

**Commonwealth of Massachusetts**



# **Child Abuse Prevention and Treatment Act (CAPTA)**

**Federal FY2018 Report  
June 30, 2017**



# Table of Contents

<b>IMPLEMENTATION OF THE DCF CASE PRACTICE MODEL (CPM)</b> .....	<b>3</b>
<b>DCF CENTRAL OFFICE NURSE</b> .....	<b>6</b>
<b>REGIONAL CLINICAL CONSULTATION</b> .....	<b>7</b>
<b>CHILDREN’S CHARTER DIVISION OF KEY PROGRAM, INC.</b> .....	<b>9</b>
<b>PARENTS HELPING PARENTS’ PARENTAL STRESS LINE</b> .....	<b>11</b>
<b>FAMILY ENGAGEMENT AND VOICE</b> .....	<b>13</b>
<b>AMENDMENTS TO CAPTA MADE BY THE COMPREHENSIVE ADDICTION AND RECOVERY ACT OF 2016 (CARA)</b> .....	<b>15</b>
<b>TRAFFICKING AMENDMENTS TO CAPTA</b> .....	<b>16</b>
<b>CAPTA ASSURANCES</b> .....	<b>16</b>
<b>BUDGET</b> .....	<b>16</b>
<b>CITIZEN REVIEW PANELS OF MASSACHUSETTS</b> .....	<b>18</b>
• <b>STATEWIDE CHILD FATALITY REVIEW TEAM</b> .....	<b>19</b>
• <b>DCF FAMILY ADVISORY COMMITTEE</b> .....	<b>25</b>
• <b>DCF YOUTH ADVISORY COMMITTEE</b> .....	<b>26</b>

## **CHILD ABUSE PREVENTION TREATMENT ACT (CAPTA) STATE PLAN**

### **1. Implementation of the DCF Case Practice Model (CPM)**

#### CAPTA Priority Areas

- Improving the intake, screening and investigation of reports of abuse and neglect
- Improving case assessment, management, and provision of services

#### FY2017 CAPTA Expenditures, Activities and Accomplishments

For FY2017, DCF budgeted \$68,000 in CAPTA funds to support training, coaching, facilitating and other critical implementation needs for practice and policy changes. In addition, \$60,500 in CAPTA funds was budgeted to support policy drafting, updating, and implementation.

#### Policy Development: Alignment with DCF Intake and Case Management Practice Models

The Child Welfare League of America (CWLA) report continues to firmly drive the Department's work addressing child near fatalities, child fatalities and promoting child safety, permanency and well-being. Tragic events surrounding several high profile cases between 2013 and 2015 have informed reforms to DCF operations, policies and practices and led to greater focus on assessing a child's safety, risk in the context of parental capacities.

In Between FY 2016 and FY2017 the Department completed and implemented the following policies: Protective Intake, Children Missing or Absent from the Care and Custody of the Department, Family Assessment and Action Planning, and Supervision. The Department also revised the current policy notifying the District Attorney and Law Enforcement, along with the In-Home Casework and Case Closing Policies. The Education Policy is being updated to include the changes to ESSA and McKinney Vento. The Foster Care Review Policy has been revised and is ready for implementation. Implementation is pending the completion of iFamilyNet 6.0. Metrics have been developed for all new policies to test for fidelity of the operationalized policy, and to inform the need for related training, oversight, and policy revisions.

#### Protective Intake Policy

The new Intake Policy became effective on February 28, 2016. FY2017 realized the first year of full implementation and practice of this new policy. The Department has begun to analyze the first set of completed metrics for the screening process to determine how the new policy is working and what could be improved. During October 2017, the Department is conducting focus groups with screeners, response workers, intake supervisors, Area Program Managers, Area Clinical Managers, Ongoing workers and Supervisors, and legal staff. One focus group has been scheduled for each Region to explore how the Protective Intake Policy is working, improvements recommended by staff, and challenges Area Offices have encountered in the first eighteen months of implementation. Implementation Coaches, who worked with screeners and supervisors on the implementation of the policy, will also be used to support ongoing fidelity to the policy where needed.

#### Supervision Policy

The Supervision Policy became effective February 28, 2016. Policy specific training was conducted prior to implementation. Subsequent practice focused training began in July 2016 and was completed August 2016. This policy sets forth the minimum exceptions required for DCF supervision frequency and types

of supervision, and outlined the use of Area Clinical Reviews to provide team based management support for case decisions. Implementation Coaches are working with social workers and supervisors on the implementation of the policy into practice. The Department is working to identify topics for ongoing and advanced supervisory training. Advanced supervisory trainings are being created and offered in response to staff and manager requests and needs.

Metrics will be reviewed to assess the impact of regular consistent supervision on increased monthly in person child visits, the reduction of child near fatalities and fatalities, child safety, risk, timely permanency, and well-being.

#### *Policy for Missing or Absent Children from the Care or Custody of the Department*

This policy became effective September 26, 2016. The purpose of this policy is to establish clearly defined direction and timelines for notifying authorities and initiating search processes when a child in the Department's care or custody is identified as missing. This policy also addresses the Department's response to children who are absent from Department-approved placements but whose whereabouts are known, as well as establishing their safety and well-being when located and returning them as quickly as possible to Department-approved placement. While this policy focuses on locating children who are in Department care or custody, many of the procedures may be relevant to situations where a Department-involved child who remains in parental custody is identified as missing. Upon completion of a full year of implementation and practice, metrics will be reviewed to assess the impact of this policy to improve the Department's ability to respond to and locate missing and trafficked children. Implementation Coaches are working with social workers and supervisors on the continued integration of the policy into practice.

Training on this policy began in September 2016 and continued through November 2016. All internal staff including after-hours staff and the Judge Baker Child Abuse Hotline was trained, as were all external providers who have children in the care or custody of the Department in their programs. A Frequently Asked Question page has been established on the DCF Intranet, and all questions submitted via the Intranet are responded to within two working days. Law enforcement was notified of the policy by the Commissioner and provided access to the policy. Massachusetts Juvenile Police Officers were presented with the policy and provided with an overview by policy division staff.

In response to feedback from contracted providers and law enforcement departments and officials the Department, is revising and simplifying the policy. Revision is expected in early 2018.

#### *The Policy for Referrals to the District Attorney and Local Law Enforcement Authority*

This policy was amended in February 2, 2017 to align with the Protect Intake Policy and include mandatory referrals at screening to the District Attorney and the local law enforcement authority when it is suspected that a child may be the victim of human trafficking or sexual exploitation.

#### *Family Assessment and Action Planning Policy (FAAP)*

The Family Assessment and Action Planning Policy became effective February 6, 2017. This is the largest undertaking of practice change the Department has taken on for some time. FAAP prioritizes child safety and permanency and centers on engaging family members in an integrated process of exploring their individual parental capacities and needs as they directly relate to the reasons the family came to the attention of the Department. This family assessment process is the Department's family-focused, participatory process of gathering information about the family's history, reason for the Department's involvement, functioning, parental capacities, strengths and needs and about how well the safety, permanency and well-being needs are being met for the child. It is based on the information gathered in

the Family Assessment that staff will utilize to establish the Action Plan with the family and child(ren)/youth. Priority areas for observable changes are identified to maintain the child's safety and achieve permanence; this is the focus for action planning. For each priority area, actions, tasks, services and supports for each open consumer and other identified participants are identified and then developed with the family and youth.

