question or request for information is categorized for OCA monitoring and reporting. Therefore, the number of categorized information and referral requests (65) is higher than the number of individuals (56).

Figure 3 shows that child welfare was the highest category of information and referral requests. The second highest category of information and referral was “other”. Examples of information and referrals categorized as “other” include requests for information about the role of the OCA, childcare licensing, and housing support applications.

**Figure 3: FY20 Information and Referral Request Categories (n=65)**



**For more detailed information about complaints and information and referral, refer to [Appendix A: Complaint Line](#).**

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

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The Massachusetts Mandatory Reporter Law (M.G.L. c. 119 § 51B(I))<sup>8</sup> for child maltreatment requires the OCA receive from DCF reports of abuse and/or neglect that have been investigated and supported regarding any child in certain out-of-home settings. These out-of-home settings include foster care, congregate care programs, childcare facilities, public schools, private schools, after-school and summer programs, school-funded transportation companies, and hospitals.<sup>9</sup>

OCA staff review, analyze and discuss each report from DCF. The purpose of this review is to evaluate the safety and well-being of the child(ren) involved and the quality of the DCF investigation. In select circumstances, the OCA will request supplemental information regarding the incident through collaboration with the agencies involved, such as the licensing agency.<sup>10</sup> The OCA requests this information to review any challenges the individual out-of-home setting is experiencing, such as workforce retention, training, or unclear programmatic policy.

In FY20, the OCA contacted select state agencies about approximately 30 reports received from DCF. Examples of these contacts include DCF to review concerning investigation outcome decisions or the status of specific foster homes, and the Department of Early Education and Care (EEC) to request and review investigations and corrective actions plans concerning select licensed childcare or congregate care programs.

Sometimes, the OCA will identify an out-of-home setting for an in-depth administrative review when there is concern that a failure to follow policy and/or practice placed a child at increased risk of injury or the child suffered a fatality, near fatality or serious bodily injury.<sup>11</sup> The OCA conducted eight separate administrative reviews on congregate care programs during FY20 due to either the fatality of a child, lack of supervision that placed a child at

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<sup>8</sup> <https://malegislature.gov/laws/generallaws/parti/titlexvii/chapter119/section51b>

<sup>9</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 (M.G.L. c. 119 § 51B).  
<https://malegislature.gov/laws/generallaws/parti/titlexvii/chapter119/section51b>

<sup>10</sup> The Department of Early Education and Care (EEC) is responsible for the licensing of childcare programs, congregate care programs and foster care placement agencies. The Department of Mental Health (DMH) licenses and monitors acute private and general hospitals with inpatient psychiatric units in Massachusetts.

<sup>11</sup> OCA reviews include gathering in-depth background information on the out-of-home setting, the provider agency responsible for the management of the out-of-home setting, a comprehensive review of prior reports of abuse and/or neglect filed on the out-of-home setting, and in selected reviews – non-compliance reports and corrective action plans from the licensing agency involved.

serious risk of injury, failure of a program to file a report of abuse and/or neglect with DCF, and/or a lack of adherence to COVID-19 EEC emergency regulations and protocol guidelines.

In addition to our analysis of concern for abuse and/or neglect in individual out-of-home settings, the OCA aggregates the information learned from these reviews to identify gaps or trends in policy or practice across out-of-home settings. During our FY20 reviews, the OCA identified some common themes regarding congregate care programs, which are:

- inconsistencies in workforce development and training
- poor communication among staff and/or staff and management, which led to inconsistent care of children or youth
- program policy violations

As in prior fiscal years, these themes are consistent with the issues the statewide community of human service providers are experiencing with workforce training, support, and retention. The OCA is an active participant in the discussions focused on resolving these issues.

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

In FY20, the OCA received **276 reports** of supported abuse and/or neglect in out-of-home settings. These reports contained **631 supported allegations** of abuse and/or neglect impacting at least **453 children**.<sup>12</sup> The number of supported allegations is higher than the number of reports because more than one type of allegation per child and/or more than one child or alleged perpetrator can be reported in the incident.

Within these reports, 80% of the supported allegations were related to neglect, 14% were related to physical abuse, and 6% were related to sexual abuse. The allegations of human trafficking – sexually exploited child as well as neglect-death accounted for <1% of the total.

Figure 4 shows that there was a slight increase (6%) in the number of reports of supported abuse and/or neglect in out-of-home settings in FY20 compared to FY19.

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<sup>12</sup> An exact number of children involved in the reports of supported abuse and/or neglect within out-of-home settings cannot be provided as some allegations are supported on unknown child(ren).

**Figure 4: Reports of Supported Abuse and/or Neglect in Out-of-Home Settings (FY16-FY20)**

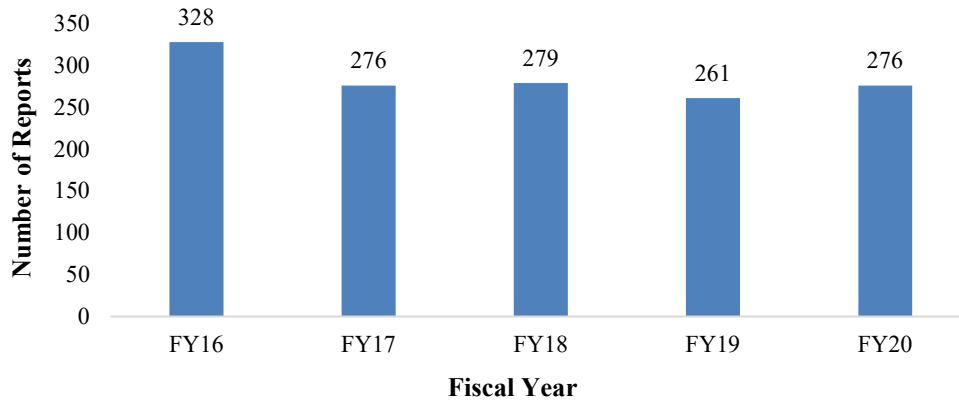
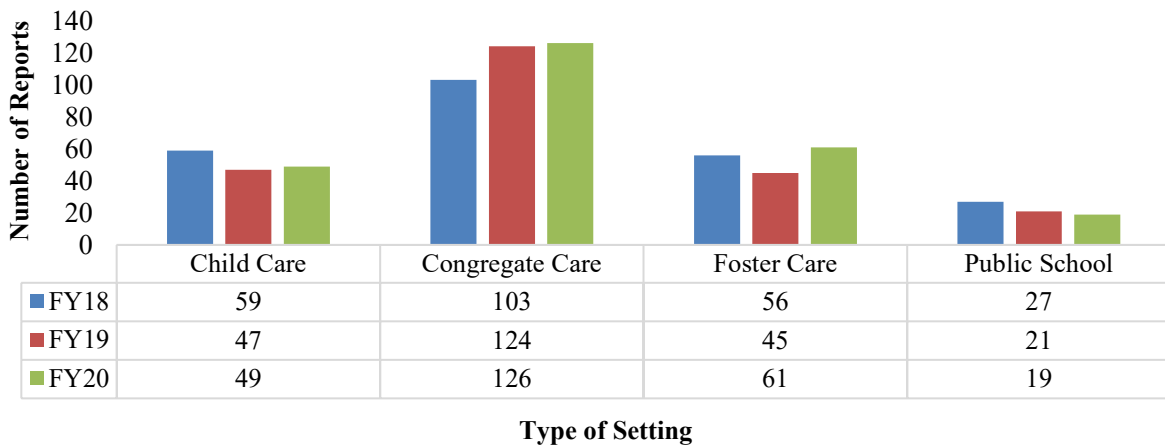


Figure 5 shows the distribution of supported reports of abuse and/or neglect received across, congregate care, foster care, childcare, or public-school settings, the four most common types of out-of-home settings.<sup>13</sup> The number of supported reports from public schools has steadily decreased over the past three fiscal years, while both childcare and congregate care programs have experienced a slight increase.

**Figure 5: Number of Supported Reports by Type of Out-of-Home Setting FY18-FY20**



<sup>13</sup> In FY20, the OCA also received six reports of supported abuse and/or neglect that occurred in a hospital setting, two reports about transportation companies, one report about a private school, and 12 reports about other settings.

## *Childcare*

In FY20 the OCA reviewed 49 supported reports of abuse and/or neglect in childcare. Of the 49 supported reports, 69% of the childcare programs were center based, while the remaining 31% were home-based.<sup>14</sup>

Within these reports, 82% of the supported allegations were related to the neglect of a child and the remaining 18% were related to the physical abuse of a child. In total, approximately 100 children were involved in these incidents.

Consistent with prior OCA fiscal year data, the most common incidents resulting in supported allegations of neglect are related to the improper or inadequate supervision of the child(ren). This includes leaving a child with an unapproved caretaker, leaving a child unattended for an extended amount of time, a child leaving childcare unattended/running away, or having more children at the childcare than the provider's license allows.

Incidents resulting in supported allegations of physical abuse are commonly related to the childcare provider or employee's inappropriate response to a child's behaviors or inappropriate attempt to modify a child's behaviors. Physical abuse in these cases often include dragging a child across the floor, pulling a child's arm, pushing a child, and slapping/hitting a child.

## *Congregate Care*

In FY20, the OCA reviewed 126 supported reports of abuse and/or neglect in congregate care settings involving approximately 197 children. The term congregate care represents a wide array of out-of-home group placements for children and youth such as group homes, residential treatment programs, and secure facilities for those involved in the juvenile justice system. These placements offer both short-term stabilization programs as well as longer-term group care.

Children and youth are commonly placed in congregate care through DCF, DMH, DYS, or other state agencies within or outside of the Commonwealth. Parents and caregivers can also place their child in select congregate care programs, depending on the child's needs. Because not all children are placed by state agencies, it is difficult to calculate the total number of children residing in congregate care.

Of the 126 supported reports of abuse and/or neglect within congregate care settings, many reports included children and youth placed in congregate care by DCF, followed by children

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<sup>14</sup> For the purpose of this report, childcare centers are referred to as center-based while family childcare homes are referred to as home-based. Definitions of "child care center" and "family child care home" can be found in the Department of Early Education and Care enabling statute (M.G.L. c. 15D § 1A)

<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter15D/Section1A>



in DYS care or custody.<sup>15</sup> Overall, approximately 16% of the reports were regarding incidents occurring in DYS facilities or private organizations who operate secure programs for DYS youth.<sup>16</sup>

Within the 126 supported reports of abuse and/or neglect, 80% of the supported allegations were related to the neglect of a child, 13% were related to the physical abuse of a child, and 7% were related to the sexual abuse of a child. Incidents resulting in supported allegations of neglect and physical abuse were commonly related to the lack of proper supervision, youth running away from the program, staff falling asleep during overnight shifts, staff crossing boundaries with the children such as connecting on social media or providing illicit substances, improper physical restraints, and using inappropriate physical discipline in response to a child's behaviors.

### *Foster Care*

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

In FY20, the OCA reviewed 61 supported reports of abuse and/or neglect in foster care<sup>17</sup>. Within these reports, 80% of the supported allegations were related to the neglect of a child, 13% were related to physical abuse and 6% were related to sexual abuse. The remaining 1% were related to the supported allegations of neglect-death or human trafficking-sexually exploited child. Of the abuse and/or neglect in foster care, 36% occurred in a DCF unrestricted or pre-adoptive foster home, 33% occurred in a kinship foster home, 18% occurred in comprehensive foster care and the remaining 13% occurred in a child-specific foster home.

Consistent with the past four fiscal years, in FY20, allegations of neglect were most supported due to children being exposed to behaviors, activities or actions that may be harmful. This can include using age-inappropriate discipline techniques, allowing a child to be exposed to adult situations, or content such as drug use and sexual content. Supervision issues were also just as common and included incidents where foster parents allowed a child

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<sup>15</sup> As of June 30<sup>th</sup>, 2020, 1,306 children receiving services from DCF were currently placed in congregate care. Refer to appendix for more information.

<sup>16</sup> For data on DYS youth who are either detained or committed during FY20, refer to the appendix section.

<sup>17</sup> The OCA did not receive any supported reports of abuse and/or neglect in DYS foster home settings.

to have unapproved contact with their biological parent or left a child with an unapproved caretaker.

### *Public Schools*

In the Commonwealth of Massachusetts, there are approximately 403 school districts for the 351 cities and towns.<sup>18</sup> During the 2019-2020 operating school year, there were 1,842 schools with 948,828 children enrolled in grades pre-kindergarten through 12<sup>th</sup> grade.<sup>19</sup>

In FY20, the OCA received 19 supported reports of abuse and/or neglect in public schools. Of these reports, 58% occurred within the Boston Public School district. According to the Department of Education, there were a total of 50,480 students enrolled in the Boston school district for the academic year 2019-2020, which is the largest school district in Massachusetts.<sup>20</sup>

Within the nineteen reports, 69% of the supported allegations were related to the neglect of a child, 15% were related to the sexual abuse of a child, 12% were related to the physical abuse of a child, and the remaining 4% were related to the human trafficking/sexual exploitation of a child. The separate reports of human trafficking/sexual exploitation of a child were school personnel who initiated and/or engaged in sexual contact with the child, including over social media or other means of technology (e.g., cell phone, computer).

Incidents resulting in supported allegations of neglect and physical abuse within the public-school setting are generally related to the lack of proper supervision, inadequate response to a child's injury, improper administration of medication, and using inappropriate physical discipline in response to a child's behaviors.

**For more detailed information, refer to [Appendix B: Abuse and/or Neglect in Out-of-Home Settings](#).**

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<sup>18</sup> Some small municipalities share school districts, especially on the middle and high school levels. These are counted as separate districts as there are different laws governing these combined districts.

<sup>19</sup><https://profiles.doe.mass.edu/general/generalstate.aspx?topNavID=1&leftNavId=100&orgcode=00000000&orgtypecode=0>

<sup>20</sup> Retrieved from <http://www.doe.mass.edu/infoservices/reports/enroll/default.html?yr=1920>.

# Critical Incident Reports

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The mandate of the OCA is broad. In addition to receiving and reviewing DCF reports of abuse and/or neglect that have been investigated and supported regarding children in certain out-of-home setting, the OCA enabling statute<sup>21</sup> requires state agencies providing services to children or young adults to notify the OCA if a child or young adult suffers a fatality, near fatality, serious bodily injury, or emotional injury. These are called critical incident reports (CIRs).

The number of CIRs submitted by each agency should not be interpreted as a comparison between agencies as the number of children and young adults served by each agency vary significantly, as do the challenges faced by the population that each agency serves. The CIRs should also not be interpreted as evidence of wrongdoing by an agency because a critical incident could be the result of an accident, illness, community violence, or other reasons not related to the reason for agency involvement. During FY20, the following EOHHS agencies reported critical incidents concerning the children and young adults they serve:<sup>22</sup>

- **Department of Children and Families (DCF)**, the state agency responsible for keeping children safe from abuse and/or neglect by providing services, family supports, and foster care or new permanent families for children when necessary, reported critical incidents involving children in its custody and children and young adults receiving services, as well as children and young adults whose families had DCF involvement within the preceding twelve months.<sup>23</sup>
- **Department of Developmental Services (DDS)**, the state agency that provides supports for individuals with intellectual and developmental disabilities, reported critical incidents involving children, and young adults receiving services in the community.

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<sup>21</sup> [M.G.L. c. 18C § 5](#): Investigation of critical incidents; coordination with other agencies; complaints; review of program effectiveness; oversight

<sup>22</sup> DDS, DMH, DPH and DYS report critical incidents if a child and/or young adult is receiving services from their agency at the time of the incident. Prior to FY19, DCF reported critical incidents about a child and/or young adult who was involved in an open case or had been involved in an open case in the preceding six months. As a result of the *Critical Incident Report Definitions Pilot Project* between the OCA and DCF in FY18 and FY19, the criteria expanded to include a child or young adult who was involved in a report of child abuse and/or neglect intake, investigation, or open case at the time of the incident or within the preceding 12 months.

