OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

Official Audit Report – Issued November 7, 2024

Department of Children and Families

For the period July 1, 2019 through December 31, 2023

State House Room 230 ■ Boston, MA 02133 ■ auditor@massauditor.gov ■ www.mass.gov/auditor

OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

November 7, 2024

Staverne Miller, Commissioner
Department of Children and Families
600 Washington Street, 6th Floor
Boston, MA 02111

Dear Ms. Miller:

I am pleased to provide to you the results of the enclosed performance audit of the Department of Children and Families. As is typically the case, this report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2019 through December 31, 2023. As you know, my audit team discussed the contents of this report with agency managers. This report reflects those comments.

I appreciate you and all your efforts at the Department of Children and Families. The cooperation and assistance provided to my staff during the audit went a long way toward a smooth process. Thank you for encouraging and making available your team. I am available to discuss this audit if you or your team have any questions.

Best regards,

Diana DiZoglio
Auditor of the Commonwealth

cc: Kate Walsh, Secretary of the Executive Office of Health and Human Services
Maria Z. Mossaides, Child Advocate of the Office of the Child Advocate

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LIST OF ABBREVIATIONS

AACAP	American Academy of Child and Adolescent Psychiatry
DCF	Department of Children and Families
EOTSS	Executive Office of Technology Services and Security
FDA	US Food and Drug Administration
FFS	fee-for-service
HHS OIG	US Department of Health and Human Services Office of Inspector General
iFN	iFamilyNet
MCO	managed care organization
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor

EXECUTIVE SUMMARY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of the Department of Children and Families (DCF) for the period July 1, 2019 through December 31, 2023.

In this performance audit, we examined DCF's process related to psychotropic medications[1] prescribed to children in its protective custody. Specifically, we determined the following:

- whether DCF obtained the required court approval for antipsychotic medications and documented its consent for psychotropic medications prescribed to children in its protective custody as required by Sections 11.14(3)(a), (4)(a), and (6)(a) of Title 110 of the Code of Massachusetts Regulations and DCF Policy 2010-001: Medical Examinations for Children Entering DCF Placement or Custody;
- whether children in DCF's protective custody received follow-up visits and recommended psychosocial services in conjunction with prescriptions for psychotropic medications in accordance with the American Academy of Child and Adolescent Psychiatry's 2005 "Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline" and the American Academy of Child and Adolescent Psychiatry's 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*;
- whether DCF maintained medical passports[2] for children in its protective custody who received psychotropic medications according to DCF Policy 85-003: Health Care Services to Children in Placement, DCF Policy 86-011: Ongoing Casework and Documentation, DCF Policy 2010-001, and Section 475 of the Social Security Act; and
- whether DCF provided oversight to children in its protective custody who received psychotropic medications that exceeded the US Food and Drug Administration's (FDA's) recommended maximum dosages.

In addition to examining DCF's process related to psychotropic medications prescribed for children in its protective custody, we determined the following:

- whether DCF updated its internal control plan to address the COVID-19 pandemic as required by the Office of the Comptroller of the Commonwealth's "COVID-19 Pandemic Response Internal Controls Guidance";

1. Psychotropic medications are used to treat mental health disorders such as schizophrenia, depression, bipolar disorder, anxiety disorders, and attention deficit / hyperactivity disorder.
2. A medical passport is a record of healthcare services that a child receives or has received, including their current medications, relevant mental health history, known mental health conditions, treatment programs, and appointments.

- whether DCF ensured that employees who had access to COVID-19 funds completed cybersecurity awareness training in accordance with the Executive Office of Technology Services and Security's Information Security Risk Standard IS.010; and
- whether DCF made outreach efforts to ensure that it reached eligible youths who aged out of DCF care to allocate funds from the John H. Chafee Foster Care Independence Program grant as required by the grant agreement ACYF-CB-PI-21-04.

Below is a summary of our findings, the effects of those findings, and our recommendations, with links to each page listed.

Finding 1 **Page 18**	DCF did not always obtain or renew court approval before children in its protective custody were administered antipsychotic medications.
Effect	If DCF does not obtain or renew court approvals for antipsychotic medications, which includes presenting treatment plans to the courts, it cannot ensure that these treatment plans are safe and appropriate for the children. In addition, this is removing the courts' oversight of children in DCF protective custody, who are too young to consent to their treatment plans and need a neutral, third party to ensure that any prescribed medications are in the children's best interest.
Recommendation **Page 19**	DCF should add monitoring controls to its policies and procedures to ensure that any Rogers guardianship orders are approved and renewed by the court.
Finding 2a **Page 22**	DCF did not document and/or update psychotropic medications listed in children's medical passports.
Effect	Without accurate and complete information, DCF and health providers may make decisions that conflict with existing medical treatments or do not reflect children's best interests, such as overprescribing psychotropic medications, which can lead to adverse side effects.
Finding 2b **Page 25**	DCF did not document follow-up doctor appointments and recommended psychosocial services in iFamilyNet (iFN) for children in its protective custody receiving psychotropic medications.
Effect	If DCF does not of not keep accurate and complete medical records in iFN, then children in DCF's protective custody may not receive the services needed to treat their conditions. This may delay the growth, development, or recovery of the children who did not receive needed care. Failure to keep accurate and complete medical records may also prevent DCF from determining which medical treatments or providers are most effective or cost-efficient for serving the medical needs of children in its care.
Finding 2c **Page 26**	DCF did not document its consent in iFN for children in its protective custody to receive psychotropic medications.
Effect	Without documentation of consent or court approval for prescriptions of psychotropic medications, DCF cannot ensure that its social workers and/or medical social workers are providing children in DCF protective custody with medical treatment that is legally required.

Recommendation Page 28	DCF should establish sufficient monitoring controls to ensure that children in its protective custody have up-to-date and accurate health records in iFN and that its social workers prevent these children from receiving medical care without approval, including the following: • DCF should review medical passports for children in its protective custody and update them at least every six months or when there are changes to a child's prescription (e.g., new prescriptions, dosage changes, or discontinued prescriptions). • DCF should update iFN with all follow-up doctor appointments and psychosocial services for children in its protective custody, including the type and frequency of these appointments and services. • DCF should document its consent for psychotropic medication for children in its protective custody in iFN and store that consent in the same location in iFN for quick and accurate reviews.
Finding 3 Page 30	DCF did not ensure that children received recommended psychosocial services in conjunction with their prescriptions for psychotropic medications.
Effect	If children do not receive the recommended therapy and psychosocial services with psychotropic medications, treatment effectiveness can be negatively affected. Further DCF cannot monitor the effectiveness of these medications and cannot identify and mitigate any side effects that these children may experience. For example, 28 children from both our samples had suicidal ideations.
Recommendation Page 31	DCF should ensure that all children in its protective custody who are prescribed psychotropic medications receive psychosocial services and DCF should implement sufficient monitoring controls to ensure that these services are provided and that the efficacy of these services is evaluated.
Finding 4 Page 32	DCF did not ensure that all employees with access to COVID-19 funds received annual refresher cybersecurity awareness training.
Effect	If DCF does not ensure that all its employees complete cybersecurity awareness training, then it is exposed to a higher-than-acceptable risk of cyberattacks and financial and/or reputational losses.
Recommendation Page 32	DCF should develop and implement policies, procedures, and controls to ensure that all its employees complete cybersecurity awareness training.

In addition, we identified an issue regarding DCF oversight of children in its custody receiving psychotropic medication in amounts that exceeded the FDA's recommended doses. For more information on this issue, see the "Other Matters" section of this report.

During our audit, additional areas of concern that were outside the original scope of our objectives came to our attention. Given the high-risk nature of these areas, we examined them while we were still engaged with the auditee. These areas include human trafficking prevention measures, as well as DCF's implementation of recommendations by the Massachusetts Commission on LGBTQ Youth. The results of this work are included within the "Other Matters" section of this audit report.

OVERVIEW OF AUDITED ENTITY

The Department of Children and Families (DCF), established by Section 1 of Chapter 18B of the Massachusetts General Laws, provides services to children ages 0 through 21 who are at risk or who have been victims of abuse or neglect, as well as their families.

According to its website, DCF "works in partnership with families and communities to keep children safe from abuse and neglect."

DCF services include adoption, guardianship, foster care, housing stabilization, and family support and stabilization. DCF has a central office in Boston and four regional offices administered by regional directors who oversee 29 local-area offices.

In fiscal year 2020, DCF provided support and services to approximately 48,000 children between the ages of 0 and 21. DCF had an annual appropriation of approximately $1.05 billion for fiscal year 2020 and an annual appropriation of approximately $1.09 billion for fiscal year 2021.

Federal law requires Massachusetts to have a plan for overseeing and coordinating healthcare services for any child in foster care placement. According to Section 422(b)(15)(A)(v) of the Social Security Act, this plan must include "an outline of the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications."

DCF's Protective Custody

Children are referred to DCF for services in several ways. Section 51A of Chapter 119 of the General Laws requires professionals whose work brings them into contact with children to be designated as mandated reporters. Mandated reporters are required to make an immediate oral report, and a subsequent written report (called a 51A report), to DCF when, in their professional capacity, they have reasonable cause to believe that a child under the age of 18 is suffering from abuse and/or neglect. If DCF considers the report to have merit, it conducts what is called a 51B investigation. For children who are in immediate danger, DCF can file a care and protection case in the Juvenile Court and request that a judge order the child's immediate removal from a household into DCF's protective custody. Children and families may also come to DCF's attention from sources other than 51A reports, including cases referred by the Juvenile Court, cases referred by the Probate Court, instances of infants surrendered under the Safe Haven Act, and parents' or other relatives' requests for DCF services.