Training occurred throughout the month of January 2017 with seven trainings a day occurring five days a week in the field. IT was an integral part of this training with both practice and IT training collaboratively. All staff and contracted case management providers were trained. E-learning have been created to support the field and posted on the DCF Intranet. Webinars were offered to management staff. A Frequently Asked Question site has been established on the DCF Intranet, and all questions are responded to within two working days. Implementation Coaches are dedicating the majority of their work with social workers, supervisors and managers on implementation of the policy into practice and metrics. Improvements to this policy are already underway to address the assessment and action planning process for youth transitioning to adulthood, and to strengthen the gathering of child and family history and medical information for children entering adoption. Additionally, upon completion of a full year of implementation and practice, metrics will be reviewed to assess the impact of FAAP on parental capacity, child safety, timely permanence and well-being.

#### Case Closing Policy

This policy had been finalized in FY 2016 and was awaiting implementation upon completion of the IT system. This period allowed the Department to strengthen the process and to more closely tie it to the IT system by providing edits, and stop gaps within iFamilyNet if certain requirements have not been completed. Metrics have been developed for the revised policy. It is anticipated that this policy will be implemented in late fall of FY2017.

#### In Home Policy

This policy had been finalized and awaiting implementation. The Department recognizes the critical need for consistent monthly in-home in-person meaningful contact and therefore, is utilizing this time to strengthen this policy. It is anticipated that this policy will be implemented during FY2018.

#### Education Policy

The Department has begun to update this policy to include the changes to ESSA and McKinney Vento. Final updates will be contingent upon greater clarity regarding federal regulations and related guidance around state plans to implement ESSA.

#### Fifth Annual Massachusetts Fatherhood Leadership Summit: Changing Systems, Changing Lives

On April 29, 2017, DCF along with six state agency partners, Massachusetts Departments of Youth Services, Housing and Community Development, Public Health, Revenue, Corrections and Career Services, The Children's Trust and the US Department of Health and Human Services, Administration for Children and Families, and several family and community representatives, convened the Fifth Annual Massachusetts Fatherhood Leadership Summit. This highly successful event drew a diverse group of approximately 200 attendees, including DCF staff, fathers who have had experiences with Massachusetts' systems, and representatives from agencies that work with and serve fathers including community organizations, various providers, schools, high level leadership and policy representatives from state and federal agencies, and judges from the juvenile and probate courts. The Summit continues to build on the

success of the past annual summits by presenting panel discussions, a keynote speaker, and workshops designed to raise awareness about the need to change systems that create barriers for father engagement.

Family COI Process

During FY2016 DCF invited family members to participate in work teams to develop several of the agency's new policies and families were given an opportunity to provide feedback on all new policies through their routine participation in the Department's monthly Statewide Managers Meetings. However, The Department believes that it can strengthen the family's perspective in policy-making as the Agency's Family Advisory Committee completes and implements its new strategic plan. DCF recognizes the value of the family's perspective in policy development.

FY2018 Proposed Expenditure Activities

The proposed expenditure for FY2018 is: \$164,211.20

*The breakdown is as follows:*

Policy Consultant:	\$71,500
Implementation Coaches:	\$68,000
Implementation Coaching Fringe:	\$24,711.20

All allocations will continue to support the work of the Department in FY2017 and support continuous policy development, training and support for FY2018.

Through on-going training, coaching and facilitation, these funds will support DCF Area Offices and Regions to assist in the implementation of the new policies and integration of these new policies into practice. Implementation Coaches will continue to assist staff at all levels with the implementation of new policies into practice and continue to assist staff in achieving fidelity of the metrics to the policy. The Policy Consultant will continue to assist the policy division with field staff focus groups, and with the revision, development and alignment of new and existing policies and practices to address the CWLA report.

**2. DCF Central Office Nurse**

CAPTA Priority Areas

- Case management, case monitoring and delivery of services to families
- Supporting collaboration between public health agencies and the child protection system to support health needs
- Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families with disabled infants with life-threatening conditions using existing social and health services.

FY2017 CAPTA Expenditures, Activities and Accomplishments

DCF budgeted \$90,530.72 for the central office nurse.

*The breakdown is as follows:*

Salary:	\$61,700.00
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Fringe: \$21,693.72  
Indirect: \$7,137.00

Much attention has been paid to the need for DCF to ensure timely access to quality health care for children and youth coming into the custody of the Department. The central office nurse continues to supervise and provide back-up support for DCF's regional nurses through case consultations, working with other state agencies, community health providers and hospitals. She is available to consult on cases involving Substance Exposed Newborns (SEN), Neonatal Abstinence Syndrome (NAS), Fetal Alcohol Spectrum Disorder (FASD), as well as serious and life-threatening medical issues for any infant, child, or youth. In addition, the DCF nurse maintains the responsibility for data tracking and analysis related to health and health care for DCF children and families. DCF has expanded its medical supports to the field, hiring a Medical Director who provides oversight of the health and medical services team, a part-time child psychiatrist, 5 regional nurses, and 29 medical social workers who are assigned to each of the 29 Area Offices. These positions are not funded with CAPTA funds.

FY2018 Proposed Expenditures and Activities

During FY2018 DCF proposes to use CAPTA funds at approximately \$94,645.43 to support this critical central office nurse position.

*The breakdown is as follows:*

Salary: \$63,551.00  
Fringe: \$23,094.43  
Indirect: \$8,000.00

**3. Regional Clinical Consultation**

CAPTA Priority Area

- Improvement of case management, including ongoing monitoring and delivery of services and treatment provided to children and their families.

FY2017 CAPTA Expenditures, Activities and Accomplishments:

DCF budgeted \$74,000 in FY2017 to purchase the services of qualified practicing clinicians. Historically, these funds have been used in two ways:

- 1) To provide case consultation to staff in complex family situations, including clinical reviews required by policy to support sound decision-making for and with families.
- 2) To purchase clinical evaluations of families or family members for which no other source of funding can be identified.

FY2017 expenditures and services for Regional Clinical Consultations were as follows:

*Western Region*

The Western Region was allocated \$17,000.

One provider is used in the region for all CAPTA consultations and evaluations.

The specifics include:

- Stabilization of children exposed to multiple and severe trauma
- Prevention of higher-level/higher cost placements
- Identification of clinical needs to keep children at home
- Risk analysis to assist Social Workers review treatment options

*Central Region:*

The Central Region was allocated \$9,000. They used their funds in the same manner as the Western Region.

*Northern Region:*

The Northern Region spent approximately \$20,000 in CAPTA funding during FY'17 for clinical consultation to staff and for consultation to the Northern Region Clinical Review Team.

This funding is utilized primarily for:

- Individual case consultation to Area Office staff
- Consultation to the Northern Region Clinical Review Team

The Northern Region continues to actively seek and recruit clinicians to serve as Area Office/Clinical Review Team consultants and have placed a priority on clinicians who reflect the diverse populations served by the eight Northern Region Area Offices.

*Southern Region:*

In FY2017 the Southern Region used the \$30,000 in allocated funds to continue clinical consultations. Clinical consultants continued to bring his expertise to Area Clinical Reviews, Family Team meetings, level of care discussions with youth being referred, and reunification discussions regarding youth in placement. The portion of the Southern Regions allocation is used to staff the Regional Clinical Review team.

*Boston Region:*

The Boston Region was allocated \$4,000 in clinical consultation. This region has had difficulty identifying appropriate vendors at the existing rate. The use of competent, outside practicing clinicians to provide case consultation and participate in clinical reviews has helped staff to identify and clarify their understanding of the mental/behavioral health issues families are experiencing and support the development of more appropriate service plans.