<sup>23</sup> 110 CMR 2.00: GLOSSARY Child in the Custody of the Department means a child placed in the Department's custody through court order, including an order under a Child in Need of Services (CHINS) petition, or through adoption surrender.

- **Department of Mental Health (DMH)**, the state agency that assures and provides access to services and supports to meet the mental health needs of individuals of all ages, reported critical incidents involving children and young adults who are its clients in the community, acute care, residential treatment programs, and hospital settings.
- **Department of Public Health (DPH)**, the state agency that promotes the health and well-being of all individuals by ensuring access to high-quality public health and healthcare services, and by focusing on prevention, wellness, and health equity, reported critical incidents involving children and young adults receiving services in the community, and in residential treatment programs licensed and funded by DPH.
- **Department of Youth Services (DYS)**, the state juvenile justice agency, reported critical incidents involving youth or young adults detained or committed by the Juvenile Court to DYS who are receiving services in the community, in group or foster care, residential treatment programs, and secure treatment centers.

### **OCA Critical Incident Definitions**

State agencies are required to submit “critical incident reports” to the OCA when the incident meets the following definitions:

**Fatality:** A fatality occurs when a child or young adult between the age of birth to 22 dies.

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

**Serious Bodily Injury:** Serious bodily injuries are accidental, the result of an underlying medical condition, or the result of abuse and/or neglect and lead to bodily injury “which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress.” [M.G.L. c. 18C § 5](#)

**Emotional Injury:** An emotional injury occurs when a child or young adult 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:** A state agency will sometimes report incidents that do not meet the definition of a critical incident, but the agency believes the incident is important to share with the OCA. An example of this type of discretionary report might involve an altercation between youth placed in an out-of-home setting or incidents of violence in the community that involve children receiving services.

## Overview of FY20 Critical Incident Reports

In FY20, the OCA received **328 statutorily required critical incident reports**. These reports detailed **497 individual critical incidents** (fatality, near fatality, serious bodily injury, and emotional injury) involving **479 children and young adults**. The number of reports does not equal the number of critical incidents or the number of children and young adults because:

- There can be more than one child or young adult impacted in a single report.
- Each impacted child or young adult can potentially experience more than one critical incident. For example, a child suffers a physical injury (serious bodily injury) while also witnessing a fatal or near-fatal violent act in the home (emotional injury).
- Multiple agencies may submit a report regarding the same child or young adult if the child or young adult is receiving services from multiple agencies.

Figure 6 shows the total number of reports each agency submitted to the OCA over the past three fiscal years. DCF serves more children and families than any other EOHHS child-serving agency. In FY20, DCF served approximately 75,400 children and young adults. Therefore, it is not surprising that, consistent with previous fiscal years, in FY20 DCF reported the majority (90%) of the total number of critical incident reports to the OCA. This is, in part, because DCF reports critical incidents involving children in its custody, children and young adults receiving services, and children and young adults whose families had DCF involvement within the preceding twelve months.<sup>24</sup> Other EOHHS child-serving agencies report critical incidents to the OCA for children and young adults currently receiving services.

Overall, there was an 80% increase in the number of critical incident reports from FY19 to FY20, with the highest increase coming from DCF reports. This increase in reporting is largely, if not exclusively, due to a significant increase in the number of emotional injury critical incidents from DCF. The OCA attributes this, in part, to the FY18-FY19 *Critical Incident Definitions Pilot Project* between the OCA and DCF. The goal of this project was to establish a shared understanding of the emotional injury, serious bodily injury and near fatality definitions and OCA critical incident reporting requirements.<sup>25</sup> Since this project, the understanding of critical incident definitions and reporting expectations has become more

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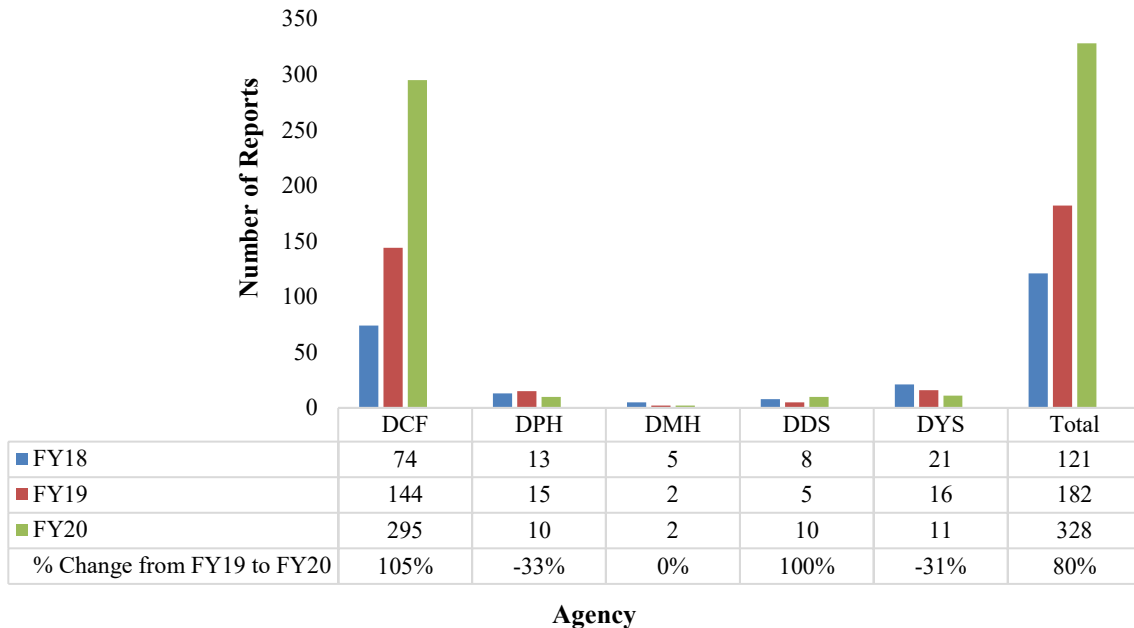
<sup>24</sup> Prior to FY19, DCF reported critical incidents about a child and/or young adult who was involved in an open case or had been involved in an open case in the preceding six months. As a result of the *Critical Incident Report Definitions Pilot Project* between the OCA and DCF in FY18 and FY19, the criteria expanded to include any child or young adult who was involved in a report of child abuse and/or neglect intake, investigation, or open case at the time of the incident, or within the preceding 12 months.

<sup>25</sup> When the pilot project was complete, during FY19 and FY20 the OCA met with the remaining EOHHS child-serving agencies to ensure their understanding of the critical incident definitions and reporting requirements.

standard practice across all 29 DCF area offices, a process that can take some time to take effect.

Since FY18 there has been a steady decline in DYS critical incident reports. Over this same period, the number of youths served by DYS has declined substantially (a 38% drop in the number of admissions to detention and a 36% drop in the number committed).<sup>26</sup>

**Figure 6: Number of Reports Submitted per Agency (FY18-FY20)**



## Overview of FY20 Critical Incidents

The OCA enabling statute defines a critical incident as a fatality, near fatality or serious bodily or emotional injury of a child who is in the custody of or receiving services from an executive agency or a constituent agency. To track and report the number of critical incidents, in FY20, the OCA updated its data collection metrics to capture each critical incident within a critical incident report more accurately. Previously, critical incident reports were reported as one event regardless of the number of critical incidents within that report.<sup>27</sup>

<sup>26</sup> Juvenile Justice Policy and Data Board. “Massachusetts Juvenile Justice System: 2020.” (November 2020) <https://www.mass.gov/doc/jjpad-board-2020-annual-report/download>

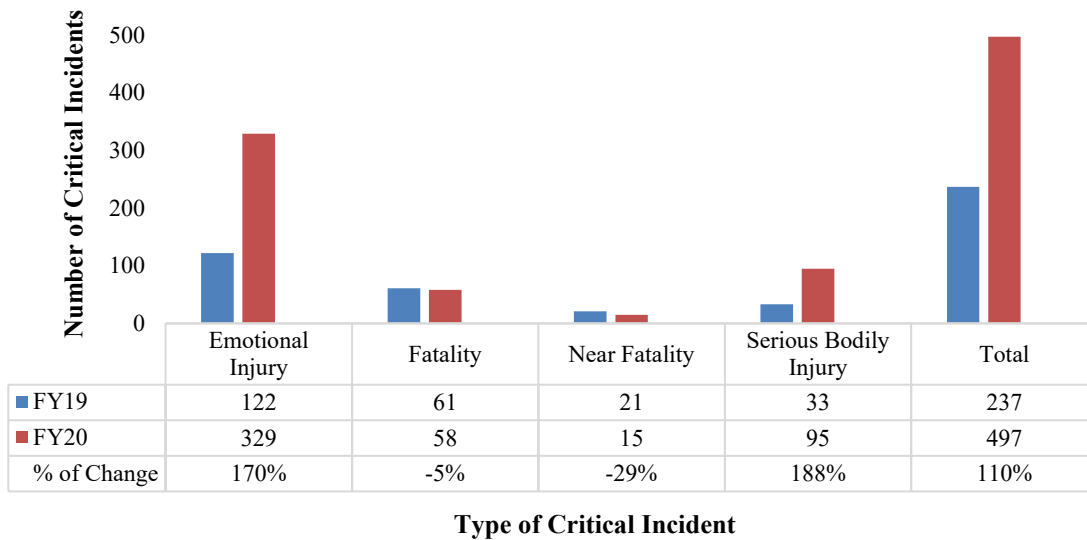
<sup>27</sup> To put this in the context of an example offered earlier in this section, a child who witnesses the fatal overdose of both of his/her parents at the same time would have previously been counted as one critical incident. For FY20 and going forward, this will be reported as two critical incidents, one emotional injury incident for each death the child observed.

**FY19 critical incident data has been restructured and presented in this report in the same manner as the FY20 data to allow for accurate cross-fiscal year comparison and analysis.<sup>28</sup>**

From FY19 to FY20, there was a 110% increase in the overall number of reported critical incidents. Figure 7 shows the number of individual critical incidents for children and young adults in FY19 and FY20, including a 170% increase in emotional injury critical incidents and a 188% increase in serious bodily injury critical incidents.<sup>29</sup>

As a result of the FY18-FY19 *Critical Incident Definitions Pilot Project*, the definition of emotional injury was developed and the definition of near fatality was refined to require verbal certification by a physician that the child or young adult’s condition at the time of the critical incident is considered to be life-threatening. Due to this change, some critical incidents that were previously categorized as near fatality are now categorized as a serious bodily injury, which has contributed to the sharp increase in the serious bodily injury critical incidents and the decrease in near fatality critical incidents.

**Figure 7: Critical Incidents by Fiscal Year (FY19-FY20)**



<sup>28</sup> The numbers presented in the FY19 OCA Annual Report remain accurate. They reflect correct data pursuant to the data collection processes used in FY19.

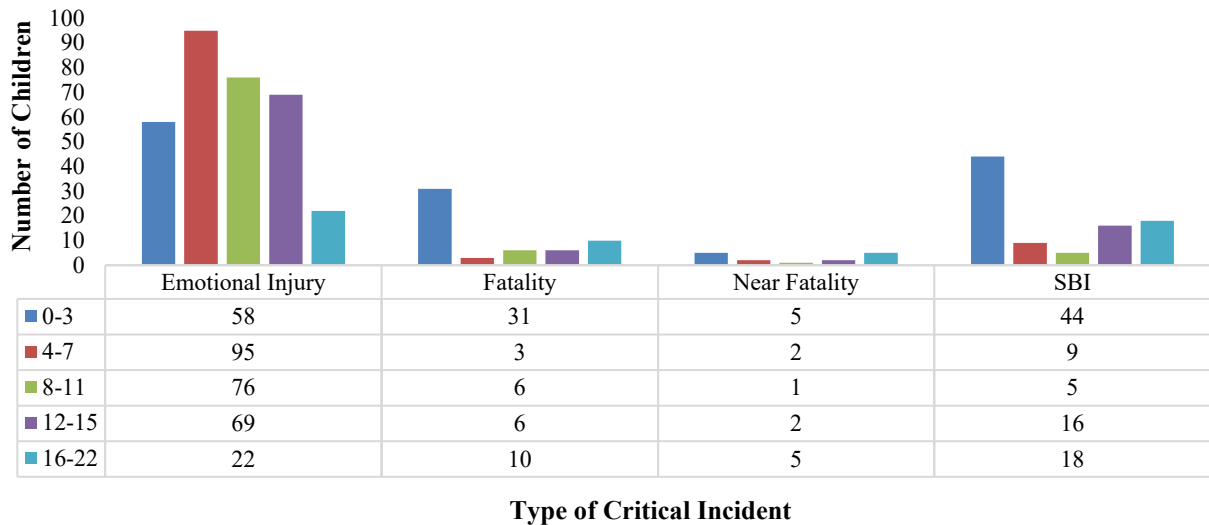
<sup>29</sup> In FY20 there were 56 child/young adult fatalities, with two children having involvement with two agencies at their time of death. Each agency submitted one report for each child, so Figure 7 includes 58 reported fatalities.

## Demographics

The OCA received reports about critical incidents impacting 479 children and young adults. Of these, approximately 55% were identified as male and 44% as female. One child (less than 1%) identified as transgender/gender non-conforming.<sup>30</sup> Currently, the agencies do not report race and ethnicity information in critical incident reports. The OCA is working with the state agencies to include this information beginning in FY21.

Figure 8 shows the age range of children and young adults for whom the OCA received a critical incident report.<sup>31</sup> Consistent with prior fiscal years, children three and under account for most fatal incidents (55%) and represent the largest category of children for whom the OCA received a serious bodily injury critical incident report (48%). The emotional injury totals shown in Figure 8 are for children ages one to three.

**Figure 8: Age Range of Children by Critical Incident Type (FY20)**



## Fatality, Near Fatality, Serious Bodily Injury Critical Incident Events<sup>32</sup>

The death or serious bodily injury of a child or young adult is a significant event that deserves prompt attention. While only the Office of the Chief Medical Examiner can make the final determination regarding the cause and manner of death, the report of a critical

<sup>30</sup> Data on gender is based on what the agency lists as the child's gender in the report and/or information in related agency reports, if available.

<sup>31</sup> If a child experienced more than one type of critical incident, they are counted separately in each category. As a result, there are 483 age notations within critical incidents, with four children experiencing two different types of critical incidents each.

<sup>32</sup> The following section focuses on the fatality, near fatality, and serious bodily injury critical incidents. Emotional injury critical incidents are discussed later in this report.