When a child is removed from a household and is in DCF's protective custody, they are placed in DCF-contracted or DCF-operated settings, such as foster care, a shelter, a short-term or group care program, or a community residential care facility.

During fiscal years 2020 and 2021, a total of 17,891 children under the age of 18 were in DCF's protective custody.

DCF's iFamilyNet

DCF implemented the Statewide Child Welfare Information System, known as FamilyNet, in February 1998. In 2009, DCF moved FamilyNet functionality to the web-based application, iFamilyNet (iFN). iFN is the system of record for DCF. Starting in May 2016, DCF hired 29 medical social workers—one for each local-area office—who are responsible for ensuring that each child's healthcare records, such as medical appointment information or medical passport information, remain up-to-date in the medical section of iFN. Social workers input healthcare information for children, including their healthcare providers, appointment dates, medical conditions, and medications, in the medical section of iFN. In addition, social workers can upload healthcare records directly to iFN. These electronic healthcare records enable the social worker to review a child's healthcare information at any time.

Pediatric Behavioral Health Medication Initiative

The University of Massachusetts Chan Medical School leads the MassHealth Pharmacy Program in collaboration with DCF and the Department of Mental Health. In 2014, this partnership created the Pediatric Behavioral Health Medication Initiative to ensure safe and effective prescribing of behavioral health medications, including psychotropic medications, for MassHealth members who are 18 years old and younger. This initiative requires prior authorizations from MassHealth for certain behavioral medication classes and/or specific medication combinations that have limited evidence for safety and efficacy within the pediatric population. For example, pharmacy claims with any combination of four or more behavioral health medications within a 45-day period require a prior authorization from MassHealth.

Psychotropic Medications

Psychotropic medications are provided to patients with diagnosed mental health disorders. These medicines may be prescribed to children in protective custody. During the audit period, 3,899 (22%) of the 17,891 children in DCF's protective custody were prescribed at least one psychotropic medication.

According to the American Academy of Child and Adolescent Psychiatry's (AACAP's) 2005 "Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline," "Many children in state custody benefit from psychotropic medications as part of a comprehensive mental health treatment plan." For example, these medications can help control mental health symptoms such as mood swings, anger outbursts, hallucinations, and delusions. Although there are benefits to prescribing children in protective custody psychotropic medication, it is important that the medication is only a part of an overall health treatment plan, which should include monitoring the side effects of these medications and providing mental health services.

According to the US Food and Drug Administration's (FDA's) *Approved Drug Products with Therapeutic Equivalence Evaluations*, referred to as the Orange Book,[3] psychotropic medications can have potentially serious side effects associated with them, including drowsiness, upset stomach, increased appetite and weight gain, other metabolic abnormalities, allergic reactions, mania, seizures, low sodium, serotonin syndrome, and suicidal ideation. According to AACAP's 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*, healthcare professionals should routinely monitor children receiving this class of medication for adverse side effects like these and avoid prescribing children too many medications.

We used the MassHealth Pediatric Behavior Health Initiative Medication List[4] to determine what specific psychotropic medications were prescribed to children in DCF's protective custody. These medications included the following:

- antianxiety and antidepressant medications, such as Zoloft, which are used to treat anxiety or depression;

3. The Orange Book lists all medications that the FDA has deemed safe and effective. For each medication, the Orange Book includes information such as side effects, warnings, dosage recommendations, indications, and more.
4. This medication list was created by MassHealth's Pharmacy Program in collaboration with DCF and the Department of Mental Health and includes medications prescribed for pediatric behavior health diagnoses.

- antipsychotic medications, such as Haldol, which are used to treat symptoms of some mental disorders, including schizophrenia;
- mood stabilizing medications, such as lithium, which are used to treat mood disorders, such as bipolar disorder;
- stimulants, such as Adderall, which are used to treat attention deficit / hyperactivity disorder; and
- other medications, such as Armodafinil, which are used to treat excessive drowsiness and/or narcolepsy.

The table below shows the breakdown of psychotropic medication types and how many prescriptions for each were filled for children in DCF's protective custody who were in a fee-for-service (FFS) plan.

Medication Type	Number of Prescriptions Filled
Antianxiety	1,065
Antidepressant	21,585
Antipsychotic	10,564
Mood stabilizer	10,776
Stimulant*	48,453
Other	1,244
Total	93,687

* Stimulants in this list included some hypertension medications that are also used to treat attention deficit / hyperactivity disorder. These medications were listed on the MassHealth Pediatric Behavior Health Initiative Medication List for this reason.

Psychotropic Medication Consent

When a healthcare provider recommends prescribing psychotropic medication(s) to a child in DCF's protective custody, DCF must consent to the prescription. A social worker engages with the child in protective custody and the foster family or residential facility providing care regarding the prescribing provider's recommendations, and the social worker, doctor, and caregiver (i.e., foster family or program provider) together develop a plan for the child's well-being. Additionally, the social worker should document DCF's consent for the use of psychotropic medications, should ensure that the prescription(s) are filled, and should document the consent in iFN throughout the child's time in DCF's protective custody.

Rogers Guardianship Order

Rogers guardianship order proceedings are named for the 1983 Massachusetts court case, *Rogers v. Commissioner of Mental Health*, in which the court stated that antipsychotic medications are so intrusive,

and their side effects are potentially so severe, that a court must review the treatment plan and approve their prescription and use for children in DCF's protective custody.

In order to apply for a Rogers guardianship order, DCF must present the court with a Clinician's Affidavit as to Competency and Proposed Treatment Plan from the healthcare professional for the prescription and administration of the proposed antipsychotic medication. This treatment plan includes the name of the antipsychotic medication, the dosage, the dosage range, proposed alternative medications, risks of potential side effects and/or adverse reactions, and the benefits of the medication.

If the judge approves the Rogers guardianship order, the treatment plan presented to the judge remains in effect for a specified amount of time. After the specified amount of time has lapsed, or at least annually, the Rogers guardianship order must be reviewed and renewed.

Medical Passport

All children placed in DCF's protective custody are issued a physical medical passport. A medical passport is a record of healthcare services that a child receives, including current medications, relevant mental health history, known mental health conditions, all treatment programs, and appointments. The medical passport remains with the child and in the possession of the foster family, group home, or residential facility throughout the child's time in protective custody or foster care placements. DCF requires its social workers to review these physical medical passports every six months to keep the children's related medical records in iFN updated with their most recent healthcare information.

Psychosocial Services

Psychosocial services are mental health treatment services designed to reduce patients' emotional or behavioral symptoms and usually include general therapy, group therapy, and behavioral therapy. Such therapies may be used instead of, or in combination with, psychotropic medications to treat children with mental health conditions. AACAP's 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems* recommends, "All youth with complex behavioral needs, including youth in foster care, should receive a combination of evidence-based psychosocial interventions and psychotropic medication when indicated, not just psychotropic medication alone."

FFS and Managed Care Program

MassHealth members can receive benefits on an FFS basis or through a managed care program. MassHealth directly pays healthcare providers under the FFS model for medical services rendered to an eligible MassHealth member. Healthcare providers can bill MassHealth directly through the Provider Online Service Center, which connects to the Medicaid Management Information System, using its MassHealth-issued provider identification.

MassHealth's managed care program consists of two managed care organizations (MCOs), Tufts Health Together and Boston Medical Center HealthNet Plan, both of which provide healthcare services to members through MCO plans. Each MCO plan assigns members a group of doctors and other healthcare providers who work together to provide members with coordinated healthcare services. The doctors and other healthcare providers contractually agree to follow certain federal and state requirements about how they provide services. MCO plan enrollees select a primary care physician to provide basic healthcare and make any necessary specialist referrals. MassHealth pays the MCO a capitation payment,[5] the amount of which is based on a rating category assigned by the Executive Office of Health and Human Services, for each member enrolled in the MCO plan. Rating categories are based on risk factors for each member, such as whether the member needs facility-based care (e.g., skilled nursing facilities) or behavioral health treatment.

Office of the Comptroller of the Commonwealth's Pandemic Response Guidance

On September 30, 2020, the Office of the Comptroller of the Commonwealth provided guidance in response to the COVID-19 pandemic for state agencies. This guidance helped state agencies that were experiencing significant changes to identify their goals, objectives, and risks associated with the COVID-19 pandemic. Objectives included the following: telework; return-to-office plans; a risk assessment of the impact of COVID-19 on department operations; changes to business processes; safety protocols for staff members and visitors; and tracking of COVID-19-related awards and expenditures, which were tracked separately from other federal, state, and local expenditures.

5. Medicaid programs make fixed monthly payments to MCOs for members enrolled in its Managed Care Program. Each payment is made to MCOs to cover the cost of the healthcare services of the member, and the amount of each payment is based on the healthcare needs of each member.