*FY2018 Proposed Expenditures and Activities*

During FY2018 DCF proposes to use CAPTA funds at approximately \$74,000 to continue to purchase clinical consultations and evaluations as follows:

*Western Region: \$11,000*



CAPTA funds will be used for clinical consultation as well as augmenting the capacity to provide evaluations; this region will spend its allotment primarily on the following:

- Stabilizing children exposed to multiple and severe trauma
- Prevention of higher-level/higher cost placements
- Identification of clinical needs to keep children at home safely, when possible
- Risk analysis to assist Social Workers in review of treatment options

*Central Region: \$9,000*

The Central Region will use their funds in the same manner as the Western Region.

*Northern Region: \$20,000*

Funds will be used for clinical consultation to staff and for consultation to the Northern Region Clinical Review Team.

*Southern Region: \$30,000*

Funds will be used for continued use of clinical consultation and evaluative Services for the Regional Clinical Review and for a licensed Psychologist for Area based consultative services at family team meetings as well as Clinical Review Teams.

*Boston Region: \$4,000*

The Boston region will continue with clinical case consultations which will support:

1. Consultation on assessed risk to children in the home;
2. Assistance with planning services to stabilize children exposed to multiple and severe trauma so that they are able to remain at home or avoid placement in higher level, higher cost settings; and
3. Participation in clinical reviews to help staff identify or clarify their understanding of the mental/behavioral health issues families and children are experiencing to enable the development of more appropriate service plans.

#### **4. Children's Charter Division of Key Program, Inc.**

##### *CAPTA Priority Area*

- Improving the intake, assessment, screening and investigation of reports of abuse and neglect
- Improvement of case management and delivery of services

### *FY2017 CAPTA Expenditures, Activities and Accomplishments*

For several years, DCF has contracted with Children's Charter, a division of Key Program Inc., to provide state-of-the-art forensic clinical evaluations for DCF's most complex cases of child maltreatment that need intensive, in-depth assessment and treatment services to children involved in criminal court cases. As a statewide service, Children's Charter accepts referrals from any DCF area office. Children's Charter provides forensic evaluation services to children, between the ages of 3 and 17, who have experienced and/or witnessed trauma.

In fiscal year 2017, Children's Charter continued the geographical expansion from last fiscal year related to providing forensic evaluation services to serve a greater number of geographical areas in the commonwealth. The Western Region of Massachusetts continues to have challenges in generating referrals due primarily to the physical location to Children's Charter and the lack of transportation assistance/resources. The Department's Central Region has continued to see an increase in referrals indicating that Children's Charter has established a strong presence within the DCF area offices that cover this part of the state. Children's Charter continues their strong relationship in the Boston, Southern, and Northern regions of Massachusetts evidenced by the number of referrals received annually from the area offices within these regions. FY2017 data confirms that Children's Charter has maintained the significant strides in expanding their forensic evaluation service. Historically the Boston Region was the primary referral source for the program. Overall the numbers of referrals generated were similar across most of Massachusetts excluding the Western Region.

Children's Charter FY2017 data shows that they remain committed to being a statewide resource. In FY2018 there will be an emphasis placed on identifying and strategizing on how the program can be accessed by families in the Western Region of Massachusetts. This was a goal set last year however a larger statewide service procurement for all other domestic violence services took priority. The Children's Charter's team approach has been critical in responding to the most difficult and sometimes "high profile" cases involved with the Department of Children and Families. DCF continues to be the primary referral source for forensic evaluations maintaining a 95% referral rate while community stakeholders, schools, and self-referrals total approximately 5% of referrals received annually.

Children's Charter continues to provide valuable expertise and consultation services in the areas of court testimony, case management, and investigative services. In addition to DCF, the Children's Charter has established sound collaborative relationships with police, district attorneys, courts, physicians, and other community partners. The Director of the forensic evaluation program reports that over 70% of the evaluations are utilized by the courts in assisting them with making court rulings on behalf of the children. The primary purpose of the court-related evaluations is related to the permanency of children. In addition evaluations aide the courts in determining critical services that must be in place to achieve the goal of reunification. Over the past two years, a new trend developed: the Children's Charter reports an increase in referrals for attachment and bonding issues. Data suggests that this is still a small percentage of the total number of evaluations. However, this is a trend that will be tracked more closely. It is important that there be data and related evidence that informs an understanding of the effectiveness of the Children's Charter in achieving the intent and purpose of the forensic evaluation service. DCF will continue conversations and group meetings to identify methods of tracking the use of forensic evaluations to inform permanency decisions, and to measure outcomes related to the permanency of children in court related cases.

### *FY2018 Proposed Expenditures and Activities*

During fiscal year 2018, Children's Charter will continue to provide multi-disciplinary forensic evaluations to approximately 115 children and families with complex family situations in which children

may have experienced and/or witnessed trauma. Children's Charter will continue to enhance their ability to integrate multidisciplinary expertise into their evaluations and provide consultation and court testimony to augment the Department's capacity to assess families who present a significant level of child protection related risk. The services that Children's Charter provides have been, and continue to be, highly valued by DCF Area Offices, courts, healthcare professionals, and other community stakeholders. Also in FY2018 Children's Charter and DCF will continue to focus on strategies related to underserved priority geographical areas in Massachusetts; such as the Western Region. As is evidenced during FY 2015 and FY 2016 the increase in staffing has had a positive impact on reaching geographical areas that had not been reached in previous fiscal years. This was evidenced by the increase utilization from the Central/North Central Region, which had not traditionally utilized Children's Charter, and the steady level of referrals from the Boston, Northern and Southern Regions. Continuing to develop the capacity of this resource to operate fully statewide will continue in FY2018 with an emphasis on building relationships with community stakeholders in all the regions of Massachusetts, and especially in the Western Region. The cost for conducting related information sharing sessions will be born by the Department and, therefore will not impact the amount and/or level of direct care funding. Training was identified as a priority area for Children's Charter staff in FY 2016. This again has been identified as a need for next fiscal year.

The Children's Charter contract is monitored by the Director of the DCF Domestic Violence Unit (DVU). With the transition of other domestic violence service contracts to the Department of Public Health, focused attention will be more possible with Children's Charter. In addition to efforts to improve the data collection system and developing outcome measurements for the program, DCF will continue to strategize the most effective way of gathering information about how Children's Charter evaluation services benefit the family, including whether families are receiving the necessary and appropriate services that may lead to them becoming independent of state services. This outcome focused data will enable the Department to analyze statistically the program's effectiveness with families who have different goals such as those who are remaining intact, those who are being reunified, and those families whose parental rights are being terminated.

## **5. Parents Helping Parents' Parental Stress Line**

### CAPTA Priority Area

- Case management, case monitoring, and delivery of services to families
- Developing information to educate the public on the role of the child protection system.

### FY2017 CAPTA Expenditures, Activities and Accomplishments

DCF has long supported the availability of a Parental Stress Line [1-800-632-8188] in Massachusetts. The Parental Stress Line's mission is: Empowering parents to nurture children and prevent child abuse.

During FY2017, DCF used CAPTA funds to continue to contract with Parents Helping Parents (PHP) to pay for staff time and associated costs (space, supplies, etc.) to operate the Parental Stress Line and also to recruit, train and support volunteers. PHP's Parental Stress Line plays a key role in the primary prevention work being done in Massachusetts to prevent child abuse before it occurs. The Parental Stress Line is a 24-hour helpline that offers support, empathy, and crisis intervention counseling to parents and caregivers who are having difficulty coping with the stresses of parenting. Information and referral to other services are provided, but the primary purpose is to provide parents with someone to talk to about their parenting problems.