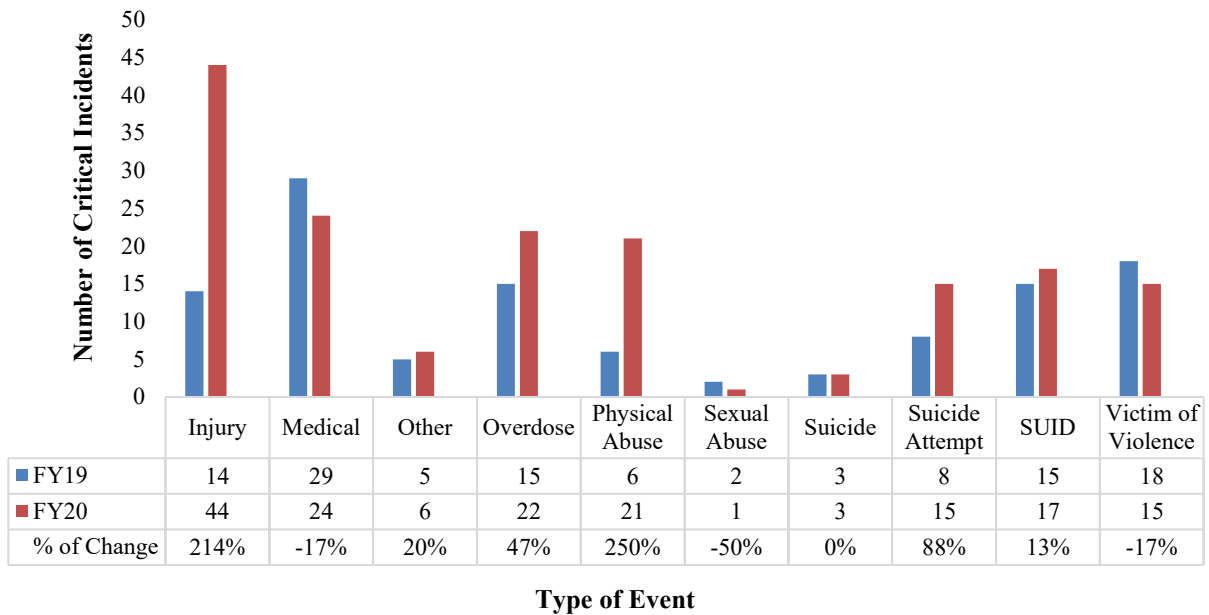


incident to the OCA provides information about the nature and circumstances of the event that led to the injury or death of a child or young adult.

The OCA categorizes and analyzes all critical incidents and events that led to the injury or death of the child or young adult involved. We use the information learned from these reported incidents to determine policy and/or practice changes that could be instituted or refined to prevent future risks to children, to determine whether there are trends or patterns that may need to be addressed by new policies or procedures, and to identify trends where the Commonwealth would benefit from greater data gathering and analysis.

Figure 9 compares the overall number of fatalities, near fatalities and serious bodily injuries by type of event across all reporting state agencies for FY19 and FY20.<sup>33</sup> **The largest increases over the past year were in the injury, overdose, physical abuse, and suicide attempt categories.**

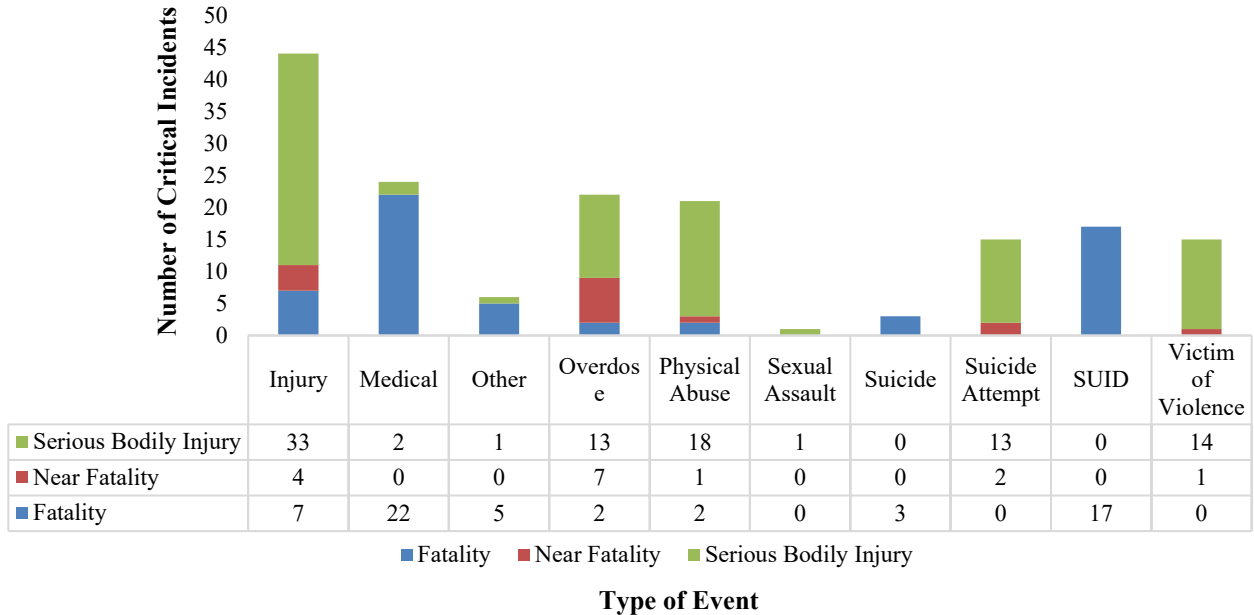
**Figure 9: Fatality, Near Fatality, and Serious Bodily Injury Critical Incidents by Type of Event (FY19-FY20)**



<sup>33</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)

Figure 10 shows a breakdown in the number of fatalities, near fatalities, and serious bodily injuries within each type of event in FY20.

**Figure 10: Fatality, Near Fatality, and Serious Bodily Injury Critical Incidents by Event (FY20)**



The OCA is committed to working across the various child-serving systems, and particularly in collaboration with state agencies, to prevent the physical harm and/or death of all children and young adults due to injury, overdose, suicide, and violence. In addition to the information and efforts described below, the OCA will continue to work with the reporting agencies to develop strategies aimed at protecting children’s safety.

## INJURIES

There was a 214% increase in injuries between FY19 and FY20. Significant trends in the injury category include:

- **Serious bodily injuries** had the largest increase, with 33 in FY20 compared to five in FY19. Of the 33 serious bodily injuries in the injury category, 18 were the result of falls. The remaining were the result of motor vehicle incidents (accidents or children being hit by cars), burns, accidental gunshot wounds, and unexplained causes.
- **Injury-related near fatalities** increased from two in FY19 to four in FY20. Of the four near fatalities, three were the result of near drownings and one was the result of a motor vehicle accident.
- There was no increase in **injury-related fatalities**, with seven in both FY19 and FY20. Consistent with FY19, FY20 fatalities were primarily the result of motor

vehicle accidents and drownings. Other FY20 fatalities included a fall, and two occurred while children, who both had complex medical conditions, were in congregate care settings. The fatalities in congregate care both resulted in staff at each program being found negligent in their care of the children, and that negligence contributed to the deaths of the children.

### ***OCA Activities Involving Childhood Injuries***

In addition to our ongoing work with the child-serving agencies to understand and reduce preventable childhood injury and death, the OCA is an active participant in the Massachusetts Child Fatality Review (CFR) program. The CFR program was established in 2000 following the passage of [M.G.L. c. 38, § 2A](#) and fulfills a federal requirement for Title IVE funding [SEC. 470. \[42 U.S.C. 670\]](#). The purpose of child fatality review is to decrease the incidence of preventable child fatalities and near fatalities. The law requires Massachusetts to have two types of CFR teams: local child fatality review teams (CFRTs) and a state child fatality review team (SCFRT).

Eleven local child fatality review teams meet under the leadership of their respective District Attorneys' office 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 OCA is a member of the state team and OCA staff attend the state and many local CFRT meetings.

In FY19 and FY20, the OCA recommended and secured funding from the Legislature to support the implementation of recommendations outlined in the OCA state and local child fatality review team assessments completed in FY17 and FY18.<sup>34</sup> This included funding to hire a Child Fatality Review Program Coordinator at the Department of Public Health to assist in facilitating this implementation process.

In FY20, OCA staff attended local CFR and state team meetings and worked closely with the Office of the Chief Medical Examiner (OCME) and DPH to implement the recommendations outlined in the OCA local and state team assessments. The collective goal is to build a more robust CFR program to work toward preventing childhood deaths in Massachusetts.

### **OVERDOSE**

When the OCA receives a critical incident report about the overdose of a child or young adult, the OCA uses the information provided in the report and from our internal review of the incident to determine if the overdose was accidental or the result of a suicide attempt. If there is information that the overdose was the result of a suicide attempt, the OCA will

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<sup>34</sup> <https://www.mass.gov/service-details/oca-project-reports>

categorize the event as a suicide attempt. If there is no information the overdose was the result of a suicide attempt, the OCA will categorize the event as an overdose.

**The number of reported overdose events increased by 47% from FY19 to FY20.** In FY19 there were 15 critical incidents categorized as overdose, and in FY20 there were 22. In FY20, there were a total of 21 children involved in the overdoses, as one child overdosed in two separate incidents. Since the OCA received two separate critical incident reports about the child and the overdoses, these overdose events are counted separately, which accounts for the difference between the number of overdose events (22) and number of children involved (21).

There was an increase in the number **serious bodily injuries** from an overdose, from two in FY19 to 13 in FY20. The circumstances of the overdoses were as follows:

- Six children under age six accidentally ingested their caregiver's prescribed medication or illegal substances (Fentanyl, THC). For five of the children this occurred in the child's home and for one child it occurred in a foster home.
- Three youth accidentally overdosed on medication. At the time of the overdose, one youth was in foster care and the other two youth were in congregate care.<sup>35</sup>
- Three youth accidentally overdosed in the community. Two youth overdosed on benzodiazepines and one youth ingested alcohol and marijuana.

**Near fatal** overdoses decreased from nine in FY19 to seven in FY20. The circumstances of the overdoses were as follows:

- Three children under age five accidentally ingested their caregiver's prescribed medication. For all three children this occurred within their respective homes.
- In two separate incidents, one child and one youth accidentally ingested opioids at their homes.
- One child in congregate care was accidentally provided too high a dose of their prescribed medication.
- One youth in foster care accidentally overdosed on an unknown substance.

**Fatalities** due to overdose decreased from four in FY19 to two in FY20. The two fatalities were the result of youth who overdosed at their respective homes on suspected opiates.

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<sup>35</sup> One of the youths in congregate care accidentally overdosed in two separate incidents during FY20, resulting in two separate critical incident reports to the OCA. As a result, this youth is counted twice in the FY20 injury data.

### *OCA Activities Involving Child and Young Adult Overdoses*

The OCA communicates with DCF about its work with children and young adults who are using substances or involved in a critical incident due to witnessing the overdose of another individual. For the past two fiscal years, DCF informed the OCA that its Critical Incident Team, which includes the Director of Substance Use, meets weekly to review reports related to the overdose of a child or young adult, or the emotional injury of a child or young adult from witnessing an overdose. This multidisciplinary Critical Incident Team provides feedback and recommendations based on these reviews back to the DCF area offices. In addition, DCF provided the OCA with the following information about its current and ongoing substance use initiatives:

Consistent with prior fiscal years, the focus of DCF's work is to first address the impact of parental substance use/misuse on the immediate safety of the child(ren) the child's longer-term well-being and to plan intervention accordingly. In addition, DCF has:

- Expanded its substance use expertise and capacity by having three substance use coordinators assigned to each of the five DCF regions. The substance use coordinators provide consultation to social workers, supervisors and management. These consultations include areas such as family engagement strategies, education, planning, and service provisioning case management for parents struggling with substance use disorders. They also help provide substance use related resources and training of DCF staff on about the impact of parental substance use on a child's welfare and development.
- The DCF substance use coordinators participate in many of the statewide opioid task forces and coalitions.
- On a quarterly basis, the DCF substance use coordinators meet with the Department of Public Health (DPH) Bureau of Substance Addition Services (BSAS) to discuss trends, collaboration, and access to substance use services for families. The Substance Use Director additionally participates in an intra-agency collaboration with BSAS's Office of Youth and Young Adult Services quarterly meeting to address the needs of youth with substance use disorders.

### **PHYSICAL ABUSE**

**The number of reported physical abuse critical incident events increased by 250% from FY19 to FY20.** In FY19 there were six critical incidents categorized as physical abuse, and in FY20 there were 21. Of the 21 physical abuse critical incidents, 21 children were involved with 90% of the children aged three or under. The remaining 10% of children were between the ages of four and seven. Furthermore, 86% of the children were male and 24% were female.

Through DCF's investigation of each incident, it was determined that the child's parent(s) was the alleged perpetrator(s) in 76% of the incidents. Of these, two incidents had multiple perpetrators including the child's parent(s) and an extended relative or a neighbor. In 14% of the incidents, the alleged perpetrator could not be identified. In the remaining 10% of incidents, the alleged perpetrator was the partner of the child's parent.

In total, 95% of the physical abuse critical incidents occurred in the child's home and 5% occurred in a community-setting.

### *OCA Activities Involving Physical Abuse*

The OCA conducted extensive reviews of each physical abuse report. For the fatalities, the OCA met with DCF senior leadership and provided substantial feedback about case practice concerns and recommendations for improvements. The concerns identified in both fatalities involved DCF decision making regarding the care and custody of the child, concerns about the frequency or content of contacts with external treatment providers, concerns about a lack of internal consultation with DCF subject matter experts (e.g., domestic violence, substance use, mental health), and inadequate clinical formulation.<sup>36</sup> The recommendations to DCF included:

- 1. DCF should develop criteria and guidance for when case consultation with DCF management and/or its DCF specialists is mandatory, including domestic violence and mental health specialists.**
- 2. DCF should develop a reunification policy that requires a managerial review prior to a decision to reunify children.**
- 3. DCF should update its Ongoing Casework and Documentation Policy to include more specific requirements regarding frequency of contact and content to be addressed between social workers and providers during collateral checks.**

The OCA is working with DCF on these and other policy and practice-related recommendations, with the goal of improving case practice, support and services to DCF-involved children and families of the Commonwealth.

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<sup>36</sup> DCF definition of clinical formulation: A holistic way of putting everything you have learned about a family together, incorporating the goals of both the family and the Department, to create a realistic plan that sets forth the hopes and vision for what needs to change to promote a family's safety, permanency and well-being. The formulation is dynamic and changes based on new information that is divulged or gathered. The information should become fuller and richer over the life of a case.

## SUICIDE ATTEMPTS

**The number of reported suicide attempts increased by 88% from FY19 to FY20.** In FY19, there were eight critical incidents categorized as suicide attempts and in FY20 there were 15. Of these 15 suicide attempts, 13 resulted in serious bodily injuries and two in near fatalities. All of them involved youth aged 11-17, which is consistent with FY19.

Of the 13 **serious bodily injuries**, nine youth attempted suicide by overdose.<sup>37</sup> Six youth overdosed at home and three others overdosed in their foster homes. Four youth attempted suicide by hanging and all of them were in out-of-home settings, such as a psychiatric hospital or congregate care program.

Of the two **near fatalities**, one youth attempted suicide by overdose and one youth by hanging. Both occurred at the youths' respective homes.

### *OCA Activities Involving Suicide Attempt*

As part of the OCA's focus on preventable childhood injury and death and following a review of a decade's worth of trend data, the OCA has prioritized addressing youth suicide. Suicide is a leading cause of death among youth and young adults ages 10-24 both nationally and in the Commonwealth. According to the most recent available data, in 2017, one youth died by suicide every four days in Massachusetts.

During FY20, the OCA researched youth suicide among different cohort groups and released a report entitled, [Youth Suicides in Massachusetts: A Cohort Perspective in National Context](#). The OCA took a comprehensive look at youth suicide in Massachusetts across all categories of children and young adults and focused in on our most vulnerable populations, including youth involved with the child protection and juvenile justice systems.<sup>38</sup>

Childhood, adolescence, and young adulthood are important social, emotional and brain development periods and, as such, suicide prevention efforts for youth vary from those aimed at adults. As a result of the findings and recommendations in the OCA's report, the OCA will:

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<sup>37</sup> Information in either the critical incident report from the reporting agency or learned upon internal review of the incident showed that the overdose was the result of a suicide attempt by the youth. As a result, the OCA categorized the overdose as a suicide attempt and not an overdose.

<sup>38</sup> National research shows that suicide attempts are three times as prevalent in juvenile justice residential placements and more than three times as prevalent for children and youth under the care of child protective services, than they are in the general Massachusetts has no published analyses of suicidality among children and youth in contact with the child protection or juvenile justice system. Gallagher, C. A, Dobrin, A. (2006, June). Deaths in juvenile justice residential facilities. *Journal of Adolescent Health* 38(6); 662-668. <https://doi.org/10.1016/j.jadohealth.2005.01.002>

- Research the various prevention efforts underway in the state and see how they align with data on suicidality by cohort groups.
- Conduct a statewide survey of state agencies, schools, community organizations, care providers and health professionals to comprehensively map their prevention initiatives, gaps and/or needs, as well as barriers to developing effective youth suicide prevention efforts.
- Interview state and local leaders in youth suicide prevention.
- Create a database to track and update youth suicide prevention initiatives at the local and state level to identify gaps and measure effectiveness.