Cybersecurity Awareness Training

The Executive Office of Technology Services and Security (EOTSS) has established policies and procedures that apply to all Commonwealth agencies within the executive branch. Section 6.2 of EOTSS's Information Security Risk Management Standard IS.010 states,

> *The objective of the Commonwealth information security training is to educate users on their responsibility to help protect the confidentiality, availability and integrity of the Commonwealth's information assets. Commonwealth Offices and Agencies must ensure that all personnel are trained on all relevant rules and regulations for cybersecurity.*

To ensure that employees are clear on their responsibilities, EOTSS's policies require that all employees in state executive branch agencies complete a cybersecurity awareness training course every year. All newly hired employees must complete an initial security awareness training course within 30 days of their orientation.

John H. Chafee Foster Care Independence Program Grant

DCF received $7.9 million from the federal government through the John H. Chafee Foster Care Independence Program to give direct financial assistance to help current and former foster children recover from the pandemic. The Supporting Foster Youth and Families through the Pandemic Act prohibited states from allowing children to age out[6] of foster care during the pandemic. This law also allocated money to distribute to young people in foster care and to former foster children who had aged out of the system before the pandemic but were still under the age of 26. In the five-year Child and Family Services Prevention Plan that Massachusetts submits to the federal government, the Commonwealth commits to providing support to the child welfare system to promote the safety and well-being of children within the Commonwealth.

6. On a child's 18th birthday, they become a legal adult and can decide whether they want to stay in DCF care. If they decide to stay, DCF continues to provide services to them, including helping design a transition plan for them; providing them a safe, affordable place to live; getting them important documents such as photo identification, a Social Security card, and their birth certificate; and helping them find local health services until they are 21 years old.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of certain activities of the Department of Children and Families (DCF) for the period July 1, 2019 through December 31, 2023.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did DCF obtain required court approval for antipsychotic medications and document its consent for psychotropic medications prescribed to children in its protective custody as required by Sections 11.14(3)(a), (4)(a), and (6)(a) of Title 110 of the Code of Massachusetts Regulations and DCF Policy 2010-001: Medical Examinations for Children Entering DCF Placement or Custody?	**No; see Findings 1 and 2c**
2. Did children in DCF's protective custody receive follow-up visits and recommended psychosocial services in conjunction with prescriptions for psychotropic medications in accordance with the American Academy of Child and Adolescent Psychiatry's 2005 "Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline" and the American Academy of Child and Adolescent Psychiatry's 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*?	**No; see Findings 3 and 2b**
3. Did DCF maintain medical passports for children in its protective custody who received psychotropic medications according to DCF Policy 85-003: Health Care Services to Children in Placement, DCF Policy 86-011: Ongoing Casework and Documentation, DCF Policy 2010-001, and Section 475 of the Social Security Act?	**No; see Finding 2a**
4. Did DCF provide oversight to children in its protective custody who received psychotropic medications that exceeded the US Food and Drug Administration's (FDA's) recommended maximum dosages?	**No; see Other Matters**

Objective	Conclusion
5. Did DCF update its internal control plan to address the COVID-19 pandemic as required by the Office of the Comptroller of the Commonwealth's "COVID-19 Pandemic Response Internal Controls Guidance," and did DCF ensure that employees who had access to COVID-19 funds completed cybersecurity awareness training in accordance with the Executive Office of Technology Services and Security's (EOTSS's) Information Security Risk Standard IS.010?	**No; see Finding 4**
6. Did DCF make outreach efforts to ensure that it reached eligible youths who aged out of DCF care to allocate funds from the John H. Chafee Foster Care Independence Program grant as required by the grant agreement ACYF-CB-PI-21-04?	**Yes**

To accomplish our audit objectives, we gained an understanding of the aspects of DCF's internal control environment relevant to our objectives by reviewing its internal control plan and applicable policies and procedures, as well as by interviewing DCF employees and management.

To obtain sufficient, appropriate evidence to address our audit objectives, we performed the procedures described below.

Sampling Strategies for Children in DCF's Protective Custody

DCF provided us with a list of all 3,899 children in its protective custody who received at least one psychotropic medication during the audit period. We separated this list based on whether the child was enrolled in a fee-for-service (FFS) plan (3,204 children) or managed care organization (MCO) plan (695 children). This separation allowed us to further refine the FFS population based on our detailed access to claim information.

- First, we removed claims for children who were receiving psychotropic medications that exceeded the FDA's recommended maximum dosages, which totaled 299 children, bringing the population from 3,204 to 2,905 (see the "Maximum Dosages" section of this report).
- We removed the claims for children in the FFS plan population of 2,905 who had fewer than 24 claims for psychotropic medications (meaning they were not prescribed the medication during the length of the audit period). This gave us a population of 1,180 children in DCF's protective custody with an FFS plan who consistently received at least one psychotropic medication during the audit period.

For Objectives 1, 2, and 3, we selected a random, statistical sample[7] of 118 out of 1,180 children in DCF's protective custody enrolled in an FFS plan and who were prescribed at least one psychotropic medication, using a 95% confidence level,[8] a 50% expected error rate,[9] and a 15% desired precision range.[10]

In addition, we selected a random, nonstatistical sample[11] of 50 out of 695 children in DCF's protective custody enrolled in a managed care plan who were prescribed at least one psychotropic medication.

For Objective 4, we selected a random, nonstatistical sample of 40 out of 299 children in DCF's protective custody in an FFS plan who, based on Medicaid Management Information System (MMIS) data, received psychotropic medications that exceeded the FDA's recommended maximum dosages.

Rogers Guardianship Orders and Department Consent

To determine whether DCF obtained required court approval for antipsychotic medications and documented its consent for psychotropic medications prescribed to children in its protective custody, we took the following actions:

We met with DCF officials to go through its iFamilyNet (iFN) system to gain an understanding of where all the Rogers guardianship orders should be located in iFN. Next, we reviewed the MMIS All Services Report[12] for each child listed in both our FFS and MCO samples and identified the claims for psychotropic medication(s) for these children to determine whether each child was prescribed an antipsychotic and/or another type of psychotropic medication. (As previously stated, any child prescribed an antipsychotic medication required a Rogers guardianship order, and any child prescribed another psychotropic

7. Auditors use statistical sampling to select items for audit testing when a population is large (usually over 1,000) and contains similar items. Auditors generally use a statistics software program to choose a random sample when statistical sampling is used. The results of testing using statistical sampling, unlike those from judgmental sampling, can usually be used to make conclusions or projections about entire populations.
8. Confidence level is a mathematically based measure of the auditor's assurance that the sample results (statistic) are representative of the population (parameter), expressed as a percentage.
9. Expected error rate is the number of errors that are expected in the population, expressed as a percentage. It is based on the auditor's knowledge of factors such as prior year results, the understanding of controls gained in planning, or a probe sample.
10. Desired precision range is the range of likely values within which the true population value should lie; also called confidence interval. For example, if the interval is 90%, the auditor will set an upper confidence limit and a lower confidence where 90% of transactions fall within those limits.
11. Auditors use judgmental (i.e., nonstatistical) sampling to select items for audit testing when a population is very small, the population items are not similar enough, or there are specific items in the population that the auditors want to review. Auditors use their knowledge and judgment to select the most appropriate sample. For example, an auditor might select items from areas of high risk. The results of testing using judgmental sampling cannot be used to make conclusions or projections about entire populations; however, they can be used to identify specific issues, risks, or weaknesses.
12. Each MMIS All Services Report documents the healthcare services that MassHealth has paid for a specific member, including pharmacy services.

medication required DCF consent. We determined whether Rogers guardianship orders and/or DCF consent forms were included in iFN. In addition, for the Rogers guardianship orders not documented in iFN, we requested and reviewed hard copies of the Rogers guardianship orders from DCF, who reached out to juvenile courts in order to provide them to us.

Based on the results of our testing, we determined that, during the audit period, DCF did not always obtain or renew required court approval before children in its protective custody were administered antipsychotic medications and did not properly maintain Rogers guardianship orders in iFN. See Findings 1 and 2c for more information.

Psychosocial Services and Follow-up Visits

To determine whether children in DCF's protective custody who were prescribed psychotropic medications received follow-up doctor appointments and recommended psychosocial services, we took the following actions:

- We inspected the MMIS All Services Reports for the children in both our FFS and MCO samples and identified all psychosocial service claims and follow-up doctor appointment claims.
- We compared the services in the MMIS All Services Reports to what DCF documented in iFN by searching social worker notes, encounter forms, and medical passports for evidence that the children in our samples received psychosocial services and follow-up doctor appointments in conjunction with prescribed psychotropic medications.

Based on the results of our testing, we determined that, during the audit period, children did not always receive recommended psychosocial services in conjunction with their prescriptions for psychotropic medications and DCF did not properly maintain healthcare records in iFN. See Findings 2b and 3 for more information.

Medical Passports

To determine whether DCF maintained medical passports for children in its protective custody who received psychotropic medications, we took the following actions. We inspected the medical passport in iFN for each child in both our FFS and MCO samples to determine whether the medications and dosages listed on each medical passport matched the medications and dosages in each child's MMIS All Services Report.

Based on the results of our testing, we determined that DCF did not properly maintain healthcare records in iFN during the audit period. See Finding 3 for more information.