The Parental Stress Line continues to receive approximately 4,000 calls during the year. Calls to PHP's Parental Stress Line are answered by volunteers who are recruited and trained by Parental Stress Line staff. The training program covers child abuse and neglect prevention and intervention, child discipline, healthy parent-child communication and relationships, telephone counseling techniques and other relevant material. Counselors answer calls to the Parental Stress Line. All volunteers have access to a supervisor round the clock to answer any questions or talk through any issues that arise.

### *Who Calls the Parental Stress Line and What Happens*

The Parental Stress Line uses a multi-faceted approach in assisting callers, providing support to draw on callers' inner resources and information and referrals to link callers to external resources. In each call, counselors attempt to look at the holistic nature of the caller's concerns, and then tailor the information and support provided to fit the unique needs of the caller's situation. Rather than providing advice, counselors assist callers in thinking through the steps that will help them move toward their identified goal.

### *Callers fall into 6 categories:*

- *First time* callers
- *Repeat callers* who mention having called the helpline before or discuss a situation that the counselor is familiar with
- *Chronic callers* who use the hotline very frequently (several times per week) over a long period of time (many have been calling for years) and show no change in their situations over time
- *Inappropriate callers* who are not calling within the purpose of the helpline; while this includes sexually inappropriate callers, it also includes people calling for reasons unrelated to parental stress
- *Agency callers* who identify themselves as working for an agency, calling on behalf of clients or for information about the hotline
- *Unknown callers* are most often callers whom the counselor is unsure of whether or not they have called before.

### *Caller Concerns:*

- Family Conflict
- Child discipline
- Partner conflict
- Parenting Burn-Out
- Teenager behavior
- Overburdened
- Communication Problem
- Mental Health - child
- Infant crying/behavior
- Community Resources

At the end of each call, PHP assesses whether the caller was satisfied, dissatisfied, or expressed no indication regarding satisfaction. To eliminate bias, satisfaction is based on either what the caller says usually towards the end of a call or how they sound (moving from crying to talking normally). Callers overwhelmingly end calls positively, saying "thanks for listening" more frequently than "thanks for talking." PHP's tracking historically indicates that a vast majority of callers express satisfaction; while only a very small percentage expresses dissatisfaction.

### FY2018 Proposed Expenditures and Activities

During FY2018 DCF proposes to use CAPTA funds at \$45,000 to continue contracting with Parents Helping Parents (PHP), the current vendor of the Parental Stress Line.

## **6. Family Engagement and Voice**

### CAPTA Priority Area

- Case management, case monitoring and delivery of services to families.

### FY2017 CAPTA Expenditures, Activities and Accomplishments

Family Engagement at the Department happens at all levels. The Department strives to make its decision-making processes transparent by engaging former clients and other community members at all levels of decision-making.

In FY2017, \$65,000 was budgeted in CAPTA funds to provide stipends to parents and former consumers to participate in the decision-making processes at the Department. The funding also supports Parent Leadership Trainings to help former consumers prepare to be confident, effective participants and productive members of area boards and other forums where the voice of former consumers must be present. These funds also supported DCF's parent stipends associated with DCF's Fatherhood Initiative and The Commission on the Status of Grandparents Raising Grandchildren.

The Family Advisory Committee (FAC) is a diverse group foster and adoptive parents, mothers, fathers, and kin who have formerly had open protective cases with DCF, and/or people who were involved with DCF as youth. Their viewpoint is necessary as DCF strives to assist children and youth in achieving permanency/forever homes.

*Some examples of how the FAC assists DCF are as follows:*

- Participating in the Statewide Managers monthly meetings;
- Participating in both the Trauma-Informed Leadership Teams (TILT), and Fathers Engagement Leadership Team (FELT);
- Providing "family voice" to DCF's policy development and practice implementation processes; and
- Working as a "bridge" to the community to explain DCF's policies and practices, partnering with Family Resource Centers, Patch Offices, and other community-based organizations.

Most recently, the FAC assisted DCF in creating an "Engagement Principle" that will provide structure and support for the future work of the FAC and DCF.

*That Principle is:*

DCF engages and empowers children, youth, families, and communities to promote family success and build capacity. Together, we create and nurture partnerships to identify shared goals that support safety, permanency, and well-being. DCF welcomes and appreciates the participation of everyone affected by our work as we collectively endeavor to improve the lives of children and families.

### Commission on the Status of Grandparents Raising Grandchildren

The mandate for the Commission is to address issues of concern raised by grandparents and other kin who are raising children. Since its inception in FY 2009, the Director of Family Engagement or a member of the Community and Family Engagement Team has participated as a member of this Commission. In 2015, the Commission received an appropriation from the state in order to hire a full-time Program Coordinator. Since 2016, a Program Coordinator has served on the Community and Family Engagement Team at DCF. The work of The Commission, in conjunction with the Community and Family Engagement Team, continues to guide the work of the committees, recruit generous donations of time and resources from community members, and continues to ensure that an increasing number of grandparents are involved. These efforts have resulted in many accomplishments, including:

- The ability to provide correct and accessible information in order for Grandparents to access support and make knowledgeable decisions
- The ability to sustain a website: <http://www.massgrg.com> including the ability to provide updates and revisions to tip sheets for grandparents regarding:
  - Working with DCF
  - Available supports in the community
  - How to work with the courts and other legal issues that grandparents face
  - Information about the Commission and its mandate
  - Information on the opioid crisis, other substance issues and their impact on families
- The ability to assist with the implementation of Grandparent's Support Groups throughout the state
- The ability to continue to build a network of supporters and facilitators of support groups that meet quarterly
- The ability to continue to provide legislative advocacy on bills that affect the lives of children and their families
- The ability to plan the annual statewide conference for grandparents, kinship caregivers, and providers

The Grandparents Commission continues to base its work plans on the feedback received from grandparents during the *Learning and Listening Tour*, through annual conferences and ongoing dialogue with stakeholders.

### FY2018 Proposed Expenditures and Activities

The Commission on the Status of Grandparents Raising in FY2018 will continue to support the work in FY2017 and include the following areas in their FY2018 work plan:

- Expand consumer participation and membership on DCF local Area Boards
- Provide oversight and tracking of the Commissions fidelity in practice to the CPM from the family perspective

- Improve the Family Liaison program with the Ombudsman's Office and creates trainings for future Liaisons regarding the Liaison Role, Trauma-Informed Practice, Managing Yourself (self-care and self-awareness), Meditation and Conflict Resolution, Court Process: Juvenile & Probate, Kinship Care and Grandparent's Rights, Recognizing Limits and Barriers

In FY2018, DCF proposes to use the \$65,000 budgeted in CAPTA funds to continue to support parents and former consumers to participate in the decision-making processes at the Department. Specifically, these funds will continue to be used to provide stipends for consumer's time. The funding also supports Parent Leadership Trainings to former consumers to prepare them to be confident participants and productive members of area boards and other forums where the voice of former consumers must be present. These funds also supported DCF's parent stipends associated with DCF's Fatherhood Initiative and work with the Commission on the Status of Grandparents Raising.

### **Amendments to CAPTA made by the Comprehensive Addiction and Recovery Act of 2016 (CARA)**

To address the special needs of substance exposed newborns, Congress reauthorized and amended the Child Abuse Prevention and Treatment Act (CAPTA) in 2003 by adding certain provisions regarding reporting and safety of substance exposed newborns. CAPTA was reauthorized in 2010 and modified earlier language to include infants diagnosed with fetal alcohol spectrum disorder (FASD). In an effort to increase monitoring and oversight, and help states address the effects of substance abuse disorders on infants and their families, H.R. 4843 "Infant Plan of Safe Care," was signed into law under Title V, Section 503, of the Comprehensive Addiction and Recovery Act of 2016 ("CARA"). This section further amended CAPTA with provisions that enhance state requirements to address the health and substance use disorder and treatment needs of the infant and family caregiver, collect data and provides more directive of HHS to increase monitoring.