### **Emotional Injury Events**

Childhood trauma is a root cause of many issues that can impact a child’s development, and the impact of childhood trauma can place enormous burdens on our educational, healthcare, judicial and social service systems. Given this understanding of the impact of trauma on the lives of children and young adults, in 2016 the OCA requested a statutory change in the definition of a critical incident to include emotional injury in the categories of incidents required to be reported. As a result, effective in July 2016, emotional injury was added to the OCA’s statutory definition of critical incident.

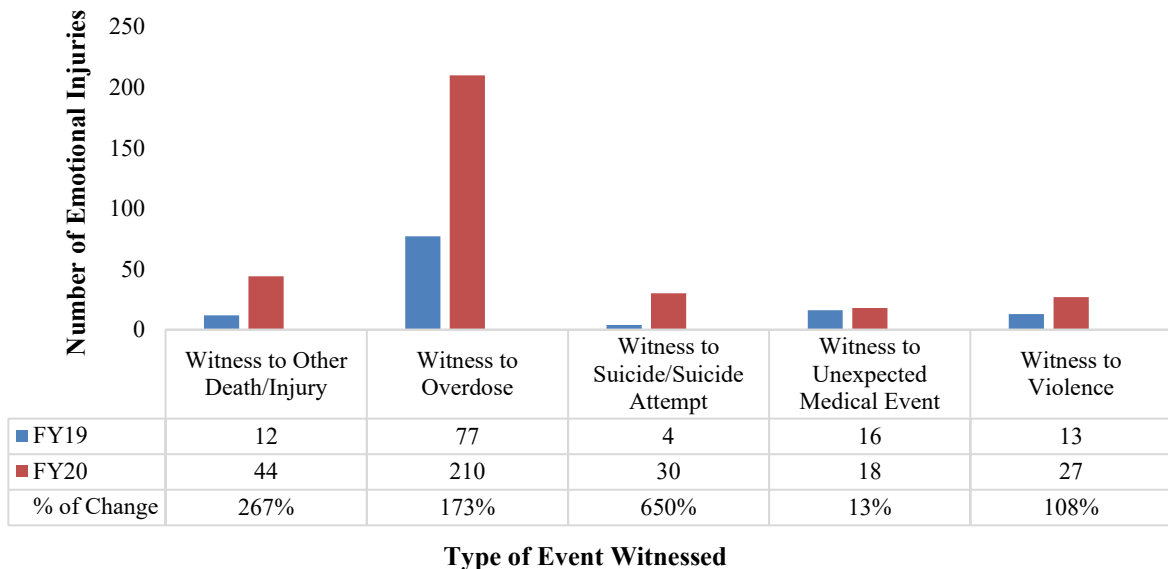
Determining when an emotional injury has occurred is complex and developing a definition of emotional injury for the purposes of critical incident reporting required careful consideration. Effective FY18, the OCA defines **emotional injury** as an instance when “a child or young adult is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.” This includes any setting, such as the home, school, or community.

**The number of reported emotional injury critical incident reports increased by 170% from FY19 to FY20.** During FY19, the OCA worked with the reporting agencies to ensure a common understanding of the new emotional injury definition. As expected, during FY19 and FY20, the number of reported critical incidents involving an emotional injury sharply increased as the new definition was applied. In FY19, the OCA received reports of 122 emotional injury critical incidents involving 116 children and young adults. In FY20, the OCA received reports of 329 emotional injury critical incident involving 320 children.

Figure 11 compares FY19 and FY20 emotional injury critical incidents, broken down by the type of event the child witnessed. Overall, in 66% of the critical incidents, children witnessed an event that led to the near fatality of another individual, with the remaining 34% of critical incidents involved children witnessing the event that led to the fatality of another individual.



**Figure 11: Emotional Injury Critical Incidents by Type of Event Witnessed (FY19-FY20)**



Reflected in the emotional injury critical incident reports over the past three fiscal years is the seriousness of the Commonwealth's ongoing opioid epidemic. Each year, children who witness an overdose are the highest category of emotional injuries. In FY19, 60% of the incidents involved children witnessing an overdose. In FY20, 64% of the incidents involve children witnessing an overdose of a family member or other individual in their home, with 85% of them being non-fatal and 15% fatal.

***OCA Activities Involving Emotional Injury***

The term “emotional injury” is not consistently used in child welfare or scientific research; the OCA uses the term to differentiate between a child witnessing an event (an emotional injury) from a child being the direct victim of the event. As such, emotional injuries are best understood as a type of Adverse Childhood Experience (ACEs), a term coined by the Centers for Disease Control (CDC) to describe examples of abuse, neglect, and household dysfunction that could be potentially traumatic for children and have a lifelong impact on their overall health, safety, and well-being.<sup>39</sup>

The original definition of an ACE included witnessing violence in the home and growing up in a household with substance misuse problems. Over time, researchers have added other types of experiences to the list of ACEs, including seeing, overhearing, or experiencing the

<sup>39</sup> <https://www.cdc.gov/violenceprevention/aces/index.html>

consequences of household challenges (e.g., domestic violence, mental health issues, parental substance use), witnessing violence, and/or living in an unsafe neighborhood.<sup>40</sup>

In addition to the work the OCA’s Childhood Trauma Task Force has undertaken to ensure children who experience trauma receive needed supports, in June 2019, the OCA engaged Commonwealth Medicine to analyze and suggest policies, programs, and practices that are responsive to children who witness events that result in the near fatality or fatality of another individual. Commonwealth Medicine provided the OCA with the following recommendations:

- Increase awareness of the impact of emotional injuries, as defined by the OCA, by exploring a public awareness campaign.
- Leverage state agency, provider, and community organization partnerships to help develop a process for identifying, tracking and reporting emotional injuries.
- Address gaps in services, as many agencies and providers interviewed for this project asked for access to training to better serve children with trauma and emotional injuries. This could include creating a centralized referral system to evidence-based practices and services focusing on trauma care or specific emotional injury types.

The OCA understands that an emotional injury does not necessarily lead to trauma; many children will not need intervention after witnessing a death or life-threatening incident.<sup>41</sup> However, the OCA does not believe that a formal diagnosis of trauma should be a precursor to an intervention to address a child’s emotional injury if that intervention is evidence-based and effective in combating the negative consequences of witnessing events that lead to the near-fatality or fatality of another individual. In fact, if provided with the necessary supports at home, in school, and in their community, most children will recover and continue to thrive.

To ensure children who might need intervention and support are identified, the OCA will conduct further research on the impact of witnessing an emotional injury by age, as well as

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<sup>40</sup> California Department of Public Health and Department of Social Services. (2020, October). *Adverse childhood experiences data report: Behavioral Risk Factor Surveillance System (BRFSS), 2011-2017: An overview of adverse childhood experiences in California*  
[https://www.cdph.ca.gov/Programs/CCDC/DCDC/SACB/CDPH%20Document%20Library/Essentials%20for%20Childhood%20Initiative/ACEs-BRFSS-Update\\_final%2010.26.20.pdf](https://www.cdph.ca.gov/Programs/CCDC/DCDC/SACB/CDPH%20Document%20Library/Essentials%20for%20Childhood%20Initiative/ACEs-BRFSS-Update_final%2010.26.20.pdf)

<sup>41</sup> The OCA has chosen to use the definition of individual trauma developed by the federal Substance Abuse and Mental Health Service Administration (SAMHSA) in 2014, as this is a commonly referenced definition that is meant to be used across multiple sectors: “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”  
[https://ncsacw.samhsa.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf)

effective national and state intervention and support initiatives and programs that could be replicated or scaled up in Massachusetts. The OCA will also continue the work of the Childhood Trauma Task Force.

## **OCA Critical Incident Report Follow-Up with Reporting Agencies**

When the OCA receives a critical incident report, we conduct an immediate administrative review to learn more about the circumstance of the incident and the reporting agency's involvement with the family. For critical incident reports received from DCF, we focus our review on whether there was a missed opportunity for DCF to assist the family and protect the child and assessing case practice and compliance with DCF policies and procedures. For children and young adults receiving services from agencies other than DCF, OCA staff request additional information in select cases to review policy and case management practices.

When the OCA determines the actions or inactions of a reporting agency may have contributed to the incident, or the child, young adult or family is not receiving quality services to meet their needs, we may request investigation reports from the agency, speak with staff, and review case records to learn more about the family history and involvement with the agency. This information is helpful to identify case practice concerns specific to the child and family involved, as well as system-wide patterns and trends about child maltreatment, injury, suicide and other issues or associated risk factors. When the OCA identifies an individual case practice concern or system-wide pattern or trend, we contact the agency involved to share information and promote accountability.

During FY20, the OCA provided direct feedback on 44% of the total critical incident reports received. Of the feedback provided, 97% of the reports were received from DCF, with the remaining 3% of reports received from DDS, DPH, and DYS. Through its review, the OCA determined that the two reports received by DMH did not require feedback.

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

DCF is the designated state child protective service agency responsible for keeping children safe from abuse and neglect by providing services, family supports, foster care, and new permanent families for children when necessary. DCF serves more children and families than any other EOHHS child-serving agency.

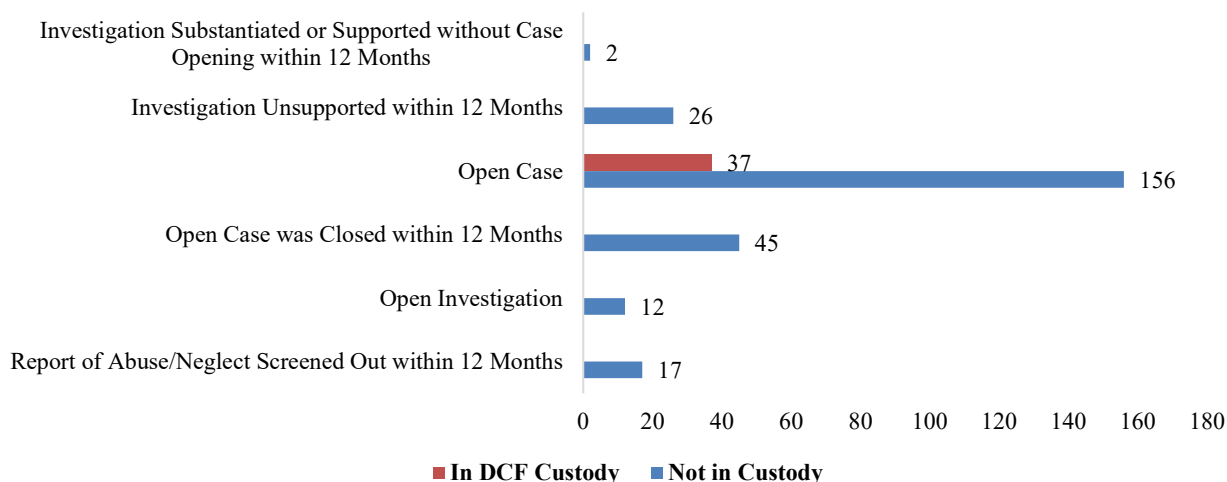
In FY20, DCF served approximately 75,400 children and young adults. Therefore, it is not surprising that, consistent with previous fiscal years, in FY20 DCF reported the majority (90%) of the total number of critical incident reports to the OCA. This is, in part, because DCF reports critical incidents involving children in its custody, children and young adults receiving services, and children and young adults whose families had DCF involvement

within the preceding twelve months.<sup>42</sup> Other EOHHS child-serving agencies report critical incidents to the OCA for children and young adults currently receiving services.

During FY20, DCF submitted **295 statutorily required critical incident reports**, representing a 105% increase compared to FY19. Of these 295 reports, the OCA identified **464 individual critical incidents** involving **449 children and young adults**.<sup>43</sup> The OCA received critical incident reports from every one of the 29 DCF Area Offices, including one report from DCF’s Central Office Special Investigations Unit (SIU).

Figure 12 shows the type of DCF involvement that qualified the critical incident to be reported to the OCA. Of the 295 DCF critical incident reports received, 193 occurred in open cases, meaning DCF was actively providing services to the family when the critical incident occurred. In 45 of the reports, the family had received services from DCF at some point in the 12 months prior to the incident, but their case was closed at the time of the critical incident.

**Figure 12: Type of DCF Involvement Qualifying Case as a Critical Incident Report (FY20) (n=295)**



<sup>42</sup> Prior to FY19, DCF reported critical incidents about a child and/or young adult who was involved in an open case or had been involved in an open case in the preceding six months. As a result of the *Critical Incident Report Definitions Pilot Project* between the OCA and DCF in FY18 and FY19, the criteria expanded to include any child or young adult who was involved in a report of child abuse and/or neglect intake, investigation or open case at the time of the incident, or within the preceding 12 months.

<sup>43</sup> There are more children/young adults than number of reports as there can be more than one child or young adult involved in a critical incident report.

**The number of children and young adults identified in DCF CIR reports (449) submitted to the OCA is 0.006% of the total population served by DCF in FY20. Of these 449 children and young adults:**

- Seventy-nine percent of the incidents happened in the child's home, 12% occurred in a community-setting, and 9% occurred in an out-of-home placement setting, such as foster care or congregate care.
- Eighty-seven percent of the critical incident reports involved a child who was not in the custody of DCF at the time of the incident, while the remaining 13% of reports involved at least one child who was in DCF custody at the time of the incident.

**Of the 295 critical incident reports submitted by DCF, the OCA provided case-specific written and/or verbal feedback about identified concerns in 139 of them.** The identified case practice concerns did not always contribute to the critical incident, but the concerns that the OCA identified warranted the attention of DCF. Case practice concerns included:

- a child was inappropriately left in the care and/or custody of a parent/caregiver
- a child and/or family has not been visited monthly, per DCF policy, and there is a lack of documentation regarding attempts to visit
- inadequate safety planning with a family
- the permanency goal for a child, whether it be reunification or adoption, is not clear and/or it is not clear why the child has not achieved permanency yet
- closing a case with a family without the protective concerns that led to DCF involvement being addressed.

**For more detailed information, refer to [Appendix C: Critical Incident Reports](#).**

# Child Welfare Data Work Group

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In FY18, the Child Advocate and DCF Commissioner convened a working group to review and recommend changes and improvements to the various reports DCF was mandated to file with the Legislature. In response to this effort, the Legislature statutorily mandated a Child Welfare Reporting Task Force in Section 128 of Chapter 47 of the Acts of 2017, which is called the “Data Work Group” (DWG).

The DWG is co-chaired by the Child Advocate and the DCF Commissioner, and includes members from the Legislature, the Committee for Public Counsel Services, and a variety of advocacy and provider organizations as well as experts on data collection and reporting. The DWG was directed 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
- identification of existing reports that ought to be revised or eliminated

The DWG met continuously from September 2017 until state offices were closed in March 2020. In FY18 and FY19, the DWG reviewed all of the DCF reports to understand what questions each report was seeking to answer, what data would answer the question, and whether structured data existed that could provide the needed information. There were a few reports where the rationale could not be determined, and others where the original issue appeared to be resolved. The DCF Quarterly Profile report was redesigned in FY18 to provide more demographic information, such as racial and ethnic disproportionality, information on transition-age youth over the age of 18 and additional process and outcome measures.