Maximum Dosages

To determine whether DCF provided oversight to children in its protective custody who received psychotropic medications that exceeded the FDA's recommended maximum dosages, we reviewed each child's full medical record in iFN for the sample of 40 and determined whether children were over the maximum dosage. We further determined whether DCF documented its consent for the psychotropic medication and the reasoning for the high dosage.

Based on the results of our testing, we determined that DCF should provide more oversight for children in its custody receiving psychotropic medication in amounts and dosages that exceed the FDA's recommendations. See Other Matters for more information.

Internal Control Plan and Cybersecurity Awareness Training

To determine whether DCF updated its internal control plan to address the COVID-19 pandemic, as required by the Office of the Comptroller of the Commonwealth's "COVID-19 Pandemic Response Internal Controls Guidance," we reviewed DCF's fiscal year 2020 internal control plan.

To determine whether DCF ensured that employees who had access to COVID-19 funds during the audit period completed annual refresher and/or initial cybersecurity awareness training in accordance with EOTSS's Information Security Risk Management Standard IS.010, we obtained and inspected transcript reports of cybersecurity awareness training for all 10 employees who had access to COVID-19 funds.

Based on the results of our testing, we determined that, during the audit period, DCF updated its internal control plan to address the COVID-19 pandemic. However, DCF did not ensure that all employees with access to COVID-19 funds received annual refresher cybersecurity awareness training during the audit period. See Finding 4 for more information.

John H. Chafee Foster Care Independence Program Grant

To determine whether DCF made outreach efforts to ensure that it reached eligible youths who aged out of DCF care in order to allocate funds from the John H. Chafee Foster Care Independence Program grant,

we interviewed DCF management and requested and reviewed DCF's plan for reaching out to youths eligible for these funds.

We noted no exceptions in our testing; therefore, we determined that, during the audit period, DCF made outreach efforts to ensure that it reached eligible youths who left DCF care to allocate funds from the John H. Chafee Foster Care Independence Program grant.

We used a combination of statistical and nonstatistical sampling methods for testing, and we did not project the results of our testing to any corresponding populations.

Data Reliability Assessment

We received from DCF a list of children in DCF's protective custody who were prescribed at least one psychotropic medication during the audit period and separated the list by children who were enrolled in an FFS plan and children who were enrolled in an MCO plan. We performed validity and integrity tests first on the list of children enrolled in an FFS plan, including (1) testing for blank fields, (2) scanning for duplicate records, and (3) tracing a sample of 20 children on the list to protective custody court documents. We also performed validity and integrity testing on the children enrolled in a MCO plan, including (1) testing for blank fields, (2) scanning for duplicate records, and (3) tracing a sample of 25 children on the list to their MCO plan from MMIS. To verify the completeness of the list provided by DCF, we attempted to extract a list from MMIS of all children in DCF's protective custody who were prescribed at least one psychotropic medication. However, MMIS does not distinguish different levels of custody, and the focus of our audit objective was children in DCF's protective custody. Therefore, we used the list provided by DCF as it was the only source of data available.

To determine the reliability of the data from MMIS, we relied on the work performed by OSA, completed in 2020, that tested certain information system controls in MMIS. As part of that work, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. As part of this audit, we performed validity and integrity tests on all MMIS data, including (1) testing for blank fields, (2) scanning for duplicate records, (3) looking for dates outside of the audit period, and (4) determining whether each child's age on the date of service was between 0 and 17.

We also received from DCF a list of employees who had access to COVID-19 funds. We performed validity and integrity tests on this list, including (1) testing for duplicates, (2) testing for blank fields, and (3) tracing

the list back to a list that we generated from the Human Resources Compensation Management System, which is the Commonwealth's official payroll system.

Based on the results of the data reliability assessment procedures described above, we determined that the information we obtained was sufficiently reliable for the purposes of our audit.

Other Matters

During this audit, additional areas of concern that were outside the original scope of our objectives came to our attention. Given the high-risk nature of these areas, we examined them while we were still engaged with the auditee. These areas include human trafficking prevention measures, as well as DCF's implementation of recommendations by the Massachusetts Commission on LGBTQ Youth.

We emailed DCF to determine what corrective measures the agency took, or was taking, to address the findings and concerns referenced in the US Department of Health and Human Services Office of Inspector General (HHS OIG) report that cited Massachusetts as one of five states where there was no evidence that children in foster care were screened for human trafficking after they had gone missing from, and later returned to, foster care. We also inquired about several related follow-up questions with DCF that addressed the detection and prevention of human trafficking.

In addition, we inquired about the Massachusetts Commission on LGBTQ Youth's 2023 annual report with DCF and whether it had implemented the recommendations

The results of this work are included within the "Other Matters" section of this audit report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. The Department of Children and Families did not always obtain or renew court approval before children in its protective custody were administered antipsychotic medications.

The Department of Children and Families (DCF) did not always obtain or renew required court approval before children in its protective custody were administered antipsychotic medications. Our fee-for-service (FFS) and managed care organization (MCO) samples included 36 children[13] who were prescribed one or more antipsychotic medications, therefore requiring a Rogers guardianship order. Of these 36 children, we found that 4 children[14] were administered antipsychotic medication without a required Rogers guardianship order from the court.

We also found that DCF did not always obtain court approval for antipsychotic medications in a timely manner. Specifically, we determined that six[15] children in our samples were administered antipsychotic medications through an expired Rogers guardianship order. One of these children received medication for eight months past the expiration date for their Rogers guardianship order and without an updated order.

If DCF does not obtain or renew court approvals for antipsychotic medications, which includes presenting treatment plans to the courts, it cannot ensure that these treatment plans are safe and appropriate for the children. In addition, this is removing the courts' oversight of children in DCF protective custody, who are too young to consent to their treatment plans and need a neutral, third party to ensure that any prescribed medications are in the children's best interest.

Authoritative Guidance

According to Section 11.14 of Title 110 of the Code of Massachusetts Regulations,

> *(2) No Consent by Department. The Department shall not consent to the administration of antipsychotic medication for any individual, but shall in all cases seek . . . prior judicial approval for children in Department custody and wards of the Department. . . .*

13. This number represents 25 children needing Rogers guardianship orders from our FFS sample of 118 and 11 children needing Rogers guardianship orders from our MCO sample of 50. The remaining members in each sample did not require a Rogers guardianship order, as they were not prescribed an antipsychotic medication.
14. This number represents one child from our FFS sample and three children from our MCO sample.
15. This number represents five children from our FFS sample and one child from our MCO sample.

(4) Judicial Approval for Wards and Children in Department Custody.

(a) When any individual, organization, facility, or medical provider seeks the Department's consent to medicate with antipsychotic drugs a child, who is a ward of the Department or who is in Department custody, the Department shall seek prior judicial approval for administration of such drugs even if the child's biological parents have consented to the medication.

Reasons for Issues

DCF indicated in an email to us on July 21, 2023 the following reasons for the issues with the Rogers Guardianship Orders:

- There were delays with the court because of the COVID-19 pandemic.
- The child was only in protective custody for 72 hours (although iFamilyNet [iFN] indicated different and no supporting evidence was provided to us).
- DCF was unaware the child was taking the antipsychotic medication.
- The child never took the medication, but the prescription was filled.

In addition to the above reasons, DCF's policies and procedures do not include monitoring controls to ensure that DCF applies, and receives approval, for Rogers guardianship order and renews them in a timely manner.

Recommendation

DCF should add monitoring controls to its policies and procedures to ensure that any Rogers guardianship orders are approved and renewed by the court.

Auditee's Response

DCF agrees with this recommendation and will make improvements to its electronic case records system to better manage and track dates of court approvals for antipsychotic medications. In Review of the case records for the 4 children identified as having no Rogers Orders issued shows that the Department adhered to existing regulations and policies for 2 of the children, as we have outlined below:

- ***The child was not in protective custody.*** *The Department followed existing regulation which governs the administration of medication when children come into custody and shortly thereafter was returned to the parents' custody obviating the need for an order. Child came into DCF custody on previously prescribed antipsychotic medication on December 3, 2019. Per Departmental regulation [Section 11.14(4)(b) of Title 110 of the Code of Massachusetts Regulations]: "Where antipsychotic medications have been previously prescribed for a child who is a ward of the*

Department or who is in the custody of the Department, and that child is currently being treated with antipsychotic drugs without judicial authorization, the Department shall initiate the process for judicial review and application of substituted judgment. Pending judicial review the Department shall not discontinue the prescribed treatment with antipsychotic drugs, because interruption or discontinuance of the treatment might cause severe medical complications and might violate the individual's legal right to treatment." The Department adhered to this regulation, and then the child was returned to parents' custody on December 19, 2019 after a custody hearing. Therefore, no Rogers order entered; the regulation required DCF to maintain the child on medication, however because the child was in DCF custody only 16 days, judicial review of the medication was not possible prior to the child returning to parents' custody.