In the release of the DCF Protective Intake Policy in early 2016, DCF updated their data collection related to Substance Exposed Newborns (SENs). The DCF Protective Intake Policy includes a definition for DCF on SENs and those newborns diagnosed with Neonatal Abstinence Syndrome (NAS). DCF now tracks the number of 51A reports that are filed due to a SEN and those who have been diagnosed with NAS. Further practice guidance was distributed to DCF social workers on the types of information to gather and questions to ask collateral contacts for all SEN reports. Also, in the fall of 2016, DCF released guidance to hospitals and other mandated reporters on 51A filing related to SENs that highlighted the state law and CAPTA law on filing notification to DCF.

In the FY2017 budget, the Legislature and Governor established an Interagency Task Force on Newborns with Neonatal Abstinence Syndrome whose charge was to assess existing services and programs in the Commonwealth for mothers and newborns with neonatal abstinence syndrome, identify service gaps, and formulate a cross-system action plan for collecting data, developing outcome goals, and address service and support gaps in the Commonwealth. The Task Force submitted a statewide plan of recommendations to the Legislature in March of 2017 that provided for the coordination of services across executive agencies to address the needs of newborns, infants and young children impacted by exposure to substances.

In the fall of 2016, DCF partnered with Department of Public Health Bureau of Substance Abuse and other key stakeholders on an application for the SAMHSA/ACYF 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families, and Caregivers. Massachusetts was selected to participate in the Policy Academy and the follow up technical assistance. DCF, DPH, Executive Office of Health and Human Services, Office of the Attorney General, Massachusetts Health Policy Commission, MassHealth and the medical community make up the core members of the Policy Academy Team and oversee the implementation of the State Action Plan.

There was significant overlap of the Policy Academy Team and the members of the Massachusetts NAS Task Force. The recommendations of the NAS Task Force and the Policy Academy Action Plan are complimentary in their goals and recommendations. Both plans highlight the areas that need to be addressed to implement the Plan of Safe Care requirements. Massachusetts is in the process of developing the components of the Plan of Safe Care that will lead to an implementation strategy, with the technical assistance provided by the Policy Academy.

In a separate document, the Department has submitted a formal Program Improvement Plan (PIP) to support full compliance with the Plans of Safe Care provisions under CAPTA by June 30, 2018.

There have not been any substantive changes to state law or regulations that could affect the state's eligibility for the CAPTA State Grant (section 106(b)(1)(C)(i) of CAPTA)

### **Trafficking Amendments to CAPTA**

Massachusetts DCF embeds best practices associated with the identification and response to Human Trafficking in all current policies. Three recent policies have specifically outlined Human Trafficking: the Protective Intake Policy (February 2016), The Missing or Absent Children from Department Care or Custody policy (September 2016) and the Policy for Referral to the District Attorney and Local Law Enforcement Authority (Spring 2017). The Protective Intake policy included two new allegations of abuse under the umbrella of Human Trafficking: Sexual Exploitation of a Child and Labor. The Missing or Absent Children from Department Care or Custody highlights the risks and action steps associated with Human Trafficking related to a child on the run or missing. The Policy for Referral to the District Attorney and Local Law Enforcement Authority was amended to include mandatory referrals at screening to the District Attorney and the local law enforcement authority when it is suspected that a child may be the victim of human trafficking or sexual exploitation.

The work of the Child Welfare Trafficking Grant (CWTG) awarded in September 2014 through ACF continues to provide DCF staff with focused support for the implementation of protocols and policies through trainings and technical assistance.

The Department does not believe it will need any technical assistance related to implementation of the amendments to CAPTA made by the Justice for Victims of Trafficking Act; however, should that be reevaluated the Department will contact the appropriate capacity building center.

### **CAPTA Assurances**

On May 18, 2017, the signed Governor's Assurance Statements relating to child sex trafficking (Attachment F) and assurance statement relating to substance-exposed infants and plans of safe care (Attachment G) was submitted to ACF / CB Regional Office.

### **Budget**

In the chart below, we present the FY17 and FY18 planned budget for the grant. We provide two views: expenditures grouped by category and expenditures grouped by the grant objectives. Expenditures reported reflect spending incurred/projected during the respective state fiscal years and do not necessarily correspond with the federal fiscal year spending reported in the CFS-101.



CHILD ABUSE PREVENTION AND TREATMENT ACT		
Expenditure Category	FY17	FY18
Salary (nurse)	\$ 61,700	\$ 63,700
Salary (Implementation Coaching Consultant)	\$ -	\$ 68,000
Fringe Benefits (nurse)	\$ 21,694	\$ 23,149
Fringe Benefits (ICC)	\$ -	\$ 24,711
Travel	\$ 10,582	\$ 10,582
Equipment	\$ -	\$ -
Conference Incidentals	\$ 15,000	\$ -
Supplies	\$ -	\$ -
Contract Services:		
<i>Policy Development/Consultation</i>	\$ 51,400	\$ 71,500
<i>Parent Stipends (Family Engagement)</i>	\$ 65,000	\$ 65,000
<i>Regional Clinical Consultants</i>	\$ 74,000	\$ 74,000
<i>Key Program (assist troubled youth and their families)</i>	\$ 95,675	\$ 95,675
<i>Parents Helping Parents (Build Stronger Families)</i>	\$ 45,000	\$ 45,000
<b>Subtotal Direct Cost</b>	\$ 440,051	\$ 541,317
<b>Indirect Cost</b>	\$ 7,137	\$ 8,000
<b>GRAND TOTAL</b>	\$ 447,188	\$ 549,317

Grant Objectives	FY17	FY18
Intake, Assessment, Screening and Investigation of Reports of Abuse and Neglect	\$ 73,538	\$ 129,943
Creating or Improving Interagency Protocols to Enhance Investigations	\$ -	\$ -
Case Management, Monitoring and Service Delivery	\$ 265,215	\$ 323,060
Developing and Improving Risk and Safety Assessment Tools	\$ -	\$ -
Upgrading Technology that Tracks Reports of Child Abuse and Neglect	\$ -	\$ -
Improving Skills of Individuals Providing Services to Children, Including Social Worker Retention	\$ -	\$ -
Developing Training Protocols for Mandated Reporters	\$ -	\$ -
Developing Research Based Strategies for Training Mandated Reporters	\$ -	\$ -
Developing Services for Families of Disabled Infants with Life-threatening Conditions	\$ 30,177	\$ 31,616
Developing Information to Educate the Public on the Child Protection System	\$ 22,500	\$ 22,500
Developing Community Based Programs to Integrate Shared Leadership Between Parents and Professionals	\$ -	\$ -
Supporting Collaboration between Child Protection and Juvenile Justice	\$ 30,177	\$ 31,616
Supporting Collaboration between Public Health Agencies and Child Protection System	\$ -	\$ -
Administration:		
<i>Personnel and Overhead</i>	\$ 10,582	\$ 10,582
<i>Supplies and Administrative Costs</i>	\$ -	\$ -
<i>Administrative Activities</i>	\$ 15,000	\$ -
<i>Other</i>	\$ -	\$ 1
Administrative %	5.72%	1.93%
<b>GRAND TOTAL</b>	\$ 447,188	\$ 549,318