In FY19 a new Annual Report was redesigned which incorporated many of the current free-standing reports and corrected duplicative requirements and inconsistencies in reporting periods. Updates were also negotiated to correct errors in original legislative language of the Fair Hearings Report. Recommendations to the Legislature were submitted to revise the legislative language to reflect the changes to the DCF reports recommended by the DWG, including the substitution of the newly revised reports for the existing statutory reports. These recommendations also included provisions for the continuation of the DWG. The Senate passed a bill in late FY19, and the House in late spring FY20. These proposed legislative changes were pending at the close of FY20.

In FY20, the DWG redesigned a report covering the Foster Care Review process. This report, which covers FY20, will be issued in FY21.

A list of topics to be explored in FY21 has been developed to guide work planning and include the following:

- disproportionality decision points
- Family First program services
- outcome data
- service costs
- sexual orientation and gender identity
- visitation

# Juvenile Justice Policy and Data Board

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The OCA chairs the [Juvenile Justice Policy and Data \(JJPAD\) Board](#), which was created as part of *An Act Relative to Criminal Justice Reform* (Chapter 69 of the Acts of 2018). The 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 JJPAD Board has two subcommittees – a Data Subcommittee and a Community-Based Interventions Subcommittee – both of which are chaired by the OCA. The Childhood Trauma Task Force, described in more detail below, also operates under the umbrella of the JJPAD Board.

## FY20 Activities and Accomplishments

### *Improving Aggregate Data Collection*

- In November 2019, the JJPAD Board issued its first [annual data report](#), which includes data on youth interactions with a variety of justice system entities and process points, including arrests, court filings, detention, probation and commitments to the Department of Youth Services. The report also examined the data in a variety of ways, including by the youth's race/ethnicity, age and gender; by the offense type/severity; and by geography. The JJPAD Board released a [second annual data report](#) with FY20 data in November 2020.
- In 2020, the Data Subcommittee began work on developing recommended standards for juvenile justice and child-serving entities to use when reporting key demographic variables to the Office of the Child Advocate (OCA) for JJPAD reports. There are currently no state-level requirements that entities report data broken down by specific categories (e.g. race, ethnicity, gender identity, sexual orientation) in any particular way, which makes it difficult if not impossible to measure any big-picture trends, disparate impact, and/or gaps/challenges across the entire juvenile justice system. The JJPAD Board issued these data reporting standards as part of the November 2020 Annual Report.
- The JJPAD Board and the OCA continued work on a juvenile justice system data website, which makes a variety of juvenile justice system data available to the public on an interactive dashboard. This website launched in fall 2020:  
<https://www.mass.gov/resource/massachusetts-juvenile-justice-system-data-and-outcomes-for-youth>.



### *Expanding and Improving Community-Based Interventions*

- In November 2019, the JJPAD Board [released a report](#) providing an assessment of challenges and opportunities for improving the accessibility, consistency and quality of youth diversion programs, and making recommendations for next steps the Commonwealth should take to improve access to diversion and community-based interventions for youth. These recommendations included launching a state-operated Youth Diversion Learning Lab.
- In 2020, the Community-Based Interventions Subcommittee continued work on youth diversion, focusing on developing a program design plan for the Youth Diversion Learning Lab. Subcommittee members reviewed the research on successful diversion programs, studied examples of diversion programs in Massachusetts and other states, and developed a detailed set of recommendations for what a “model diversion program” would look like. The Subcommittee released the [Model Program Guide](#) in March 2021.

### *Identifying Early Impacts of Juvenile Justice Statutory Changes*

- The JJPAD Board was charged by the Legislature with assessing the impact of juvenile justice system statutory changes made in the 2018 criminal justice reform legislation. In November 2019, the Board [released a report](#) looking at the early impact of specific reforms, including:
  - Raising the lower age of juvenile delinquency to 12 years old
  - Removal of juvenile court jurisdiction of certain low-level offenses such as “disturbing school assembly”
  - New requirements for School Resource Officers and school districts
  - Increased opportunities for judicial diversion
  - Revisions to various juvenile arrest/bail procedures

Over the course of CY2019, the JJPAD Board collected concerns and questions regarding implementation challenges, and ultimately formed two working groups to discuss these concerns in more detail. The Board’s 2019 report included a set of recommendations intended to address implementation concerns following changes in juvenile arrest procedures, revisions to juvenile arrest/bail procedures, and laws regarding the roles and duties of School Resource Officers.

# Childhood Trauma Task Force

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The OCA chairs the Childhood Trauma Task Force (CTTF), which was also created by *An Act Relative to Criminal Justice Reform* (Chapter 69 of the Acts of 2018). The CTTF is charged with determining how the Commonwealth can better identify and provide services to youth who have experienced trauma, with the goal of preventing future juvenile justice system involvement.

The Task Force is a subcommittee of the Juvenile Justice Policy and Data Board, and is comprised of members representing a broad spectrum of child-serving and juvenile justice organizations.

## FY20 Activities and Accomplishments

- In December 2019, the CTTF issued its first report, [Next Steps for Addressing Childhood Trauma: Becoming a Trauma-Informed and Responsive Commonwealth](#). In the report, the CTTF laid out a set of findings about current efforts across the Commonwealth related to childhood trauma, and made recommendations for next steps the state should take to ensure all child-serving organizations are trauma-informed and responsive.
- A primary finding of the 2019 report is that the Commonwealth should develop and adopt a statewide framework for “Trauma-Informed and Responsive” organizations, including a shared definition of “trauma informed and responsive” practice in the Commonwealth as well as principles of a trauma informed and responsive approach that can apply to any system or organization that come into contact with children and youth. In 2020, the CTTF began work on developing such a framework. The group released [a full report in December 2020](#), with a complete Framework as well as detailed recommendations for supports needed to help child-serving organizations adopt the Framework.

In the first weeks of the COVID-19 outbreak, the CTTF saw the need to address the impact of the pandemic on children’s mental health and well-being. The Task Force understood that, given the seriousness of this unprecedented situation, it was necessary to actively prepare for an anticipated rise in children’s behavioral and mental health needs. In June 2020, the CTTF issued [“Protecting our Children’s Well-Being During COVID-19: Recommendations for Supporting Children and Families Who Have Experienced Trauma and Stress During the Pandemic.”](#) The report, which builds on the findings and recommendations from the group’s December 2019 report, identifies traumas and stressors children and their families may experience during the pandemic, presents findings based on post-disaster trauma research and

interventions, and highlights child-centered trauma and mental health initiatives throughout Massachusetts.

To ensure that children who experience trauma and stress during this pandemic have access to the support they need, the CTF recommended that action be taken on three important fronts:

1. Building capacity on the child-serving “front line” to address traumatic stress and behavioral health needs.
2. Increasing availability of behavioral and mental health services and supports in schools.
3. Increasing availability of community-based behavioral health services.

# Mandated Reporter Commission

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The Child Health and Wellness Bill signed by Governor Baker on November 26, 2019 established the [Mandated Reporter Commission](https://www.mass.gov/mandated-reporter-commission)<sup>44</sup> (“MR Commission”). The Child Advocate is the Chair of the MR Commission which is charged with reviewing the current mandated reporter law and regulations for child abuse and/or neglect, and to make recommendations on how to improve the response to, and prevention of, child abuse and/or neglect. The MR Commission is comprised of statutory members who represent a wide range of viewpoints from public entities and groups who have extensive experience with mandated reporting in the Commonwealth.

The need for a review of the Commonwealth’s child maltreatment reporting structure was identified by a working group assembled by the Joint Committee on Children, Families and Persons with Disabilities in early 2018. In May 2018, the House Committee on Post Audit and Oversight issued its report “Raising the Bar: A Vision for Improving Mandated Reporting Practices in the Commonwealth” which recommended that the Massachusetts Legislature enact legislation to require coaches, administrators, and other staff employed by or volunteering with a private athletic organization to act as mandated reporters. It further recommended that the Commonwealth institute a standardized online mandated reporter training with an Executive Office of Health and Human Services approved curriculum developed in conjunction with other stakeholders. Additionally, reports by the Massachusetts Legislative Task Force on Child Sexual Abuse Prevention,<sup>45</sup> the Residential Schools Interagency Task Force,<sup>46</sup> as well as the State Auditor’s 2017 report “Review of Mandated Reports of Children Born with a Physical Dependence on an Addictive Drug at the UMass Memorial Medical Center, Inc.”,<sup>47</sup> identified the need for clarifications to mandated reporting responsibilities, especially in institutional settings.

Since its original passage in 1973, the mandatory reporting statute has been updated several times<sup>48</sup> but a comprehensive review has never been undertaken. The MR Commission was created by the Massachusetts Legislature, under the chairmanship of the Office of the Child

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<sup>44</sup> <https://www.mass.gov/mandated-reporter-commission>

<sup>45</sup> Available at: [Report SD.2251 \(malegislature.gov\); Child Sexual Abuse Prevention Task Force Report.pdf \(childrenstrustma.org\)](#)

<sup>46</sup> Available at: [MA OCA Residential Schools Report April 2017 \(mass.gov\)](#)

<sup>47</sup> Available at: [2017-4601-3C Substance-Exposed Newborns at UMass Memorial Medical Center \(UMMC\)](#)

<sup>48</sup> Since 1989 the statute has been updated six times: in 1990 changes were made to MGL c. 119 §51A(a), in 1997 podiatrists were added to the list of mandated reporters, in 2002 some categories of religious personnel/clergy were added to the list of mandated reporters, in 2008 the definition of “mandated reporter” was moved from §51A to MGL c. 119 §21, in 2008 the definition of mandated reporter language changed from “family childcare systems” to “family child care systems,” and in 2018 animal control officers were added to the list of mandated reporters.

Advocate, to review the statute to recommend systematic changes. The statute creating the Commission<sup>49</sup> requires that the Commission review specific topics including any proposals to expand mandated reporting requirements. The Commission has also focused on potential unintended consequences of mandated reporting and the racial and ethnic disparities in mandated reporting. The Commission's work is assessing proposals through an equity lens while also seeking to improve the safety net for children who are victims of abuse and neglect.

The MR Commission began meeting in February 2020 and is currently meeting approximately twice a month. As a result of the COVID-19 pandemic, MR Commission meetings convened virtually starting in March 2020 and the OCA expects to continue virtual meetings of the MR Commission. The MR Commission meetings remain open to the public pursuant to the Open Meeting Law.

The OCA recognizes the seriousness of the responsibility of chairing this Commission and is grateful for the outstanding effort of Commission members who consistently delve deeply into difficult and complex topics in order to produce thoughtful and refined recommendations to the Legislature.

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<sup>49</sup> Statute available at: [Session Law - Acts of 2019 Chapter 124 \(malegislature.gov\)](https://malegislature.gov/Session-Law-Acts-of-2019/Chapter-124)

# Child Sexual Abuse Prevention Task Force

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The Child Sexual Abuse Prevention Task Force (CSAP Task Force) was established by the Legislature in 2014 (Section 34 of Chapter 431 of the Acts of 2014) to develop guidelines and tools for the prevention of child sexual abuse by organizations serving children and youth, and to increase public awareness about child sexual abuse, including how to recognize signs, minimize risk and act on suspicions or disclosures of such abuse. This multidisciplinary team is co-chaired by the Child Advocate and the Executive Director of the Children's Trust.

In FY17, the Task Force released the report *Guidelines and Tools for the Development of Child Sexual Abuse Prevention and Intervention Plans by Youth Serving Organizations in Massachusetts*.<sup>50</sup> This was followed in FY18 with a series of nine regional community forums to introduce youth serving organizations to the recommendations in the CSAP Task Force report and to seek input from the 138 organizations that participated regarding the tools and supports they needed to implement child sexual abuse prevention policies and efforts.

The CSAP Task Force identified the need to address children with problematic sexual behavior and agreed to explore recommendations for addressing the needs of these youth. In FY19, the CSAP Task Force launched a new working group was convened consisting of representatives from Children's Trust, OCA, DCF, DPH, DYS, Children's Advocacy Centers (CACs), Massachusetts Adolescent Sexual Offender Coalition, Attorney General's Office and the District Attorney's offices to address issues associated with children and youth exhibiting problematic sexual behaviors. They studied and identified successful model solutions based on early intervention, guidelines for response, assessment and treatment standards, and professional training. Five pilot programs were launched in FY20.

Additionally, in FY20 the design was launched of an interactive website that will provide the tools for youth-serving organizations to conduct a self-assessment and to design policies and procedures to prevent child sexual abuse. This website is designed to provide a customized experience depending on the needs of each organization and will provide training and other supports. The website, Safe Kids Thrive, is the first of its kind and launched in the fall of 2020.

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<sup>50</sup> [https://www.enoughabuse.org/images/stories/Child\\_Sexual\\_Abuse\\_Prevention\\_Task\\_Force\\_Report.pdf](https://www.enoughabuse.org/images/stories/Child_Sexual_Abuse_Prevention_Task_Force_Report.pdf)

# Transition-Age Youth

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The Commonwealth has made significant strides in assisting this population of transition-age youth (TAY) and supporting cooperation among the EOHHS youth-serving agencies, yet gaps in services and supports remain. The OCA was eager to better understand the status of services for transition-age youth and engaged Commonwealth Medicine to provide an independent assessment. Commonwealth Medicine conducted an environmental scan of EOHHS services for transition-age youth, engaged provider and youth stakeholders to provide input on services, and researched transition-age youth programming best practices from other states. This work concludes with recommendations to improve outcomes for emerging adults engaged in the state's systems of care.

Out of this assessment and recommendation the OCA and Commonwealth Medicine created an interdepartmental working group across the health and human services Secretariat. The group began working on the implementation of the recommendations in late 2019. After COVID-19 began, the group pivoted to focus on urgent issues of transition-age youth and developed a pilot to assure safe and stable housing to TAY in the Springfield and Worcester areas that may struggle with stability. This pilot has successfully launched, and results are expected back in Fiscal Year 2022.





# Projects, Initiatives, and Committees

In addition to the OCA's statutorily required work and leadership on our Task Force and Commissions, the Child Advocate and OCA staff participate as a member on many diverse boards, councils, and initiatives across the state that work toward improving the lives of children and young adults in the Commonwealth. This includes prevention, intervention, and support services. 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.