- ***The child never took the medication, but the prescription was filled.*** *The child was never placed on antipsychotic medication, although it was discussed with the provider. Therefore, no Rogers Order entered. In support of this fact, the Department provided a screen shot of the Social Worker's dictation, which stated: "Once the provider was told about Rogers being needed, they didn't write it and the med never started."*

- *For the other 2 cases, the Department acknowledges that there were delays in scheduling that should have been mitigated or eliminated.*

- *With respect to the 6 cases identified as having delayed extensions of existing Rogers Orders, the Department believes that the [Office of the State Auditor (OSA)] has incorrectly identified one of the children as having a gap in the Rogers order as outlined:*

  - ***OSA identified a gap in the Rogers orders for a child in placement under a Child Requiring Assistance (CRA) application.*** *CRA from 8/2019 to 6/2020, then child returned to parent; C&P custody began in 3/2021. DCF does not consent for CRA children - parents' consent. No Rogers would have been issued between 8/2019 and 6/2020 during CRA custody. A Rogers Order is only required for children in DCF custody as a result of a Care & Protection Petition. - Orders previously provided to OSA are attached to this response.*

- *For two other cases, there were situations that involved extenuating circumstances beyond the Department's control:*

  - ***No gap, but delayed Rogers following emergency prescription due to parents' failure to appear in court.*** *Child was prescribed antipsychotic medication as an emergency while placed in an inpatient hospital at the time that the Department. The Rogers hearing was scheduled for temporary custody hearing, but that was continued for 10 days due to parents' failure to appear in court. The Rogers hearing was completed at the next court date.*

  - ***Gap related to Rogers extension due to failure of Guardian Ad Litem (GAL) to provide the court with an updated affidavit.*** *Antipsychotic drugs had been prescribed for some time. Due to issues with the GAL not submitting an updated affidavit, the judge vacated the Order previously authorized on 11/10/2020, revoked the GAL and appointed a new GAL. Antipsychotic medications need to be tapered and cannot be stopped abruptly in most cases. Rogers was reinstated on 12/16/2020 after new GAL appointed.*

For the remaining 3 cases, the Department acknowledges that there were delays in scheduling that should have been mitigated or eliminated.

The Department agrees with the Auditor's recommendation to establish better monitoring controls and is working to make several enhancements to the electronic legal case records in iFamilyNet. One of the suggestions that has been made is to better utilize the Department's electronic case filing system to better manage and track dates of judicial approval for prescribed antipsychotic medications.

Auditor's Reply

We commend DCF for working on steps to better manage the tracking of court approvals for children receiving antipsychotic medications.

Regarding the two cases DCF disagrees with us about—it should be noted that, although DCF states that one child was returned to their parents shortly after entering custody, we were not provided evidence for when the child was returned. Based on the information in iFN, the child was in protective custody for over two years. In addition, regarding the child that DCF states never took the medication, but the prescription was filled, we note that a prescription should not be filled before obtaining a Rogers guardianship order. An open question remains regarding what happened to the medication that was received but not consumed. For the one case with a delay in extension for its existing Rogers order that DCF objected to, we were not provided any supporting documentation to show the child was under CRA. According to iFN the child has been in custody since August 2019.

2. The Department of Children and Families did not properly maintain healthcare records in iFamilyNet for children in its protective custody who received psychotropic medications.

DCF did not properly maintain healthcare records in for children in its protective custody who received psychotropic medications. During the audit period, 117 of the iFN 118 children who were prescribed at least one psychotropic medication in our FFS sample had incomplete or missing mental health and psychosocial service information. In addition, 49 of the 50 children who were prescribed at least one psychotropic medication in our MCO sample had incomplete or missing mental health and psychosocial service information.

As a result of not updating iFN to reflect up-to-date healthcare records, DCF cannot provide adequate oversight and ensure that the health and mental health needs of all children in its protective custody are being met. In addition, DCF and providers could be creating a treatment plan that is not safe or effective

for a child, because there is important information missing that would affect this child's healthcare (for example, a history of depression or scheduled follow-up appointments to check the dosage of a new medication).

Below is a summary of the specific issues we identified in iFN.

Specific Healthcare Records	Number of Documentation Issues—FFS Plan	Number of Documentation Issues—MCO
Medical passports	104 out of 118	43 out of 50
Follow-up doctor appointments and psychosocial services	116 out of 118	46 out of 50
Rogers guardianship order / department consent for psychotropic medications	109 out of 118	47 out of 50

a. The Department of Children and Families did not document and/or update psychotropic medications listed in children's medical passports.

DCF did not list and/or update the psychotropic medications prescribed to children in their medical passports in iFN. Specifically, 104 of the 118 children who were prescribed at least one psychotropic medication in our FFS sample had medical passports that did not list any of their psychotropic medication prescriptions or had incomplete information about their prescriptions. In addition, 43 of the 50 children in our MCO sample had medical passports that did not list any psychotropic medication prescriptions or had incomplete information about their prescriptions.

Without accurate and complete information, DCF and health providers may make decisions that conflict with existing medical treatments or do not reflect children's best interests, such as overprescribing psychotropic medications, which can lead to adverse side effects.

Authoritative Guidance

According to DCF Policy 86-011: Ongoing Casework and Documentation,

> *It is the policy of the Department that the Social Worker documents casework activity for each family, in the family's case record in FamilyNet. Each client and collateral contact is documented in dictation and entered into FamilyNet as soon as possible. It is expected that dictation will be entered into FamilyNet no later than one month following the contact.*

According to DCF Policy 85-003: Health Care Services to Children in Placement,

> *All children in placement will have a medical passport containing pertinent and available medical, dental, mental health and developmental information prior to or at the time of placement. . . . This information contained in the medical passport will be reviewed in conjunction with the Service Plan every 6 months at Foster Care Review and will be updated when warranted. . . .*
>
> ***PROCEDURES SUBSEQUENT TO PLACEMENT. . . .***
>
> 3. ***Encounter Form.*** *The Social Worker ensures that the medical and dental appointments are documented by use of the encounter form. . . . Upon receipt of the second page of the encounter form, from either the physician or substitute care provider, the Social Worker completes the form and submits it for data entry or directly enters information into FamilyNet. . . . After data entry into FamilyNet, the encounter form should be placed in the special document section envelope with the copy of the passport. . . .*
>
> 6. ***Case Review.*** *In preparing for a case review the Social Worker reviews the child(ren)'s current health care status by identifying any recent medical/dental problems and whether the child(ren) has received any necessary routine care and follow-up treatment. The Social Worker ensures that current medical information is available in the case record. This includes:*
>
>   - *an up-to-date copy of the medical passport in the case record by either copying the substitute care providers medical passport or adding to the case record medical passport;*
>   - *current encounter forms in the case record and up to date information in FamilyNet;*
>   - *current evaluation, test, and treatment results in the case record.*

According to DCF Policy 2010-001: Medical Examinations for Children Entering DCF Placement or Custody,

> *The information that the Social Worker documents in the medical sections of FamilyNet includes, but is not limited to:*
>
> - *Name, address and telephone number of the primary medical practitioner;*
> - *Names and dates of medical or oral health examinations or tests, the practitioner who completed the examinations or tests and any recommendations, findings or treatments;*
> - *Medical, oral health and behavioral health conditions that have been observed or diagnosed;*

- *Medications that are prescribed;*
- *Known allergies;*
- *Immunizations that have been given; and*
- *Health-related equipment that is being used.*

According to Section 475 of the Social Security Act,

> *(1) The term "case plan" means a written document . . . and includes at least the following: . . .*
>
> *(C) The health and education records of the child, including the most recent information available regarding . . .*
>
> *(v) the child's known medical problems;*
>
> *(vi) the child's medications; and*
>
> *(vii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.*

Auditee's Response

DCF agrees with the recommendation for additional monitoring controls to ensure up-to-date and accurate documentation of a child's health care in iFN. DCF is working to address controls around these documentation issues, and will review the existing policy, purpose, and guidelines for the medical passport as well as the documentation requirements for all medical visits.

DCF agrees with the OSA's broad concern that children in DCF custody must not receive medications that are contraindicated based on other medications they are taking. Sometimes, providers do have access to the child's complete electronic medical record. For continuity of care, DCF makes every effort to keep a child with their medical provider of origin. If a child's medical provider changes, DCF requests that record to transfer immediately to a new provider.

While the medical passport was never intended to be a substitute for the child's office medical record, DCF recognizes the importance of maintaining up to date records regarding psychotropic medications and other medical treatment in a child's iFN record and is exploring how we can make better use of technology to do so. In February 2024 and monthly thereafter, the Department began batch loading medication data based on MassHealth pharmacy claims. MassHealth Pharmacy Claims Data is used to create medication records for children in custody. The information can be viewed on the Medical/Behavior Info page which is available in the Person Demographics for the child. In addition, we are exploring ways to use MassHealth claims to capture other data such as visit dates and diagnoses.

Auditor's Reply

We commend DCF for taking steps to improve its recordkeeping practices. We will follow up on this issue in approximately six months as part of our post-audit review.

b. The Department of Children and Families did not document follow-up doctor appointments and recommended psychosocial services in iFamilyNet for children in its protective custody receiving psychotropic medications.

DCF did not document follow-up doctor appointments and recommended psychosocial services in iFN for children in its protective custody who received psychotropic medication. For 116 of the 118 children in our FFS sample and 46 of the 50 children in our MCO sample, we were unable to determine the type and frequency of therapy provided to the children or whether they received follow-up doctor appointments at all.

If DCF does not keep accurate and complete medical records in iFN, then children in DCF's protective custody may not receive the services needed to treat their conditions. This may delay the growth, development, or recovery of the children who did not receive needed care. Failure to keep accurate and complete medical records may also prevent DCF from determining which medical treatments or providers are most effective or cost-efficient for serving the medical needs of children in its care.