## **CITIZEN REVIEW PANELS OF MASSACHUSETTS DEPARTMENT OF CHILDREN AND FAMILIES (DCF)**

### **Background and Summary**

- The Child Abuse and Prevention Treatment Act (CAPTA) was enacted in 1974 to comprehensively address child abuse and neglect issues. CAPTA, which authorizes the award of Child Abuse and Neglect Grants, Parts I and II was amended by the “CAPTA Amendments of 1996” on October 3, 1996. A new requirement was the establishment of three Citizen Review Panels. The Panels provide opportunities for citizens to have a role in ensuring that States are meeting their goals of protecting children from abuse and neglect. On December 20, 2010, President Obama signed Public Law 111-320, a new five-year reauthorization of the federal Child Abuse Prevention and Treatment Act (CAPTA). The CAPTA reauthorization in 2010 continues to include CRPs as part of their focus;
- The purpose of the Panels is to identify systems issues, barriers and trends, and develop recommendations for improving case practice, policy, training, service delivery and coordination.
- States are allowed to use existing panels for this purpose as long as each panel plays a role in evaluating the extent to which each State agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State plan, and offers recommendations on how child protective services can be improved and strengthened.
- Panel members may review specific cases of child fatalities and near fatalities, as well as state policies and procedures to evaluate the extent to which the Department of Social Services is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan.
- According to Federal requirements, Citizen Review Panels are to be made up of volunteer members of the community and include individuals with expertise in the prevention and treatment of child abuse. Each Panel is required to meet at least quarterly and produce an annual report containing a summary of its activities.
- In compliance with the CAPTA, the Department established its three Citizen Review Panels as of June 1999.
- In 2003, following a review of the panel functions, members of the CJA Task Force (one of the designated DCF review panels) elected not to participate as one of the state CRPs. It was the opinion of many on the Task Force that they were concerned about a conflict of interest if they were involved in any of the fatality/near fatality cases in their professional roles. Based on this change, a new configuration of the Citizen Review Panels was developed for 2003-2004. This plan continued through FY 2015 but changed CRP Three in FY 2016 - 2017:
- Utilize the **Statewide Child Fatality Review Team** as Citizen Review Panel One.
- Utilize the **DCF Family Advisory Committee** as Citizen Review Panel Two.
- Utilize the **DCF Youth Advisory Board** as Citizen Panel Three.

## **CITIZEN REVIEW PANEL ONE**

### **Statewide Child Fatality Review Team**

The child fatality review legislation enacted by the Massachusetts legislature in July 2000 was designed to bring professionals together from a variety of disciplines and experiences to examine individual fatality cases. The objectives of this review are to facilitate interagency networking and collaboration and to produce recommendations for changes that will protect the health and safety of children.

The law establishes the State Team within the office of the Chief Medical Examiner, and the Local Teams within each of 11 District Attorneys' offices. Members of the teams are drawn from state departments of public health, social services, mental health, mental retardation, education, and youth services. There is also representation from the American Academy of Pediatrics, the Massachusetts SIDS Center, the Massachusetts Hospital Association, state and local police, and the juvenile courts.

#### *I. Mission*

The Massachusetts Statewide Child Fatality Review Team (Citizens' Review Panel) is committed to reviewing and evaluating child fatalities and the child fatality reporting system, and to make recommendations relative to their findings to insure the safety and the appropriate placement of children in need of aid. The CRP will achieve this commitment by examining the policies and procedures of State and local agencies; examining, where appropriate, specific cases; evaluating the extent to which agencies are carrying out their child protection responsibilities; and preparing and making available to the public, an annual report.

The common goal of the State and Local Child Fatality Review Teams is to decrease the incidence of preventable child deaths and injuries. The Local Teams collect information on individual cases, discuss case information in team meetings and advise the State Team by making recommendations for changes in law, policy and practice that will prevent child deaths. Through the review process, child fatality review teams promote collaboration among the agencies that respond to child deaths and provide services to family members.

A principal responsibility of the State Team is to provide ongoing advice and support for the Local Teams through training, guidance and the dissemination of information pertinent to the protection of children. A second responsibility is to review Local Team recommendations and combine them with its own research in making final recommendations to the governor, the legislature and the public.

During 2016, Local CFR Teams reviewed 92 child deaths and made 25 recommendations to the State CFR Team to prevent future deaths. The annual report contains more information on the types of deaths reviewed as well as a list of all the recommendations made to the State CFR Team during 2016.

Please see the Massachusetts Child Fatality Review Program 2016 Status Report at <http://www.mass.gov/eopss/docs/ocme/skm-654e17062918060.pdf>

#### *II. Structure*

The Massachusetts Child Fatality Review law establishes a State Team and 11 Local Teams. The State Team is under the direction of the Chief Medical Examiner, and the Local Teams are the responsibility of each of 11 districts headed by a District Attorney. These districts correspond to the state's counties, although two of the districts combine more than one county (Franklin and Hampshire Counties are combined, as are Barnstable, Dukes and Nantucket). Local Teams can meet as frequently as they want

but the law mandates a minimum of four meetings per year. There is no meeting requirement for the State Team, but in practice the team meets quarterly.

The composition of the State and Local Teams is also mandated, but not limited, by the law.

### *Responsibilities of the State Team*

The common goal of the State and Local Child Fatality Review Teams is to decrease the incidence of preventable child deaths and injuries. The State Team accomplishes the goal of fatality and injury prevention by meeting two objectives established by law:

- It develops an understanding of how and why children die based on Local Team experience; and
- It advises the governor, the legislature and the public on changes in law, policy and practice that will prevent child deaths.

A principal responsibility of the State Team is to review Local Team recommendations and combine them with its own research in making final recommendations to the governor, legislature and the public. A second responsibility is to provide ongoing advice and support for the 11 Local Teams through training and the dissemination of information pertinent to the protection of children.

### *Responsibilities of the Local Teams*

The Local Teams prevent future child deaths by meeting four objectives established by law:

- They collect information on individual child deaths;
- They discuss this case information in team meetings and develop an understanding of the causes and incidence of child deaths;
- Through the review process, they promote collaboration among the agencies that respond to child deaths and provide services to family members; and
- They advise the State Team by making recommendations for changes in law, policy and practice that will prevent child deaths.

## *III. Meeting and Activities*

### *The Review Process*

Notifications to Local Teams: Each Local Team receives two notifications of child deaths in their districts at least quarterly. One notification consists of copies of death certificates (which, in some cases, may not be finalized) that originate in the cities and towns of the Commonwealth and are sent to the Department of Public Health (DPH) Registry of Vital Records and Statistics. DPH sends these death certificates to the Chief Medical Examiner, who in turn forwards them to the Local Teams. In the case of infants under one year of age, DPH attaches birth certificates to the death certificates, which facilitates a review of the infant death by providing critical information on the health status and prenatal care of the mother.

The second notification to the teams is a report from the Department of Public Health, which supplements the death certificates and contains the following information:

- deaths of children living in the district who died in the district
- deaths of children living in the district who died in another district
- deaths of children living in another district who died in the district

Case Selection: Any death of a child from birth through 17, from any cause, may be chosen for review by the team. It is recommended that, at a minimum, Local Teams review the following:

- any death from an injury, intentional or unintentional;
- any sudden or unexpected deaths, including SIDS;
- all cases accepted by the Office of the Medical Examiner; and
- All cases with previous DCF involvement or cases that have been prosecuted by the District Attorney's office.

Two types of deaths usually not reviewed are homicides under investigation and deaths ruled as "pending," both in cause and in manner, by the Medical Examiner. "Pending" as a cause and manner of death is applied to those cases in which further laboratory testing or other investigation is needed and is still incomplete.