Name	Target Population	Type of Intervention	Role of the OCA
<p><b>Children’s Behavioral Health Initiative</b>            The CBHI 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.  <a href="https://www.mass.gov/childrens-behavioral-health-initiative-cbhi">https://www.mass.gov/childrens-behavioral-health-initiative-cbhi</a></p>	Children and youth under age 21 with mental and behavioral health needs	Problem solving across areas of expertise to improve and streamline services and identify areas for improved state action	The OCA is a member of the CBHI Advisory Council
<p><b>Children’s Trust</b>            The Massachusetts Children’s Trust is a leader in efforts to stop child abuse in Massachusetts.  <a href="https://www.childrenstrustma.org/">https://www.childrenstrustma.org/</a></p>	Children and families of the Commonwealth at risk of child welfare system involvement	Community based programs focused on strengthening families and preventing child abuse	The Child Advocate is a statutory member of the Children’s Trust Board
<p><b>Child Fatality Review Program</b>            The Massachusetts CFR program was established in 2000 purpose of child fatality review is to “decrease the incidence of preventable child fatalities and near fatalities” in the Commonwealth.” Eleven local teams meet under the leadership of the District Attorneys’ Offices to conduct multidisciplinary reviews of individual deaths.</p>	Children and youth under age 18 who have suffered a preventable fatality or near fatality	Multidisciplinary collaboration to increase awareness and develop or improve policy and practice at the state and local level	The Child Advocate is a member of the state team and OCA staff attend local CFRT meetings

Name	Target Population	Type of Intervention	Role of the OCA
<p><b>Family and Child Requiring Assistance Advisory Board</b>  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 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.</p> <p>Family Resource Centers:  <a href="https://www.frma.org/">https://www.frma.org/</a></p>	<p>Youth who are involved in a Child Requiring Assistance (CRA)</p>	<p>Oversight and monitoring of the Family Resource Centers</p>	<p>The Child Advocate is a member of the Advisory Board</p>
<p><b>Governor’s Council to Address Sexual and Domestic Violence – High Risk and Assessment Work Group</b>  The GCSDV charge is to advise the Governor on how to help residents of the Commonwealth live a life free 58 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.</p>	<p>Children and youth who are victims of sexual or domestic violence</p>	<p>Multidisciplinary collaboration to ensure victims and their children are identified and receive the support and services they need</p>	<p>Though not a member of the Governor’s Council, the OCA Director of Quality Assurance participates in the High Risk and Assessment Work Group</p>
<p><b>Infant and Early Childhood Mental Health Policy Workgroup</b>  The purpose of IECMH Policy Workgroup, which is coordinated by DMH, is to provide a forum where both state and private stakeholders who touch the life of families with young children can gather to coordinate efforts, discuss most up-to-date information regarding IECMH both in Massachusetts and successful examples from other states that can be used by all stakeholders to educate and inform best practices, policies, and activities.</p>	<p>Ages birth to five</p>	<p>Coordination of policy and practice development</p>	<p>The OCA attends meetings to understand emerging issues and initiatives and to participate in policy and practice recommendations</p>

Name	Target Population	Type of Intervention	Role of the OCA
<p><b>Interagency Safe Sleep Task Force</b>  The Interagency Safe Sleep Task Force is a multidisciplinary group of state and provider agencies who aim to reduce the incidents of sudden unexpected infant death through public awareness and creating systems that reduce SUID related risk factors.  <a href="http://mass.gov/safesleep">mass.gov/safesleep</a></p>	<p>All newborns and infants birth to 12 months</p>	<p>Multidisciplinary collaboration to increase community awareness and develop or improve state agency policy and practice about safe sleep messaging</p>	<p>The OCA attends meetings to participate and contribute expertise to policy and practice improvements</p>
<p><b>Leadership Advisory Board of the Massachusetts Child Welfare Trafficking Grant</b>  Four 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.</p>	<p>Children and youth either experiencing or at risk of human trafficking and commercial sexual exploitation</p>	<p>Increase the capacity of the child welfare system to address child trafficking</p>	<p>The Child Advocate is a member of the Advisory Board and OCA staff attend the quarterly meetings</p>
<p><b>Professional Advisory Committee for Child and Adolescent Mental Health</b>  PAC was founded in 1978 as a statewide group with representatives from professional, advocacy, trade, and family organizations. 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.</p>	<p>Children and youth</p>	<p>The goal of PAC is to ensure universal access to quality mental health services for all children and youth in Massachusetts</p>	<p>OCA staff attends these meetings to stay informed of emerging issues and discuss the concerns and ideas of this committee</p>
<p><b>Psychotropic Medication Task Force</b>  The Psychotropic Steering Committee is a multidisciplinary, interagency team led by DCF that meets regularly to ensure appropriate oversight of psychotropic medication use for youth in state custody.</p>	<p>Children and youth in DCF custody</p>	<p>Legally standardize requirements across all settings</p>	<p>The Child Advocate is an active participant in this initiative</p>

Name	Target Population	Type of Intervention	Role of the OCA
<p><b>Restraint and Seclusion Initiative</b>  The Interagency Restraint and Seclusion Prevention Initiative was formed in 2009. The interagency initiative brought together DDS, DCF, DMH, DYS, DESE and EEC to work in partnership with providers, advocates, educators, schools, families and youth to focus on advancing trauma informed practices and prevent the use of coercive practices that traumatize/retraumatize youth, including restraint and seclusion use.</p>	<p>Children and youth</p>	<p>Advancing trauma informed practices and prevent the use of coercive practices that traumatize/retraumatize youth</p>	<p>The Child Advocate is an active participant in this initiative and serves as a member of both the Executive and Advisory Committees</p>
<p><b>The Children’s League of Massachusetts</b>  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.  <a href="http://www.childrensleague.org/">http://www.childrensleague.org/</a></p>	<p>Children and youth</p>	<p>Advocate for policies and quality services in the best interests of the children, youth and families of the Commonwealth</p>	<p>The OCA is a special member and staff attend the monthly meetings to stay informed of emerging issues and contribute to the collaboration</p>
<p><b>The Children’s Mental Health Campaign</b>  The CMCH is a coalition of families, advocates, health care providers, educators, and consumers from across Massachusetts dedicated to ensuring all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health in a timely, effective and compassionate way.  <a href="http://www.childrensmentalhealthcampaign.org/">http://www.childrensmentalhealthcampaign.org/</a></p>	<p>Children at risk of and/or who have mental health disorders</p>	<p>Ensuring all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health in a timely, effective and compassionate way</p>	<p>OCA staff attend CMHC meetings to stay informed of emerging issues.</p>

Name	Target Population	Type of Intervention	Role of the OCA
<p><b>Young Adult Justice Group</b> Roca, Inc. leads a roundtable of local and state agencies that work with emerging adult's (18-24) who are justice-involved or at risk of becoming justice-involved.</p>	<p>Young adults (18-24) who are justice-involved or at risk of becoming justice-involved</p>	<p>Coordination and information sharing</p>	<p>The OCA attends these meetings to better understand emerging issues and initiatives impacting justice-involved young people, and to facilitate connections between the juvenile and young adult systems</p>
<p><b>Young Children's Council</b> 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.</p>	<p>Ages birth to five</p>	<p>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</p>	<p>The Child Advocate is a member of the YCC</p>

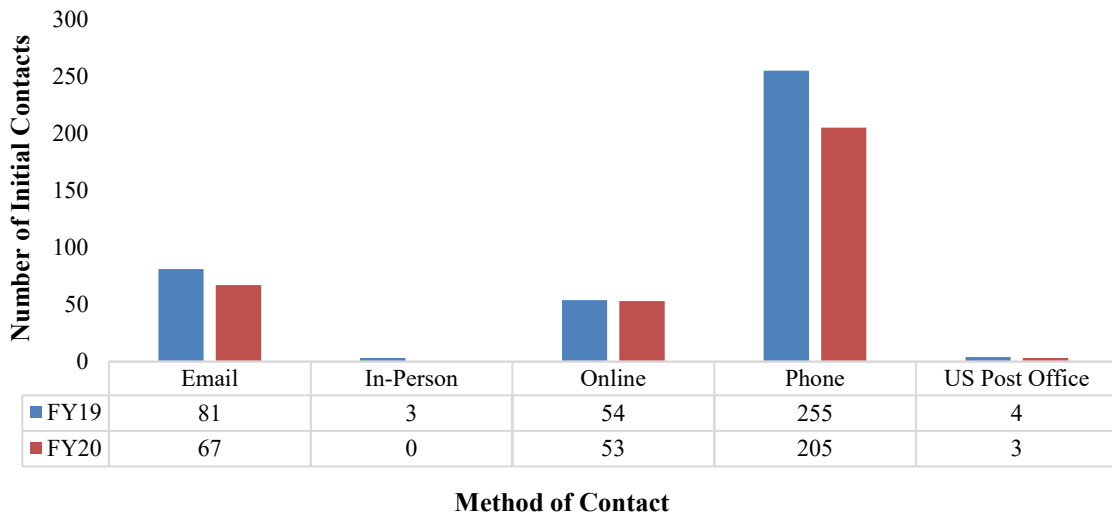
# Appendix A: Complaint Line

The supplemental statistics, data visuals, and definitions presented throughout Appendix A provides a complementary analysis of the findings outlined in the **Complaint Line** section of this report ([page 13](#)).

## Complaint Line Contacts by Method Received

Figure 13 shows that consistent with prior fiscal years, in FY20 the primary method individuals use to contact the OCA Complaint Line continues to be through the telephone (63%). The second most common method of contacting the OCA was via email (20%) followed by the online complaint form on the OCA’s website (16%), and letter mail (1%). Although the OCA accepts complaints from individuals who wish to file in person, the OCA received no walk-in complaints during FY20.<sup>51</sup>

**Figure 13: Complaint Line Contacts by Method Received (FY19-FY20)**

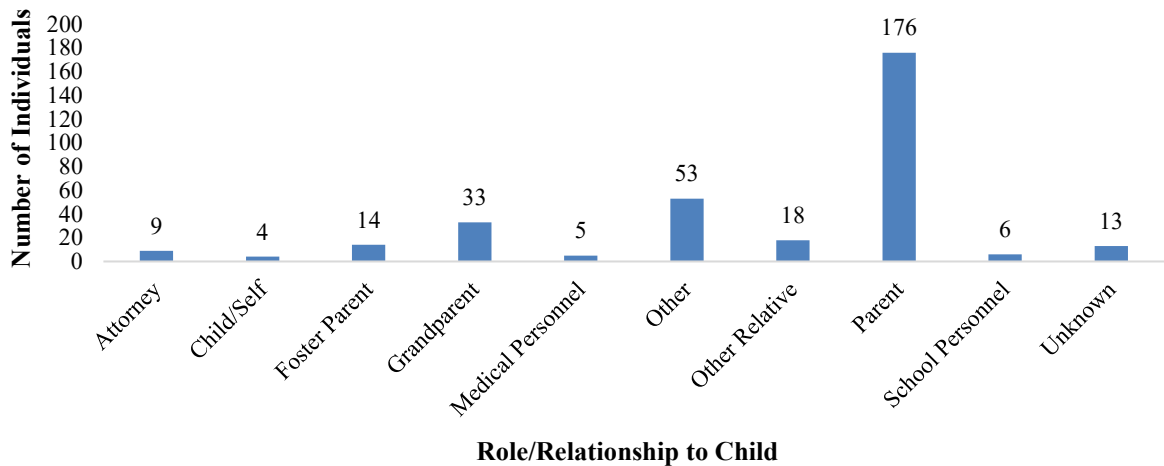


<sup>51</sup> The Office of the Child Advocate transitioned from in-office to remote work in mid-March 2020 in response to the COVID-19 pandemic. However, the Complaint Line remained accessible through the phone, email, online complaint form, fax, and letter mail.

## Individual's Role and Relationship to the Child

Figure 14 shows that consistent with the past five years, the greatest number of contacts were made by parents. In prior years grandparents were the second greatest number of contacts, but in FY20 “other” individuals contacted the OCA with more frequency. The OCA attributes this to our outreach to legislators, providers, advocates, and others during COVID-19 to inform them of our Complaint Line and that we are available as a support and resource.

**Figure 14: Individual's Role/Relationship to Child within FY20 Complaint Line Contacts (n=331)**



*Note:* In the graph above, the total number of categorized roles of individual callers (331) is higher than the total number of individuals who contacted the Complaint Line in FY20 (328) as some individuals had more than one role (i.e. a grandparent who is the child’s kinship foster parent).

*Unknown Role:* The individual submitted their complaint anonymously or chose not to disclose their relationship to the child/young adult.

*Other Role:* An individual whose role does not meet the definition of a more specific category. Examples of Other roles in FY20 include family friends, partners of parents, educational advocates, state employees, victim advocates, daycare providers, neighbors, landlords, and mental health professionals.

## Child Welfare Complaint Subcategories

The OCA captures detailed subcategories related to child welfare concerns. In FY20, of the 176 child welfare concerns, there were 328 unique subcategories identified. These subcategories include complaints and concerns about the health, safety, or well-being of a child related to their placement/permanency, visitation, a family’s child-specific payments/vouchers, or DCF involvement. A child welfare complaint or concern **does not**

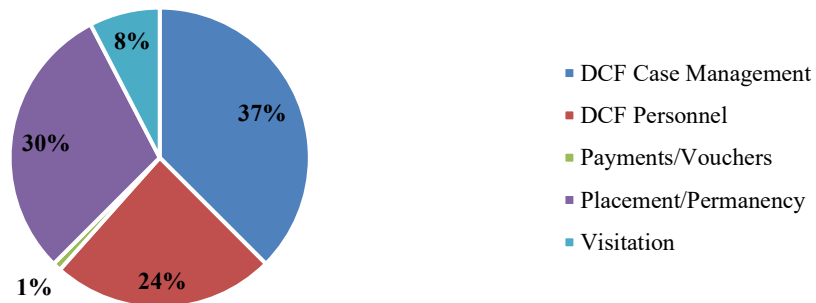
have to involve a child or family with an open DCF case. A child welfare complaint or concern can involve any child-serving state agency.

Figure 15 shows that the most common complaint in the Child Welfare subcategory was about DCF Case Management.<sup>52</sup> Complaints in this category include a concern with the way DCF has investigated a report of abuse and/or neglect, a removal of a child, provided service coordination, or has overseen an open case.

The second most common complaint in FY20 was Placement/Permanency. Complaints in this category include concerns about a child or young adult’s type of placement, plans to change a placement, or denial of a certain placement. Complaints in this category also include a change of a permanency goal (e.g reunification to adoption), the length of time a child or young adult has been in an out-of-home placement or the length of the adoption process.

The third most common complaint in FY20 was DCF Personnel. Complaints in this category include concerns about DCF personnel regarding alleged abuse of power, unfair treatment, professionalism, boundaries, timeliness, or communication. This includes any complaints and concerns about the DCF Ombudsman’s Office.

**Figure 15: FY20 Child Welfare Complaint Subcategories (n=328)**



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<sup>52</sup> The OCA re-structured the child welfare subcategories for FY20. Therefore, the child welfare subcategories cannot be compared to FY19.

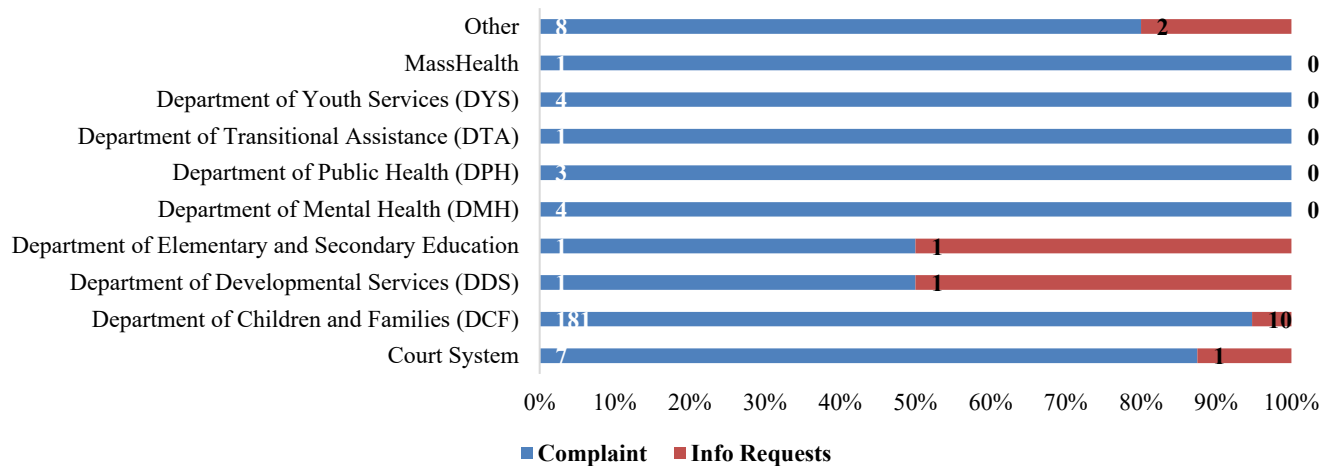


## OCA Complaint Line and State Agencies/Child-Serving Entities

Figure 16 shows that state agencies the OCA received either complaint about or a request for information and referrals during FY20. Within the 272 **complaints** received, 78% (211) of the individuals expressed concern or dissatisfaction with a particular state agency. Of the 211 individuals who identified such concerns with a particular state agency, 86% (181) were related to the Department of Children and Families (DCF).