Authoritative Guidance

According to the American Academy of Child and Adolescent Psychiatry's (AACAP's) 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*,

> *All youth with complex behavioral needs, including youth in foster care, should receive a combination of evidence-based psychosocial interventions and psychotropic medication when indicated, not just psychotropic medication alone.*

Auditee's Response

> *DCF agrees with the recommendation for additional monitoring controls to ensure up-to-date and accurate health records in iFamilyNet and medical passports. DCF is working to address controls around these documentation issues, and will review the existing policy, purpose, and guidelines for the medical passport as well as the documentation requirements for all medical visits.*

As one of DCF's critical objectives is continuous improvement, there is an opportunity for the Department to review the existing policy regarding health care services for children in placement, the purpose, use and contents of the medical passport, and the utility of the current, paper based, encounter form. This will allow for a review of updated medical recommendations and any [information technology] enhancements that may be necessary.

In addition, DCF would like to note some additional circumstances and barriers continuously being worked on by the agency: Many children receive services via Family Support Services ("FSS") . . . and will not be captured in claims. There are children who are stable on the ADHD medications, for example, who receive school supports through an IEP or 504, which also may not be clear in iFN. That child may not need additional outside support such as individual therapy.

Review of Medicaid claims data does not encompass the breadth of psychosocial services a child may be receiving.

Auditor's Reply

We commend DCF for taking steps to improve its recordkeeping practices. We agree that DCF cannot rely solely on MassHealth claims to determine whether children in its custody received recommended psychosocial services, and we did not recommend this in our audit. We reiterate our recommendation that DCF should ensure that children in its protective custody have up-to-date and accurate health records in iFN.

c. The Department of Children and Families did not document its consent in iFamilyNet for children in its protective custody to receive psychotropic medications.

DCF did not properly document its consent or court approval for the prescribing of psychotropic medications[16] for children in its protective custody. Specifically, 109 (92%) out of 118 of the children who were prescribed at least one psychotropic medication from our FFS sample did not have required documentation of DCF's consent or court approval for psychotropic medications. In addition, 47 (94%) out of 50 of the children who were prescribed at least one psychotropic medication from our MCO sample did not have the required documentation of DCF's consent or court approval for psychotropic medications.

16. DCF's consent is required for a child to be prescribed most psychotropic medications, while court approval is required for a child to be prescribed antipsychotic medications (see the "Rogers Guardianship Order" section of this report for more information). Our samples combined antipsychotic mediations with other classes of psychotropic medications.

Without documentation of consent or court approval for prescriptions of psychotropic medications, DCF cannot ensure that its social workers and/or medical social workers are providing children in DCF protective custody with medical treatment that is legally required.

Authoritative Guidance

According to Section 11.14(4)(a) of Title 110 of the Code of Massachusetts Regulations,

> *When any individual, organization, facility, or medical provider seeks the Department's consent to medicate with antipsychotic drugs a child, who is a ward of the Department or who is in Department custody, the Department shall seek prior judicial approval for administration of such drugs even if the child's biological parents have consented to the medication.*

According to the "Roles of Foster/Pre-Adoptive Parents or Other Substitute Care Providers and Social Workers" section of DCF Policy 2010-001, "The foster/pre-adoptive parent (or other substitute care provider) . . . arranges for the child to receive medical, behavior health and oral health care that is recommended by the medical practitioner and consented to by the Department."

According to DCF Policy 86-011: Ongoing Casework and Documentation,

> *It is the policy of the Department that the Social Worker documents casework activity for each family, in the family's case record in FamilyNet. Each client and collateral contact is documented in dictation and entered into FamilyNet as soon as possible. It is expected that dictation will be entered into FamilyNet no later than one month following the contact.*

AACAP's 2005 "Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline" states,

> *State child welfare agencies, the juvenile court, or other state or county agencies empowered by law to consent for treatment with psychotropic medications, should create a website to provide ready access for clinicians, foster parents, and other caregivers to pertinent policies and procedures governing psychotropic medication management, psychoeducational materials about psychotropic medications, consent forms, adverse effect rating forms, reports on prescription patterns for psychotropic medications, and links to helpful, accurate, and ethical websites about child and adolescent psychiatric diagnoses and psychotropic medications.*

Reasons for Issues

DCF did not have sufficient monitoring controls in place to ensure that children in its protective custody have up-to-date and accurate health records in iFN and that its social workers prevent these children from receiving medical care without approval.

Recommendation

DCF should establish sufficient monitoring controls to ensure that children in its protective custody have up-to-date and accurate health records in iFN and that its social workers prevent these children from receiving medical care without approval, including the following:

- DCF should review medical passports for children in its protective custody and update them at least every six months or when there are changes to a child's prescription, whichever comes first (e.g., new prescriptions, dosage changes, or discontinued prescriptions).
- DCF should update iFN with all follow-up doctor appointments and psychosocial services for children in its protective custody, including the type and frequency of these appointments and services.
- DCF should document its consent for psychotropic medication for children in its protective custody in iFN and store that consent in the same location in iFN for quick and accurate reviews.

Auditee's Response

DCF agrees with the recommendation for additional monitoring controls to ensure that the Department is documenting a child's health care in a timely and accurate way in iFN.

The iFN system is the Commonwealth's SACWIS (statewide automated child welfare information system), which supports the states' child welfare business needs and is used primarily to document the activities and services that DCF social worker staff provides to the families and children it serves. DCF also utilizes iFN to document the health care a child receives in conjunction with policy, but in no way does the iFN health care record serve as a substitute for a child's medical record kept by medical providers.

The OSA response combines both antipsychotic and non-antipsychotic medications under the heading of "psychotropic medications". Different consent procedures exist for both: Antipsychotic medication consent is provided by the court and consent is indicated by the Rogers order, which is uploaded into iFN.

Substitute caregivers are authorized to provide consent for medical treatment, including non-antipsychotic medication, per DCF policy "Health Care Services to Children in Placement". . . When a child is placed in a foster home, the foster parent signs both a Foster Parent Agreement and Child Placement agreement where they agree to manage the

child's routine health care, dental care, and emergency medical treatment when necessary. While the health care services policy requires foster parents to provide documentation of health care events, it does not require DCF to document consent for routine health care, which includes the administration of non-antipsychotic psychotropic medication.

DCF currently has multiple pathways for oversight to ensure safety and the judicious use of psychotropic medications for youth in state custody including: DCF nurses and [its] child psychiatrist are always available for consultation about the appropriate dosing and effectiveness of medications. . . .

DCF entered into an information sharing agreement with MassHealth, which enabled the documentation of psychotropic medication in the child's electronic case record.

DCF has piloted and implemented the Antipsychotic Monitoring Program (AMP), overseen by the DCF child psychiatrist. The purpose of AMP is to provide a medical review of initial requests for antipsychotic medications for youth in state custody to help inform the court and Rogers Process around the appropriateness of the use of the antipsychotic medication in that child.

DCF collaborates with the MassHealth Pediatric Behavioral Health Medication Initiative (PBHMI) to provide further expert review when there are concerns about appropriateness of psychotropic medication for youth in state custody.

DCF will continue to collaborate with other child & family serving agencies around continuous quality improvement efforts of the state's current psychotropic oversight program PBHMI as well as DCF's internal oversight systems.

Auditor's Reply

DCF states that it is not required to document consent for routine healthcare (for example, psychotropic medication, not including antipsychotics). The "Authoritative Guidance" section of this finding outlines best practices that, while not required, reflect best practices developed by healthcare professionals and experts. The AACAP 2009 "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents" goes into detail about "documenting the assent of the child and consent of the parent." In addition, iFN contains social worker notes and other references to seeking or documenting consent.

We appreciate that DCF shared its use of multiple oversight pathways to ensure safety for the use of psychotropic medications. However, we maintain our concern that DCF cannot provide proper oversight without accurate documentation of these medications and will follow up with DCF in approximately six months for our post-audit review.

3. The Department of Children and Families did not ensure that children received recommended psychosocial services in conjunction with their prescriptions for psychotropic medications.

Children did not always receive recommended psychosocial services in conjunction with their prescriptions for psychotropic medications. Specifically, 17 of the 118 (14%) children who were prescribed at least one psychotropic medication in our FFS sample received no therapy during our audit period in conjunction with their psychotropic medications, according to MMIS data. In addition, 8 of the 50 (16%) children who were prescribed at least one psychotropic medication in our MCO sample receive no therapy during the audit period in conjunction with their psychotropic medications, according to MMIS data.

We also found that an additional 24 of the 118 children who were prescribed at least one psychotropic medication in our FFS sample and an additional 10 of the 50 children who were prescribed at least one psychotropic medication in our MCO sample did not receive therapy in conjunction with their psychotropic medications for over four months.

Additionally, we could not determine the frequency that children in residential facilities received therapy based on MMIS data, because therapy is not billed separately in a residential facility, as it was with the issues above.

Below is a table that summarizes the three issues we found related to children not receiving psychosocial services.