Assembling Case Information: To accomplish the mandate of the child fatality review law, the legislature gave each local District Attorney the broad authority to collect all records and information relevant to the death of a child under review by a Local Team. This authority extends to records and information relevant to the child and their immediate family from:

- providers of medical or other care, treatment or services, including dental and mental health care;
- state, county or local government agencies; or
- Providers of social services.

The legislation also gives the Local Team the authority to obtain information covered under the Health Insurance and Portability and Accountability Act (HIPAA).

Case Review: Local teams conduct their meetings differently. However, most case reviews begin with the presentation of case details, including information provided by team members and other sources. Additional participants may be invited to the review if they have information pertinent to the case. The presenter may be the team coordinator or another member with knowledge of the case, but all members who have information concerning the case or the cause of death should contribute to the discussion. At the discretion of the team, a case may be held over to the next meeting if the information provided is unclear, or if more information is needed to complete the review. A case may also be held over if it is under investigation. Reviews are complete when the team agrees that no further information or discussion would add to the investigation of the death.

A child fatality review team does not function as a mechanism for criticizing family or agency decisions. Rather it is a forum for sharing and discussing information essential to the improvement of the state's ability to protect children from preventable death. The critical question being answered by the review is "How can we prevent a death like this from occurring again?"

Confidentiality: The Child Fatality Review law makes the following provisions for maintaining confidentiality:

- The Chair will ensure that no information submitted for case review is given to anyone outside the Local Team.
- Team members may not violate confidentiality.
- Team members may not disclose team business, except as necessary to carry out their duties and responsibilities.
- Team meetings are closed to the public.
- All information and records acquired by the team for case review are confidential and may be disclosed only as necessary to carry out team duties.
- Statistical compilations of data may be disclosed to the public, provided they contain no identifying information.

- Team members or anyone else attending team case review meetings may not be questioned in any civil or criminal proceeding regarding information presented or opinions formed during reviews, and,
- Information or records of State and Local Teams will not be subject to subpoena, discovery, or introduction into evidence of civil or criminal proceedings.

Some Local Teams begin each case review session by signing a confidentiality form; others sign the form once, at their first meeting.

IV. *Massachusetts Child Fatality Review Program: Multi-Disciplinary Approach to the Prevention of Child Deaths 2016 Status Report*

*Executive Summary*

A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury. The purpose of Child Fatality Review (CFR) is to conduct a comprehensive, multi-disciplinary review of child deaths, to better understand how and why children die, and to use the findings to take action that can prevent other deaths and improve the health and safety of children. In Massachusetts, Local Child Fatality Review Teams examine the circumstances of child deaths under their jurisdiction to determine if the death was preventable and to formulate recommendations outlining education, policy, and prevention action steps to take to prevent similar deaths in the future. These local recommendations inform the statewide prevention efforts of the State CFR Team.

During 2016, Local CFR Teams reviewed 92 child deaths and made 25 recommendations to the State CFR Team to prevent future deaths. More information on the types of deaths reviewed can be found below as well as a list of all the recommendations made to the State CFR Team during 2016.

At both the state and local level, Child Fatality Review continues to be an unfunded mandate. Local Team coordinators struggle with balancing existing work responsibilities with coordinating Local Team meetings, developing Local Team guidelines, gathering records for the review, and submitting data to the State Team and the National Child Death Review case reporting system. Delays in both death certificate and surveillance data also affect Local and State Teams' abilities to focus prevention efforts and measure progress.

In 2015, a CFR improvement working group was formed to brainstorm challenges and opportunities of the Child Fatality Review process in Massachusetts and a retreat for all State Team members was held in 2016. As a result of the working group and retreat a process for immediate feedback on recommendations made by the Local Teams to the State Team was created in 2016 and implemented in 2017. In 2016, a plan for a more comprehensive needs assessment of Local and State CFR teams was drafted, including the creation of data collection tools to conduct the needs assessment. The needs assessment began with interviews with Local Team leaders and coordinators using a set of standard questions designed to identify strengths and barriers of the CFR process in Massachusetts. In 2017, the needs assessment will continue with data collection from State team members. Other activities of the State CFR Team in 2016 included holding a Child Fatality Review conference in July 2016 and continuing to collect data on sudden unexpected infant deaths (SUIDS) using the SUID investigation form completed by the State Police. Please see the Massachusetts Child Fatality Review Program 2016 Status Report at <http://www.mass.gov/eopss/docs/ocme/skm-654e17062918060.pdf>

V. Recommendations from Child Fatality Review 2016 Status Report

During 2016, the State Child Fatality Review Team received and reviewed 25 recommendations from Local Child Fatality Review Teams. Below are recommendations formulated by the State Team based on common themes found in Local Team recommendations. The State Team recommends the following:

*Sudden Unexpected Infant Death (SUID):*

- Potentially send educational materials on sleep best practices;
- Potentially have District Attorney send letter to hospitals to ensure they are reporting deaths (may only report abuse/neglect);
- Emphasize safe sleep practices at day care: conduct safe sleep trainings including information on risk factors, non-licensed providers should not be left alone with children, direct visual contact is mandatory, transition time in day care should be the first 6 weeks, and, check with parents about milestones met at home (i.e. if first roll over happens at home);
- Create a statewide plan for the safety of substance exposed newborns;
- Talk further with child abuse expert on team about closing the loop on birthing hospitals;
- Create a year-end report to hospitals about infant deaths
- Target methadone clinics regarding safe sleep practices and breastfeeding guidelines;
- Recommend that CFRT give presentation regarding opioid child deaths to juvenile court judges conference;
- Gather information from methadone clinics to understand any screening practices and the filing of 51A reports in regards to patients with young children and positive test results
- Prenatal home visits for high risk patients.

*Suicide:*

- Recommend that juvenile probation officers receive training on how to screen children monthly for suicidal ideation;
- Request state funding for implementation of school personnel trainings on suicide prevention;
- Recommend methods of suicide (specifically in females) be tracked/studied as we have noticed a shift. Young people are using the Internet as a means of finding best methods of suicide leading to more successful attempts;
- Schools should incorporate comprehensive suicide prevention programs encompassing prevention, intervention and postvention components. Guidance for this type of program is contained on the DESE website;
- Prevention components geared to middle school and high school students, identifying peers about whom they are concerned and identifying trusted adults are two of the components which have been empirically proven to be effective in preventing suicide;
- Provide information to teams seeking information regarding suicide prevention and private schools. Do private schools have access to the same training and resources as public schools?

*Homicide:*

- Increased awareness among pediatricians is needed: What a 51A form is and how to file them, emphasize that 51As should be filed when abuse is suspected or possible not only confirmed and that investigation and evidence gathering will be undertaken by other entries after a form is completed and not the responsibility of the physician;
- The State Team should consider reviewing current evidence-based home-visiting practices and encourage their use statewide:

- Serious at-risk and antisocial behavior is the consequence of lifelong social dysfunction that can be identified as early as preschool. Evidence-based programs for dealing with these problems early exist, but correction becomes increasingly difficult as children age. There is a need for a multi-disciplinary approach to address the issue of youth violence, which should include services being offered to children and families and involvement from local school departments. Local faith communities, cultural groups, early education and care organizations, medical care providers, and social service agencies can be a safety net for families in distressed communities and should be included as part of the effort. It is further recommended to continue to monitor the development of executive functioning and intervening early with children;
- The State Team should continue to consider the need to expand the scope of intervention-based programs, build the capacity of current incentive-based programs, and consider behavioral health programs that address stigma and utilize non-conventional methods to address this problem. Current practices aimed at reducing desensitization to youth violence and enhancing positive youth development should be promoted statewide. Unfortunately, there is limited funding for children with behavioral/emotional regulation programs-agencies do not have sufficient resources to reach and educate all youth with behavioral/emotional regulation problems;