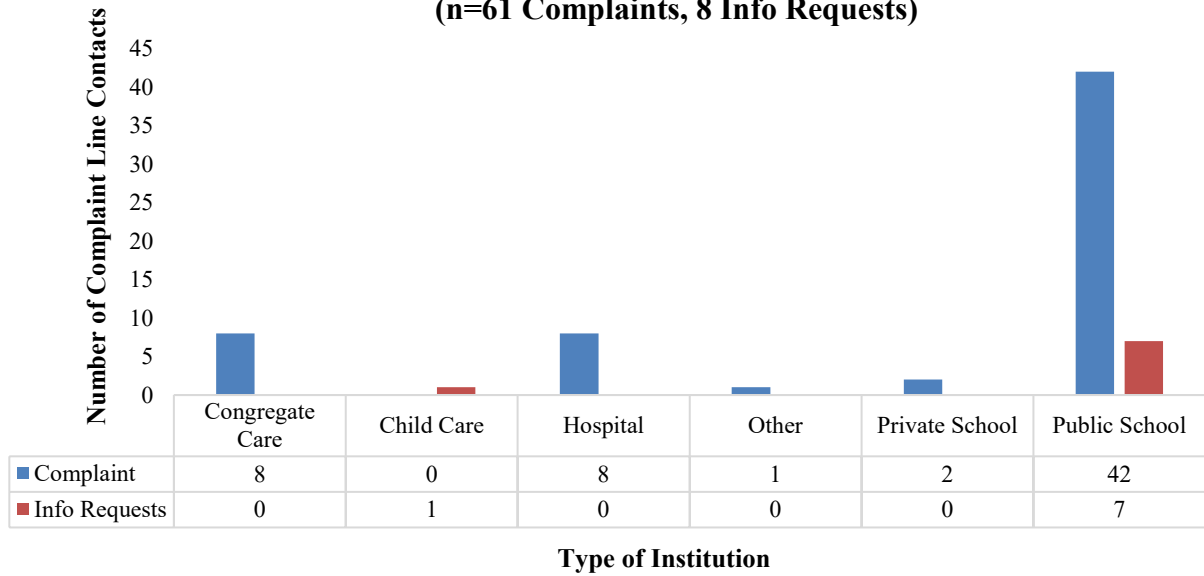
The complaints in the Other category were about the Department of Early Education and Care (EEC) and the Office of the Chief Medical Examiner (OCME). The information and referrals requests in the Other category were about the Department of Early Education and Care (EEC) and the Department of Revenue’s Child Support Enforcement Division.

**Figure 16: State Agencies discussed within FY20 Complaints and Information/Referral Requests (n=211 Complaints, 15 Info Requests)**



In addition to state agencies, within the 272 **complaints** received, 22% (61) of the individuals expressed concern or dissatisfaction with a specific child-serving entity (i.e. congregate care program, school, childcare). Figure 17 shows that of the 61 individuals who identified such concerns with a child-serving entity, 69% were related to a specific public school or public-school district. The other complaint was concerning an adoption agency.

**Figure 17: Child-Serving Entities discussed within FY20 Complaints and Information/Referral Requests (n=61 Complaints, 8 Info Requests)**



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

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The supplemental statistics, data visuals, and definitions presented throughout Appendix B provides complementary data to the information outlined in the **Abuse and/or Neglect in Out-of-Home Settings** section of this report ([pg. 17](#)).

## **Point in Time (June 30, 2020) Placement Type for DCF, DMH and DYS Involved Children and Youth**

### *Department of Children and Families*

DCF is the designated state child protective service agency responsible for keeping children safe from abuse and neglect by providing services, family supports, foster care, and new permanent families for children when necessary. DCF serves more children and families than any other EOHHS child-serving agency.

In FY20, DCF served 75,463 children and young adults. Therefore, it is not surprising that, consistent with previous fiscal years, in FY20 the majority of the total number of stage agency involved children and youth placed in our-of-home settings were by DCF.

Foster care placements provide stability and safety for children/youth that have been brought into the protective care of the state. These foster care placements may be with family or extended family, or through unrelated caretakers who have completed training and are approved as licensed foster parents assigned to a DCF social worker.<sup>53</sup> Table 1 lists the types of foster care homes, the number of children placed in each type and the definitions of the different types of foster care.

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<sup>53</sup> Massachusetts Department of Children and Families FY20 Annual Report: <https://www.mass.gov/doc/def-annual-reportfy2020/download>

**Table 1: Children Placed in Foster Care**

Foster Care Type	Total Number of Children in Foster Care (birth-17) as of June 30, 2020
<b>Kinship</b>	2,593
<b>Child Specific</b>	610
<b>DCF Unrestricted and/or Pre-Adoptive</b>	2,395
<b>Comprehensive Foster Care (CFC)</b>	1,310
<b>Total</b>	6, 908 (+ 3 in DCF Independent Living Programs <sup>54</sup> )

Congregate care is a term for placement settings that consists of 24-hour supervision for children in a varying degree of highly structured settings such as group homes, residential childcare communities, childcare institutions, residential treatment facilities, or maternity homes.<sup>55</sup> Table 2 shows the number of children who were placed in congregate care by DCF as of June 30, 2020.

**Table 2: DCF Involved Children Placed in Congregate Care**

Type of Congregate Care	Total Number of DCF Children in Congregate Care as of June 30, 2020
<b>Group Home</b>	653
<b>Continuum</b>	16
<b>Residential School</b>	428
<b>STARR (short-term residential)</b>	201
<b>Teen Parenting</b>	8
<b>Total</b>	1,306

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<sup>55</sup> Massachusetts Department of Children and Families FY20 Annual Report: <https://www.mass.gov/doc/DCF-annual-reportfy2020/download>

## *Department of Mental Health*

The Department of Mental Health Child, Youth and Family Services provides child/adolescent case management, individual and family support services, day services and out-of-home treatment services to children and youth with serious mental health needs.

Most mental health services, including medication and therapy are provided through health insurance – MassHealth (Medicaid), the Massachusetts Health Connector (health insurance marketplace) or through private insurance (employer-based).<sup>56</sup>

**Table 3: Children and Youth Placed in DMH Out-of-Home Treatment**

Service Type	Total Number of Children and Youth in DMH out-of-home Treatment as of June 30, 2020
<b>Caring Together Services</b>	
Intensive Group Home Services	27
Residential School Services	32
STARR Services	5
Transitional Age Youth Services	30
<b>Statewide Program Services</b>	
Intensive Residential Treatment	48
Clinical Intensive Residential Treatment	7
Inpatient Continuing Care	19
<b>Total in Out of Home Placements</b>	<b>168</b>

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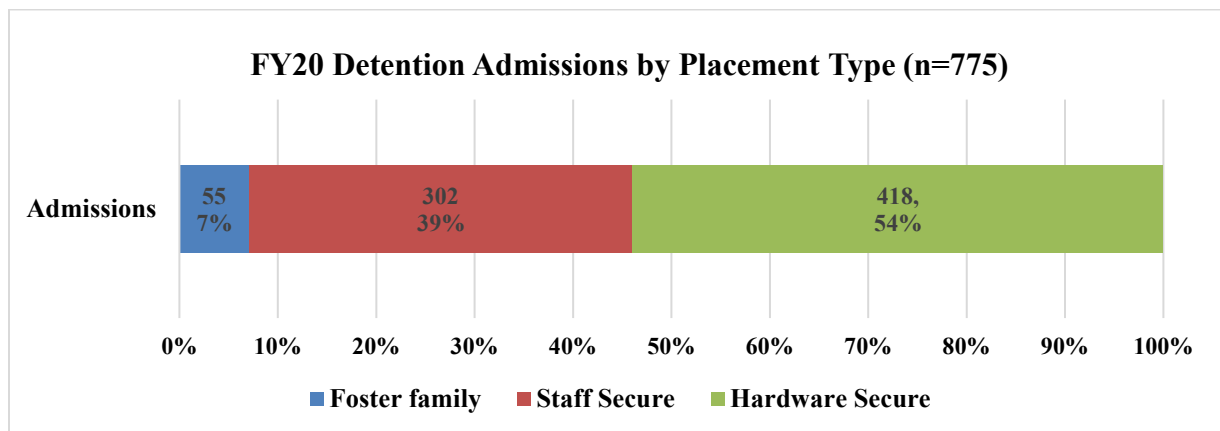
<sup>56</sup> Massachusetts Department of Public Health: <https://www.mass.gov/service-details/dmh-child-youth-and-family-services-overview>

## Department of Youth Services

DYS serves children and youth who have been committed to the care or physical custody of DYS by the courts. Youth committed to DYS’ “care” are youth who have been detained by the courts after having been charged with an offense and/or are awaiting resolution of a pending matter. Not all have been arrested; many are summonsed to court initially. Youth who are committed to DYS’ custody have been adjudicated delinquent or youthful offender of an offense against the Commonwealth. It is important to note that DYS never has legal custody of the youth committed to its custody, only physical.<sup>57</sup>

### Pretrial Detention

A youth is committed to DYS care by a judge if they have been found to be too dangerous to release pretrial as the result of a 58A (“Dangerousness”) Hearing<sup>58</sup>, or if they are unable to make the cash bail that has been set for them. Youth in pretrial detention are placed in the care of the DYS. In FY20, there were 775 detention admissions, of which 54% were detained in a hardware secure facility, 39% in a staff secure facility and 7% in a foster family placement.<sup>59</sup>



Source: Research Department, Department of Youth Services

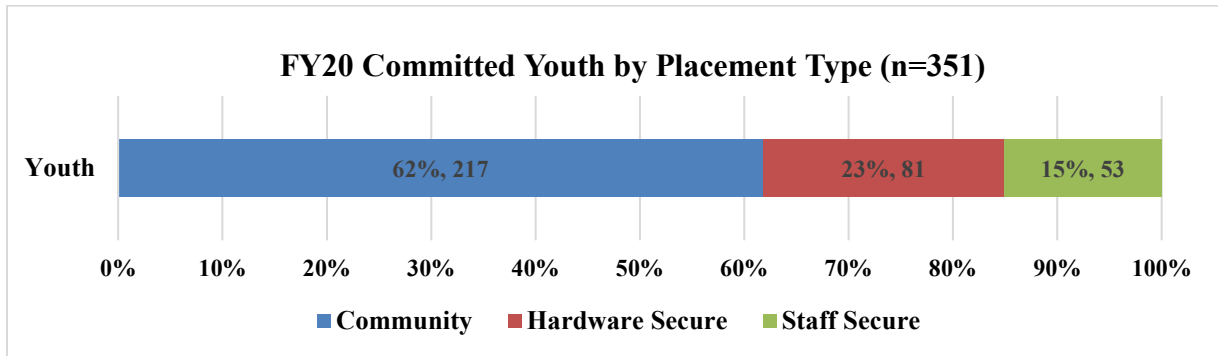
<sup>57</sup> Massachusetts Department of Youth Services: <https://www.mass.gov/service-details/department-of-youth-services-dys>

<sup>58</sup> Dangerousness hearings have two parts. In the first part, the judge determines whether the youth is dangerous; the second requires the youth to determine whether there are any conditions that would safeguard a particular individual or the community, such that the youth, though found dangerous, could be released.

<sup>59</sup> Other placement options available within the Department of Youth Services continuum of care include placement at home with District or Satellite Office Supervision; Foster Care; Transitional Living; and Revocation Facilities/Programs.

## Commitments to the Department of Youth Services

The most serious disposition the judge can make after a finding of “delinquent” is to commit the child to the physical custody of DYS until their 18<sup>th</sup> birthday (which can be extended to 19, 20, or 21 years old depending on the time and type of disposition). Since a youth’s placement type can change throughout their DYS commitment, it is best to use snapshot data to analyze the number of committed youths in various types of placements. At the end of FY20, 351 youth were committed to DYS physical custody. Of those, 62% were residing in the community<sup>60</sup>, 23% were in a hardware secure residential placement (the most serious security level) and 15% lived in a staff secure facility.



DYS committed youth who are involved with other state agencies may also be placed within programs operated by those agencies. These agencies may include, but are not limited to, DCF (i.e., foster care, residential placement); DMH (i.e., intensive residential treatment program, psychiatric hospitalization) and DPH (i.e. residential substance abuse programs); and the Department of Correction (i.e., adult correctional facility).

Youth committed to DYS who are charged with and ordered held or convicted of new offenses committed once they have attained the age of 18, are held in adult correctional settings including those operated by the Sheriffs or the Department of Correction. Youth committed to DYS until the age of 21 as youthful offenders may also receive adult sentences. Adult holds, whether bail or sentences, supersede juvenile holds.

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<sup>60</sup> Youth committed to DYS who are living in the community do so on a “Grant of Conditional Liberty” or GCL. The GCL can be revoked and a youth can be brought back to a DYS facility at the discretion of DYS. This is roughly equivalent to “parole” in the adult justice system.

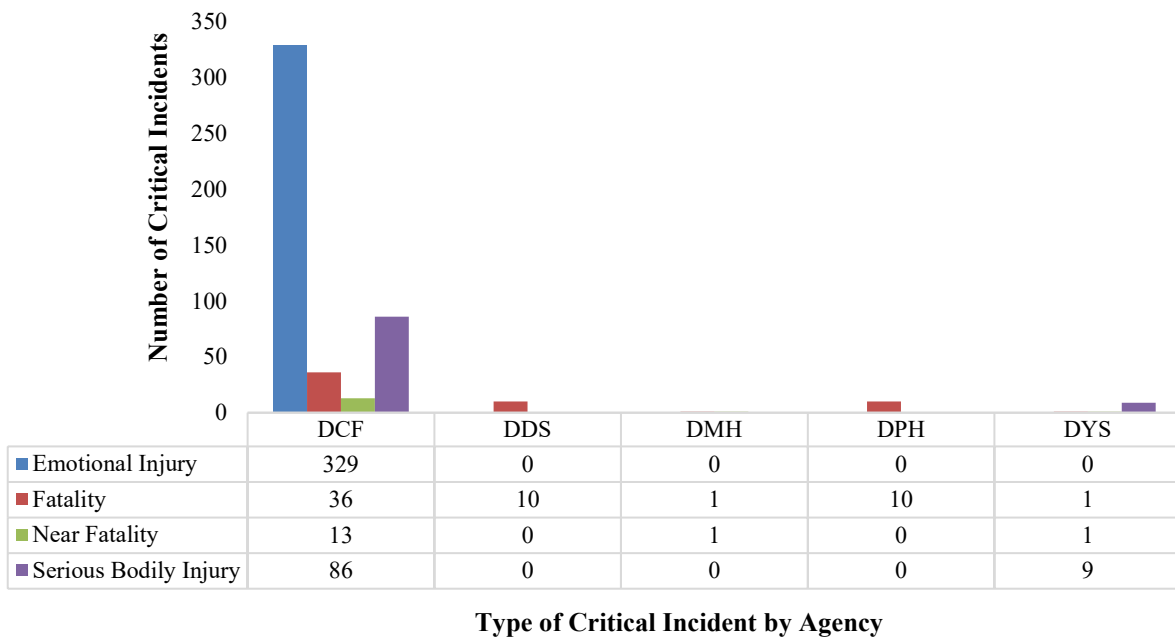
# Appendix C: Critical Incident Reports

The supplemental statistics, data visuals, and definitions presented throughout Appendix C provide complementary data to the information outlined in the **Critical Incident Reports** section of this report ([pg. 23](#)).

## Critical Incident Reports by Reporting Agency

Figure 18 shows the number of critical incidents by each reporting agency.

**Figure 18: FY20 Critical Incidents by Reporting Agency**



The 86 **DCF serious bodily injuries** were the result of five car accidents, 14 falls, 11 injuries of unknown origin, eight gunshot wounds, two medical conditions, 13 overdoses, 18 physical abuse, one sexual assault, one stabbing and 13 suicide attempts. The 13 **near fatalities** were the result of one car accident, three drownings, seven overdoses, one physical abuse and one suicide attempt. The 36 **fatalities** were the result of two car accidents, two drownings, two falls, six medical conditions, two overdoses, two incidents of physical abuse, 16 sudden unexpected infant deaths, two suicides and two unknown causes.