Issue	Number of Children from FFS Sample	Number of Children from MCO Sample
No therapy at all	17 out of 118	8 out of 50
Did not receive therapy for over four months	24 out of 118	10 out of 50
Unable to determine frequency of therapy visits	10 out of 118	3 out of 50

If children do not receive the recommended therapy and psychosocial services with psychotropic medications, treatment effectiveness can be negatively affected. Further DCF cannot monitor the effectiveness of these medications and cannot identify and mitigate any side effects that these children may experience. For example, 28 children from both our samples had suicidal ideations.

Authoritative Guidance

According to AACAP's 2015 *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems*,

> *All youth with complex behavioral needs, including youth in foster care, should receive a combination of evidence-based psychosocial interventions and psychotropic medication when indicated, not just psychotropic medication alone.*

While DCF is not required to follow these recommendations, we consider them a best practice.

Reasons for Issues

DCF does not have sufficient monitoring controls in place to ensure that children in its protective custody who are prescribed psychotropic medications receive psychosocial services.

Recommendation

DCF should ensure that all children in its protective custody who are prescribed psychotropic medications receive psychosocial services and DCF should implement sufficient monitoring controls to ensure that these services are provided and that the efficacy of these services is evaluated.

Auditee's Response

> *DCF agrees with this recommendation, in that we will continue to improve monitoring controls to document psychosocial services are provided.*
>
> *DCF agrees that we are not consistent with documenting services in iFN when children receive psychosocial services at school and through Family Support Services. Many children receive services via Family Support Services ("FSS") which is covered by Title IV E and will not be captured in MMIS claims. There are children who are stable on the ADHD medications, for example, who receive school supports through an IEP or 504, which also may not be clear in iFN. That child may not need additional outside support such as individual therapy.*

Auditor's Reply

We agree that DCF cannot rely solely on MassHealth claims to determine whether children in DCF custody received recommended psychosocial services. As stated in our reply above, we did not recommend that DCF do so. We instead recommend that DCF should ensure that all children in its protective custody who are prescribed psychotropic medications receive psychosocial services by implementing sufficient monitoring controls. Based on its response, DCF is addressing our concerns in this area.

4. The Department of Children and Families did not ensure that all employees with access to COVID-19 funds received annual refresher cybersecurity awareness training.

DCF was unable to provide evidence that 2 of its 10 employees who had access to COVID-19 funding completed annual refresher cybersecurity awareness training for fiscal year 2020. Additionally, DCF was unable to provide evidence that 1 out of 10 employees with access to COVID-19 funds completed annual refresher cybersecurity awareness training for fiscal year 2021.

If DCF does not ensure that all its employees complete cybersecurity awareness training, then it is exposed to a higher-than-acceptable risk of cyberattacks and financial and/or reputational losses.

Authoritative Guidance

Section 6.2.4 of the Executive Office of Technology Services and Security's Information Security Risk Management Standard IS.010, which went into effect October 15, 2018, states, "All personnel will be required to complete Annual Security Awareness Training."

Reasons for Issues

DCF stated that it encountered obstacles when retrieving certificates of completion of cybersecurity awareness training associated with transitioning to a different cybersecurity awareness training provider.

Recommendation

DCF should develop and implement policies, procedures, and controls to ensure that all its employees complete cybersecurity awareness training.

Auditee's Response

Since the audit review period, the Department and the Executive Office of Technology Services and Security (EOTSS) has developed and implemented additional procedures and controls to ensure compliance with annual refresher cybersecurity awareness training requirements. The trainings are offered through the Commonwealth's Learning Management System, MassAchieve. From the data in MassAchieve, DCF's Office of Management Planning and Analysis has developed and distributes monthly management reports which provide the status of individual employees' completion of cybersecurity awareness training prior to the established training deadline. Managers use these reports to follow-up with employees and ensure they complete the annual refresher training by the requisite deadline. In addition, the Department's Deputy Commissioner for Administration and Finance monthly reports out the status of the agency's compliance with completing the annual refresher cybersecurity awareness training to the agency's leadership at the monthly Statewide

Managers Meeting. Lastly, EOTSS has implemented a control which shuts down network access of employees who have not completed the annual refresher cybersecurity awareness training by the requisite deadline. Access can only be restored once the employee completes the training.

Auditor's Reply

We commend DCF for implementing stronger monitoring controls to ensure that all employees complete cybersecurity awareness training and believe DCF is taking steps to address this issue.

OTHER MATTERS

1. The Department of Children and Families should provide more oversight for children in its custody receiving psychotropic medication in amounts and dosages that exceed United States Food and Drug Administration recommendations.

During our audit, we found that 8 out of the 40 (20%) children in our maximum dosage sample received psychotropic medications in dosages that exceeded the US Food and Drug Administration's (FDA's) recommendations. Amounts and dosages of medications that exceed the FDA's recommended guidelines may be appropriate under some circumstances, and while we are not questioning prescribers' medical expertise, there should be more state oversight for children in protective custody receiving these higher amounts and dosages. The Department of Children and Families (DCF) currently does not have any oversight policies or procedures for children prescribed psychotropic medications, especially for situations when the dosages exceed the FDA's recommendations.

According to the American Academy of Child and Adolescent Psychiatry's 2005 "Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline,"

> *State child welfare agencies, the juvenile court, or other state or county agencies empowered by law to consent for treatment with psychotropic medications, in consultation with child and adolescent psychiatrist, should design and implement effective oversight procedures that:*
>
> *a) Establish guidelines for the use of psychotropic medications for youth in state custody. . . .*

For example, the State of California has adopted the Los Angeles Department of Mental Health's "Parameters 3.8 For Use of Psychotropic Medication for Children and Adolescents" guidelines. These guidelines state, "Treatment provided outside the parametric elements in this guide requires special justification or consultation and subsequent documentation in medical record."

We recommend that DCF implement maximum dosage guidelines for psychotropic medications and that DCF provide additional oversight and authorization when children in its protective custody are prescribed psychotropic medications that exceed the FDA's recommended maximum dosage. For example, DCF should contact the prescriber to ensure the safety and necessity of the dosage in question and then clearly document the reasons given by the prescriber in iFamilyNet (iFN). Given the documentation weaknesses we have described previously in this audit report, we believe this step is particularly appropriate, as the

absence of psychosocial treatment in many instances, and the lack of documentation regarding medication and other treatments, may hinder treatment with these higher-than-recommended dosages.

As our audit was nearing completion, additional areas of concern that were outside the scope of our objectives came to our attention. Given the high-risk nature of these areas, we looked into them, and the results are documented below.

Auditee's Response

[The Office of the State Auditor (OSA)] indicates that in 8 cases children received dosages that were above FDA guidelines. DCF acknowledges cases exceeding FDA guidelines but emphasizes that these guidelines are not the standard for most child psychiatrists. In Massachusetts and throughout the country, nationally accepted literature-based recommended maximum dosages prevail. Using these standards, there was one case that exceeded both FDA and literature-based recommendations (16 year old on 40 mg escitalopram- Lexapro), which was an error.

These literature-based maximums are presented in the Texas Psychotropic Medication Utilization Parameters and the [Los Angeles Department of Mental Health] Parameters for Psychotropic Medication Use (cited by the OSA above), both of which provide guidance to the DCF medical team and to pediatric mental health professionals nationally. In addition to these tools from other states utilized by the DCF medical team, DCF also follows guidance from the MassHealth Pediatric Behavioral Health Medication Initiative ("PBHMI"), that defines what is considered high risk psychotropic prescribing in pediatrics in MA. Youth who are identified as high-risk and have concerns for inappropriate use of a medication will require a Doc-to-Doc review with the DCF child psychiatrist.

DCF disagrees that exceeding FDA maximums guidelines always necessitates prescriber follow-up. Literature-based maximums, even when surpassing FDA recommendations, are accepted practice with proper justification. We appreciate the OSA's consideration of the national standard methods being used, and note that DCF consults prescribers when concerns arise about inappropriate dosing or when dosing falls outside literature-based parameters.

Auditor's Reply

Based on DCF's response, it believes that only 1 child was prescribed psychotropic medication over the FDA-recommended maximum dosage. We verified that the number is 8 children out of the sample of 40 (see the "Maximum Dosages" section). We would still recommend that more oversight be outlined for children who are prescribed psychotropic medications over the FDA-recommended maximum dosages, even if only one child was involved.

We did not state in our audit that children cannot be prescribed psychotropic medications over the FDA-recommended maximum dosages but rather that children who are prescribed these higher dosages

should also receive more oversight from DCF. We found that, of those 8 cases where children were prescribed psychotropic medications over the FDA-recommended maximum dosages, there were no notes related to the higher dosage, and iFN did not have up-to-date, accurate medication information.

We commend DCF for seeking consultation with psychotropic medication prescribers and participating in other oversight programs. However, this oversight is not documented. We recommend that DCF document all reasons/recommendations for children in its protective custody who are prescribed psychotropic medications at dosages higher than FDA-recommended maximum dosages, or literature-based maximums as mentioned in DCF's reply, so that all individuals involved in the child's mental health treatment are informed and provide proper care.

2. The Department of Children and Families should coordinate with other state agencies, law enforcement, and other child-serving agencies to address how to detect and respond to human trafficking.

In July 2022, the US Department of Health and Human Services Office of Inspector General (HHS OIG) issued a report[17] that cited Massachusetts as one of five states where there was no evidence that children in foster care were screened for human trafficking after they had gone missing from, and later returned to, foster care. Massachusetts was selected because, in fiscal year 2018, it was one of five states that reported the largest number of children who went missing from state custody. Specifically, in its report, HHS OIG identified 949 children in Massachusetts who went missing from, and later returned to, foster care. HHS OIG selected a sample of 88 out of the 949 identified children and reviewed their case files. HHS OIG found that 72 out of the 88 sampled children were not screened for human trafficking after they returned to foster care.

We reached out to DCF via email to ascertain what corrective measures the agency took, or is taking, to address the findings and concerns of this HHS OIG report. Based on DCF's responses, the agency does not agree with the findings in the HHS OIG report but has taken measures to address those concerns. Specifically, DCF stated in an email to us on January 5, 2024,

> *We also outlined subsequent actions and continuous improvement efforts that we continue to work on. . . . Our ongoing quality improvement work to date has included our Missing or Absent Program Manager presenting a series of trainings to congregate care providers. We have also created a video for DCF staff, "Missing or Absent Children/Youth: DCF Screening Guidance for All Youth" on*

17. This HHS OIG report is titled *In Five States, There Was No Evidence That Many Children in Foster Care Had a Screening for Sex Trafficking When They Returned After Going Missing*.

> *best practices for screening youth who return from being Missing or Absent (MOA), in collaboration with Support to End Exploitation Now (SEEN) at the Children's Advocacy Center of Suffolk County, My Life My Choice (MLMC), as well as the accompanying guide, "Human Trafficking: DCF Screening Guidance for All Youth." These supplementary tools and training aides have been communicated to our staff and utilized through several platforms and meetings to date.*
>
> *In addition, DCF has worked with [the Administration for Children and Families] National Human Trafficking Training and Technical Assistance Center (NHTTTAC) to create a guide for the field which is currently being vetted by executive staff for distribution and inclusion on our Human Trafficking intranet page.*

We also asked several related follow-up questions that addressed the detection and prevention of human trafficking.

Illinois was one of the other states audited in the 2022 HHS OIG report. Specifically, the Illinois Department of Children and Family Services agency developed a webpage, entitled Human Trafficking of Children, that is dedicated to the awareness of human trafficking of minors. The webpage also has educational brochures and posters in several languages available for download. Currently, DCF has one webpage, entitled Definitions of abuse and neglect, that mentions this issue but DCF does not provide details on how to detect and prevent human trafficking. We recommend that DCF create a webpage, or another platform to easily reach the public, dedicated to recognizing signs and what to do if someone has suspicions of human trafficking, like the webpage that the Illinois Department of Children and Family Services developed.

Finally, we wish to share the model legislation, policies, and regulations put forth by the advocacy organization, Shared Hope International,[18] called "Report Cards on Child & Youth Sex Trafficking 2023 Toolkit." Massachusetts received an overall F grade from this organization for its efforts to stop child and youth sex trafficking. We recommend that DCF work with law enforcement and other child-serving government agencies (e.g., the Office of the Child Advocate) to implement the model legislation, policies, and regulations. DCF should also work to determine why Massachusetts has such a high rate of children going missing from state care and address the issue.

18. According to its website, "Shared Hope is a member of the National Advisory Committee on the Sex Trafficking of Children and Youth in the United States which publishes Best Practices and Recommendations for States to combat the sex trafficking of children and youth in the United States."

Auditee's Response

The Department of Children and Families did not agree with the methodology used by the OIG when the report was issued and subsequently did a comprehensive, parallel review and found screenings were noted in the vast majority of the records the OIG reviewed. The OIG only accepted evidence of screening documentation for 22 of the 89 sample cases it deemed eligible for the review. After receiving this information, DCF conducted a thorough review of the other 67 cases in which OIG determined that there was insufficient evidence of screenings. Based on this review, we believe that there was evidence to support screenings of youth who returned to DCF placement in 82 of the 89 sample cases.

The screenings may have been missed by the OIG because [DCF] collected the data but had not been consistent with entering the information in the case record or in structured data.

Since the OIG report, DCF has made [information technology] changes to capture the screening of youth for human trafficking when they return from being missing or absent and to improve tracking of the screenings that take place. This, and other system upgrades are scheduled to begin at the end of August.

The Shared Hope report does not take into consideration the ongoing proactive, preventive continuous improvement initiatives as mentioned above, and which also include:

- *Extensive work with the Federal Administration for Children and Families and its National Human Trafficking Training and Technical Assistance Center to update and streamline information on the DCF Human trafficking employee intranet page.*
- *DCF's Clinical Manager for Field Support becoming a member of the National Child Welfare Anti-Trafficking Coalition. Participants include those creating and implementing state-level child welfare policy and practice addressing human trafficking.*
- *Collaborating with My Life My Choice to create a Commercial Sexual Exploitation of Children (CSEC) prevention training program.*
- *[CSEC] is providing training congregate care providers over the next two years.*
- *Creating a 9-part video series for DCF social workers to use with foster parents and other caregivers to increase their knowledge regarding Commercial Sexual Exploitation of Children (CSEC).*
- *In collaboration with My Life My Choice (MLMC) and Support to End Exploitation Now (SEEN), creating a training video for DCF social workers on best practices for screening youth who return from being [Missing or Absent], as well an accompanying guide, "Human Trafficking: DCF Screening Guidance for all Youth."*

Further, finalization of our negotiations with [the collective bargaining unit] will allow us to hire 5 full time supervisors and increase the Missing or Absent (MOA) unit from 10 social workers to 18. MOA social workers are dedicated to engaging and locating children who are on-the-run. Additional staff will allow for collaboration with community stakeholders as well as more prevention work with youth, families and substitute care providers.

Massachusetts has multi-disciplinary teams (MDTs) in every county to respond to Child Trafficking. These teams are based in the state's Children's Advocacy Centers (CAC) in partnership with their DA offices, local police and DCF to provide a coordinated response to CSEC. MDTs are currently operating in all CACs in the Commonwealth. DCF also collaborates with local police Departments, including the Boston Police, on child trafficking concerns.

In its Annual Report, DCF tracks the number of 51A reports and supported 51Bs for human trafficking labor and human trafficking sexually exploited child as well as the unique count of children DCF has found to have been trafficked.

DCF will also develop a website on Mass.gov where the public can find information on human trafficking prevention and detection in children.

Auditor's Reply

We commend DCF on its efforts and current initiatives to prevent children from going missing and sex trafficking in Massachusetts. Based on its responses, DCF appears to have taken steps to collaborate with relevant organizations, coordinate additional training for care providers, and hire more staff members. DCF also plans to develop a website to raise awareness of this issue. As part of our post-audit review process, we look forward to revisiting this topic with DCF and seeing what progress has been made in approximately six months from now.

3. The Department of Children and Families should collaborate with the Massachusetts Commission on LGBTQ Youth to implement all recommendations from its annual report.

The Massachusetts Commission on LGBTQ Youth's goal is to make policy recommendations to the Executive Office of Health and Human Services, the Department of Public Health, and other government entities within the Commonwealth that support LGBTQ youth. The commission's 2023 annual report[19] included the following recommendations for DCF:

1. *Ensure thorough and accurate [sexual orientation and gender identity (SOGI)] data collection through implementation of the new mandatory data elements and staff training.*
2. *Create and follow a plan for additional phases of SOGI data collection.*
3. *Report SOGI data in detail, in annual and quarterly reports.*
4. *Ensure LGBTQ community representation in decisions regarding data collection and reporting.*

19. This Massachusetts Commission on LGBTQ Youth report is titled *Report and Recommendations for Fiscal Year 2023*.

5. *Release a comprehensive LGBTQ nondiscrimination policy*
6. *Continue implementation of the Gender Affirming Medication Consent Policy*
7. *Update the Family Resource Policy with LGBTQ-Inclusive Provisions*
8. *Clarify Policy Regarding Placement Consistent with Gender Identity*
9. *Continue Policy Collaborations with the Commission*
10. *Update the LGBTQ Guide and ensure that all staff, providers, youth, and families know it exists and where to access a copy.*
11. *Expand and require LGBTQ cultural humility training.*
12. *Update and Improve the [Massachusetts Approach to Partnerships in Parenting] Training*
13. *Create a statewide database listing LGBTQ-affirming homes.*
14. *Improve recruitment of LGBTQ affirming foster parents.*
15. *Create Positions for LGBTQ Regional Specialists and Add or Adjust Other Staff Responsibilities to Promote LGBTQ Equity*
16. *Promote Youth Rights and Voices*

We asked DCF whether it had implemented these recommendations and it told us in an email on June 18, 2024,

> *DCF has been continuing to work towards implementing the recommendations of the Commission. As part of the recommendations, DCF has hired a Director of LGBTQIA+ Services and three Regional LGBTQIA+ Specialists. In addition, DCF meets regularly with the Massachusetts Commission on Lesbian, Gay, Bisexual, Transgender, Queer & Questioning Youth and requests their feedback on DCF initiatives. DCF and [this commission] also participate in an [Executive Office of Health and Human Services] workgroup that meets regularly to coordinate efforts on this topic.*

Auditee's Response

DCF appreciates the positive acknowledgement from the OSA.

Auditor's Reply

Based on its response, DCF has taken steps to implement the commission's recommendations.