The nine **DDS fatalities** were due to complex medical conditions, and the other one fatality was due to an injury.

The one **DMH near fatality** involved a youth who was receiving DMH services in the community and attempted suicide. The one **fatality** was the youth’s subsequent death from the suicide attempt. Because the OCA received two critical incident reports about this youth,



one when the youth attempted suicide and the other when the youth died, the OCA counted this as two separate incidents.

The ten **DPH fatalities** were the result of the complex medical conditions of eight of the children, one sudden unexpected death of an infant, and in one the incident that led to the fatality is unknown.

The nine **DYS serious bodily injuries** were the result of five gunshot wounds, two stabbings, one car accident and one self-inflicted injury. The one **near fatality** was the result of a gunshot wound and the one **fatality** was due to unknown causes at the time of death.

### Critical Incident Report by Type

Table 3 compares FY19 data and FY20 data broken down by fatality, near fatality, and serious bodily injury. Within the **serious bodily injury** critical incident category, four types of events experienced dramatic increases.

- The number of **injuries** increased by 28 from FY19 to FY20.
- There number of **overdoses** increased by 11 from FY19 to FY20.
- There number of **physical abuses** increased by 13 from FY19 to FY20.
- There number of **suicide attempts** increased by 8 from FY19 to FY20.

**Table 3: Types of Events within Fatality, Near Fatality, and Serious Bodily Injury Critical Incident Reports (FY19-FY20)**

Type of Event	Fatality		Near Fatality		Serious Bodily Injury		Total
	FY19	FY20	FY19	FY20	FY19	FY20	
<b>Injury</b>	7	7	2	4	5	33	58
<b>Medical</b>	27	22	2	0	0	2	53
<b>Other</b>	3	5	1	0	1	1	11
<b>Overdose</b>	4	2	9	7	2	13	37
<b>Physical Abuse</b>	0	2	1	1	5	18	27
<b>Sexual Assault</b>	0	0	0	0	2	1	3
<b>Suicide</b>	3	3	0	0	0	0	6
<b>Suicide Attempt</b>	0	0	3	2	5	13	23
<b>SUID</b>	15	17	0	0	0	0	32
<b>Victim of Violence</b>	2	0	3	1	13	14	33
<b>Total</b>	<b>61</b>	<b>58</b>	<b>21</b>	<b>15</b>	<b>33</b>	<b>95</b>	<b>283</b>

Table 4 provides the type of critical incident, type of event, and the age range of the children involved. A child is counted in more than one category if that child experienced more than one type of critical incident.

**Table 4: Type of Critical Incident and Type of Event by Age Range of Children (FY20)**

Type of Critical Incident	Type of Event	Age 0-3	Age 4-7	Age 8-11	Age 12-15	Age 16-22	Total
<b>Emotional Injury</b>	Witness to Other Death/Injury	11	9	11	12	0	43
	Witness to Overdose	37	68	43	39	18	205
	Witness to Suicide/Suicide Attempt	4	8	9	7	2	30
	Witness to Unexpected Medical Event	2	3	4	7	2	18
	Witness to Violence	5	8	9	5	0	27
<b>Emotional Injury Total</b>		<b>59</b>	<b>96</b>	<b>76</b>	<b>70</b>	<b>22</b>	<b>323</b>
<b>Fatality</b>	Injury	2	0	1	1	3	7
	Medical	9	3	4	2	3	21
	Other	2	0	1	1	1	5
	Overdose	0	0	0	1	1	2
	Physical Abuse	2	0	0	0	0	2
	Suicide	0	0	0	1	2	3
	SUID	16	0	0	0	0	16
<b>Fatality Total</b>		<b>31</b>	<b>3</b>	<b>6</b>	<b>6</b>	<b>10</b>	<b>56</b>
<b>Near Fatality</b>	Injury	2	1	0	0	1	4
	Overdose	2	1	1	1	2	7
	Physical Abuse	1	0	0	0	0	1
	Suicide Attempt	0	0	0	1	1	2
	Victim of Violence	0	0	0	0	1	1
<b>Near Fatality Total</b>		<b>5</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>5</b>	<b>15</b>
<b>Serious Bodily Injury</b>	Injury	22	5	2	2	2	33
	Medical	1	0	1	0	0	2
	Other	0	0	0	0	1	1
	Overdose	4	2	1	2	3	12
	Physical Abuse	16	2	0	0	0	18
	Sexual Assault	1	0	0	0	0	1
	Suicide Attempt	0	0	1	8	3	12
Victim of Violence	0	0	0	5	9	14	
<b>Serious Bodily Injury Total</b>		<b>44</b>	<b>9</b>	<b>5</b>	<b>17</b>	<b>18</b>	<b>93</b>
<b>Total</b>		<b>139</b>	<b>110</b>	<b>88</b>	<b>95</b>	<b>55</b>	<b>487</b>

# Appendix D: State Agency Glossary of Terms

Term	Definition
OCA – Complaint	An individual who contacts the OCA Complaint Line to expresses dissatisfaction about services being provided to a child or young adult of the Commonwealth.
OCA – Critical Incident Report (CIR)	A fatality, near fatality, or serious bodily injury or emotional injury of a child who is in the custody of or receiving services from an executive agency or a constituent agency.
OCA – CIR Fatality	A fatality occurs when a child or young adult between the age of birth to 22 dies.
OCA – CIR Near Fatality	Near fatal injuries are accidental, the result of a medical condition, or the result of abuse and/or neglect. A near fatality designation is dependent on verbal certification by a physician that the child or young adult’s condition is considered life-threatening.
OCA- CIR Serious Bodily Injury	Serious bodily injuries are accidental, the result of an underlying medical condition, or the result of abuse and/or neglect and lead to bodily injury “which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress.” <a href="#">M.G.L. c. 18C § 5</a>
OCA – CIR Emotional Injury	An emotional injury occurs when a child or young adult is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.
OCA – CIR Other	A state agency will sometimes report incidents that do not meet the definition of a critical incident, but the agency believes the incident is important to share with the OCA. An example of this type of discretionary report might involve an altercation between youth placed in an out-of-home setting or incidents of violence in the community that involve children receiving services.
OCA – Information and Referral	An individual who contacts the OCA Complaint Line to request information, referrals, or education on a specific topic and does not express dissatisfaction with any agency or program that provides services to a child or young adult of the Commonwealth.
Department of Children and Families (DCF)	DCF is the designated state child protective service agency responsible for keeping children safe from abuse and neglect by providing services, family supports, foster care, and new permanent families for children when necessary. DCF serves more children and families than any other EOHHS child-serving agency.

DCF - Clinical Formulation	A holistic way of putting everything learned about a family together, incorporating the goals of both the family and DCF, to create a realistic plan that sets forth the hopes and vision for what needs to change to promote a family's safety, permanency, and well-being. The formulation is dynamic, and changes based on new information that is divulged or gathered.
DCF - Comprehensive Foster Care	Foster homes that offer more intense therapeutic care and supports setting for children with more complex needs. This service is only provided by licensed foster care agencies in accordance with the licensing requirements of the Department of Early Education and Care (EEC) and DCF.
DCF - Congregate Care	Congregate care is a term for placement settings that consists of 24-hour supervision for children in a varying degree of highly structured settings such as group homes, residential childcare communities, childcare institutions, residential treatment facilities, or maternity homes.
DCF - Congregate Care – Continuum	Provides an array of community-based wraparound services that are designed to maintain youth within their homes and support families as the primary caregivers. This includes in-home family treatment, parent support, youth mentoring, youth and family outreach, care coordination, and linkage with both formal and informal community resources and supports. For youth who cannot be maintained safely at home, services available within Continuum include long-term and short-term, out of-home care (e.g., group home, pre-independent living, intensive foster care, or respite).
DCF - Congregate Care – Group Home	Group homes provide an array of out-of-home treatment services supporting youth and their families (in cases where the families are available) when the youth cannot function safely at home or in a family setting. Group home services provide flexible individualized treatment, rehabilitation, and support/supervision services that vary in intensity based upon individual youth and family needs.
DCF - Congregate Care – Residential School	Congregate care, out-of-home treatment services that are integrated with an onsite special education school. Youth receiving residential school services need a self-contained, integrated treatment, and educational program due to severity of behavioral risk to self or others preventing them from safely attending school offsite.
DCF - Congregate Care – STARR	Stabilization and Rapid Reintegration (STARR) programs are for youth needing immediate/emergency temporary placement and/or stabilization services, as well as for youth who require more intense services. All youth referred will receive stabilization services, while some youth will require additional assessment, treatment, and family reintegration services.
DCF - Congregate Care – Teen Parenting	Congregate Care program which provides teen parents and their children a safe place to reside where they are able to gain the skills and knowledge necessary to become competent parents and lead productive, independent lives. Program staff ensures that teen parents are connected with resources in the community such as education, medical care, childcare, and counseling.

DCF Custody	Child in the custody of the department means a child placed in the Department's custody through court order, including an order under a Child Requiring Assistance (CRA) petition, formerly known as CHINS, or through adoption surrender.
DCF Foster Care - Child Specific	Foster care placements where a non-kinship individual(s) is identified and licensed as a placement for a particular child (e.g., school teacher or parent(s) of the placed child's friend). This is a person who the family or child has a strong bond with and is significant in their life.
DCF Foster Care - Kinship	Foster care placements provided by persons related by either blood, marriage, or adoption (e.g., adult sibling, grandparent, aunt, uncle, first cousin) or other adult to whom the child and/or parent(s) ascribe the role of the family based on cultural and affectional ties or individual family values.
DCF Independent Living	Services may be provided at either scattered or centralized (e.g. apartment) sites with staff that provide outreach and care coordination to young adults and are available for face-to-face crisis intervention 24 hours a day, seven days a week. This model serves young adults 17.5 or older who are not able to be served in a family setting due to their clinical needs, but who are able to live on their own with support; independently manage community access; have attained a sufficient level of independent living skills to enable them to live without on-site staffing; require and are able to utilize staff support to strengthen these independent skills; exhibit a strong level of self-regulation; are enrolled in school or a GED program; or have completed the above and are working or involved in vocational training.
DCF Foster Care - Pre-Adoptive Foster Care	A resource that has been identified as the child's permanent family. The person(s) have been approved for the adoption and are licensed adoptive families. The child is required to be in that specific home for a minimum of six months before the adoption can be finalized.
DCF Foster Care - Unrestricted Foster Care	An individual(s) who has been licensed by the Department as a partnership resource to provide foster/pre-adoptive care for a child usually not previously known to the individual(s)
Mandated Reporter	<p>Any person who suspects a child is being abused or neglected should call DCF to make a 51A report (named for its statute, MGL c.119, §51A), but mandated reporters are legally required to inform the Department.</p> <p>Mandated Reporters are defined by MGL c.119, §51A and include: any physician; medical intern; hospital personnel engaged in the examination, care or treatment of persons; medical examiner; psychologist; emergency medical technician; dentist; nurse; chiropractor; podiatrist; osteopath; public or private school teacher; educational administrator; guidance or family counselor; day care worker; any person paid to care for or work with a child in any public or private facility, home, or program funded by the Commonwealth or licensed pursuant to the provisions of MGL c.28A; voucher management agencies; family day care system; child care food program; probation officer; clerk/magistrate of the district courts; clergy; parole officer; social worker; foster parent; firefighter or police officer; school attendance officer; allied mental health and human services professional as</p>

	licensed pursuant to the provisions of MGL c. 112, §165; drug and alcoholism counselor; psychiatrist; and clinical social worker.
DCF Permanency	Ensuring a nurturing family – preferably one that is legally permanent – for every child within a timeframe supportive of their needs.
DCF - Victim (child)	A child for whom the state determined at least one maltreatment (allegation of abuse and/or neglect) was supported or indicated. This includes children who die of child abuse and neglect. This is a change from prior years when children with dispositions of alternative (i.e., differential) response victim were included as victims. It is important to note that a child may be a victim in one report and a non-victim in another report.
Department of Developmental Services	The state agency that provides supports for individuals with intellectual and developmental disabilities.
Department of Mental Health (DMH)	The state agency that assures and provides access to services and supports to meet the mental health needs of individuals of all ages, reported critical incidents involving children and young adults who are its clients in the community, acute care, residential treatment programs, and hospital settings.
DMH – Child/Adolescent Case Management	Case Management provides comprehensive mental health and family assessment as well as individual service planning, coordination of DMH funded services, and linkage to other community supports.
DMH – Individual and Family Support Services	Individual and Family Flexible Supports provide an individualized set of services designed to prevent out-of-home placement, maintain the youth with his/her family, help the youth function successfully in the community, and assist families in supporting the growth and recovery of their child. These include services such as respite, home-based family support, individual youth support, and youth support groups.
DMH - Day Services	Therapeutic After School Programs provide youth with recreational and skill building activities and clinical services in a structured environment.
DMH – Caring Together Services	Caring Together services include a range of in home and out of the home services for children and families involved with the Department of Mental Health (DMH) and/or the Department of Children and Families (DCF). Services provide clinically intensive treatment and outreach support to help build, strengthen and maintain connections to family, home and community so that children and families can live together successfully. Families who are working with DCF or DMH may be eligible for Caring Together services.
DMH Caring Together – Intensive Group Home Services	An out of home shared living environment located in the community. Youth attend a community-based school. Individual therapy is provided, and staff work with the family to develop and support the plan for the youth to return home.
DMH Caring Together – Residential School Services	Out of home shared living environment that is typically campus based with a therapeutic school on campus and intensive services in residential housing.
DMH Caring Together - Stabilization Assessment and Rapid Reunification (STARR) Services	Out of home shared living environment available for up to 45 days. STARR programs provide a short-term intervention to help stabilize and assess youth and family needs.

DMH Caring Together - Transitional Age Youth Services	Specialized out of home shared living environment for youth ages 18 to 25 who need assistance living independently. These services provide support and skill building to youth so they can live in either shared living or independent living situations with ongoing access to clinical supports.
DMH Statewide Program - Intensive Residential Treatment Programs (IRTP)	locked settings that offer both therapeutic services and a DOE-contracted school on site for youth 13-18.
DMH Statewide Program - Clinical Intensive Residential Treatment (CIRT)	Unlocked setting for youth under 13 years old with intensive therapeutic services and DOE-contracted school on site.
DMH Statewide Program - Inpatient Continuing Care	Locked setting for youth (13-18) who require the most intensive level of clinical treatment, specialized hospital care available and on-site DOE licensed school.
Department of Public Health	The state agency that promotes the health and well-being of all individuals by ensuring access to high-quality public health and healthcare services, and by focusing on prevention, wellness, and health equity.
Department of Youth Services (DYS)	The state juvenile justice agency, reported critical incidents involving youth or young adults detained or committed by the Juvenile Court to DHS who are receiving services in the community, in group or foster care, residential treatment programs, and secure treatment centers.
DYS Hardware Secure Treatment Facilities	Characterized by physically restrictive construction and procedures that are intended to prevent youth from leaving without the approval of the Department. Hardware secure residential treatment programs are primarily long-term (6 months and longer). These programs typically provide treatment services to youth committed to DHS for Grid Level 4-6 offenses. Youth committed on Grid Level 3 offenses involving Firearms or Sex Offenses may also be considered for Secure Treatment. Initial time recommendations in these placements range from 6-18 months in duration.
DYS Staff Secure Treatment Facilities	Characterized by a system of staff development and behavior control procedures designed to prevent youth from leaving without the approval of the Department. Staff secure residential treatment program are primarily short-term (3-5 months typically). Examples include Group Homes and Chapter 766 Residential Programs. Staff secure programs emphasize accountability, pro-social skill development, and planning for community re-entry.

# Commonwealth of Massachusetts

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