*Injury:*

- A public campaign on pool safety should be promoted to the public statewide and on an annual basis. Free and/or low cost swimming lessons should be made available and accessible to all children universally;
- Use mediums like the DARE program to discuss safe alternatives to the use of drugs/alcohol to obtain a “natural high” and that other alternatives such as auto-erotic asphyxiation/choking game are inherently dangerous;
- Recommend that police view digital evidence such as computers and smartphones for last accessed websites to gain further insight into a child’s state of mind prior to a suicide or accidental death;
- Request that state team discuss case and inform local teams if teens are educated regarding the dangers of adopting behaviors seen on the Internet. Education should be incorporated in sex education or a digital safety class;
- All persons installing car seats and all agencies involved in prevention work with infants should be informed of the potential for death if the handle of the infant carrier is left in an upright position;
- We learned about Fire Ice Solutions, a gel that makes water more durable and allows first responders to act effectively and efficiently to save lives. It is recommended that all police departments in the state consider this product.

*Natural:*

- There needs to be more proactive thought about the management of medically obese children, particularly enlisting more involvement from DCF, as well as providing education to the public.
- There is a need for more child abuse pediatricians and nurses statewide. Barriers families encounter include transportation issues and difficulty following through with providers;
- Need prenatal home visits for high risk pregnancies;
- Educating providers on grief counseling to families is needed;
- Expand the Pediatric Palliative Care Program for children with life-limiting illnesses;
- DPH should change current regulations regarding DNR. Need to reach out to doctors to override original orders and have them confirm that a DNR is in place. When calls are made to 911, the DNR information should be available prior to the police or EMT arrival;
- Increase community access to and awareness of CPR classes;
- Enhance data collection procedures on sudden unexpected deaths of a child (SUDC).



*Other:*

- Create resources for parents dealing with substance use and in treatment on keeping children safe;
- Bring together and coordinate the child safety and advocacy community and substance abuse recovery programs;
- Implement a needs assessment in the recovery community to understand how to better promote safe care giving;
- Explore mandated reporting when a parent is relapsing and reiterate laws around enforcing screening and communication.
- It is known that there is a significant backlog in the processing of rape kits statewide. The State Team should continue to review current practices and consider the need for a concerted effort to process rape kits in a timely and expeditious manner.

## **CITIZEN REVIEW PANEL TWO**

### **DCF Family Advisory Committee**

In 2004, DCF assembled its first Family Advisory Committee (FAC) to meet quarterly with the Commissioner. The FAC is a group of individuals from across the Commonwealth who are diverse in race, culture, language, age and sexual orientation. They also bring a wide range of first-hand experience with the Department. Some have been foster and/or adoptive parents; some, with their families, have had open DCF cases, including those whose children were in foster care and/or residential placement.

The FAC addresses such issues as: putting the DCF core values into practice; staff training and support; building good rapport with communities; developing informational materials that are user-friendly; and recruiting and retaining neighborhood foster homes.

DCF recognized the importance of including family voices in their processes, and created the position of Family Representative to assist the Family Support Team in recruiting, orienting, and mentoring parent leaders for a variety of local and statewide decision making bodies, including the Department's: Area Boards; Procurement Review Panels; Policy Work Groups; Teaming Initiatives; Patch Teams; and the Commissioner's Family Advisory Committee. These individuals play a vital role as bridge-builders to the Department. Since its inception, FAC developed into a structured advisory that works collaboratively with DCF in providing ongoing input into the development of DCF policy and implementation planning of those policies that directly involve and impact parents and the family voice.

As a CRP, the FAC consists of at least eighteen board members, including two co-chairs. The full group meets on a quarterly basis; the Leadership Team, meets monthly. A member of the DCF Executive Leadership Team participates in Board meetings on a quarterly basis, demonstrating a commitment on the part of the FAC and DCF to engage in meaningful discussion as to what improvements are needed to improve child protection services for children and families across the Commonwealth, as well as which community partners to be engaged in this process. Notes and attendance logs are kept for all meetings. Additionally, the FAC provides support to DCF regional and area offices by interacting with the offices and Area Boards.

Members of the FAC are valued partners in DCF's Agency Leadership Team (AILT), Trauma-Informed Leadership Teams (TILT), and Fathers Engagement Leadership Teams (FELT). Members have effectively participated in the procurement review process as community representatives. FAC members

work as a bridge to the community, explaining DCF's policies and practices, partnering with the Family Resource Centers, Patch Offices, and Community Connections.

The FAC has developed a viable strategic work plan that is developed and reviewed annually. The latest report has six major objectives with specific action steps included. The goal of the annual plan is to:

Assist DCF with the inclusion of community/parent participation to ensure that parent input happens at all levels in the Department including program planning, policy development, and the delivery and monitoring of DCF services.

In addition, the FAC committed most of the year to activities to assist DCF with the inclusion of community/parent participation, including:

- An annual FAC sponsored conference and retreat. This year's retreat featured a welcoming keynote address and discussion with the DCF Commissioner;
- The FAC has conducted an agency-wide Parent Survey and plans to conduct a follow up survey in the coming year;
- The FAC assisted DCF in creating an "Engagement Principle" to provide structure and support for the future work of the FAC and DCF. The Principle states: "DCF engages and empowers children, youth, families, and communities to promote family success and build capacity. Together, we create and nurture partnerships to identify shared goals that support safety, permanency, and well-being. DCF welcomes and appreciates the participation of everyone affected by our work as we collectively endeavor to improve the lives of children and families.";
- Continue to assist DCF in the implementation, training, and coaching of the use of the Intake Assessment tools;
- Continue to assist DCF with getting systematic feedback from the families it serves on the effectiveness of its interventions and practice;

In a separate document, the Department has submitted a formal Program Improvement Plan (PIP) to support full compliance with the CRP requirements under CAPTA by June 30, 2018.

### **CITIZEN REVIEW PANEL THREE**

#### **DCF Youth Advisory Committee**

The DCF Youth Advisory Board has been active for more than seventeen years. In its current configuration, there are thirty members of the Regional Youth Advisory Boards, who have been committed to promoting change for future foster youth through their voice, advocacy, and action. Additionally, they provide recommendations to DCF regarding programs and/or policy needs, development, and implementation, as well as practice-related issues.

The Regional Youth Advisory Boards generally meet monthly, providing a medium for youth in out-of-home placement to voice their concerns and offer suggestions to DCF on issues of concern to youth in care.

Some examples of the activities of the Youth Advisory Board are as follows:

- Responded to requests for feedback on issues relevant to DCF such as policy review
- Participated in a support group for Grandparents Raising Grandchildren to inform them of the educational opportunities available for their grandchildren in agency care

- Assembled and distributed care bags for teenagers that come into DCF care. These care bags contained personal hygiene items, comfort items, clothing items, art supplies and books. They continue to identify funders/donations and expect to grow this project during the next year
- Members are working with their regional DCF foster parent recruiters to plan innovative ways they can further assist in the recruitment of adolescent foster homes
- Assisted in planning for the Youth Leadership Institute in July 2016, and are now working this year's Youth Leadership Academy and Youth Summit, to be held July 2017
- Participated in trainings for DCF staff on the importance of permanency and life-long connections for foster youth
- Continue to participate in MAPP trainings and regional recruitment events, sharing their experiences to help train and recruit foster and adoptive families
- Continue participation in CORE trainings for social workers and supervisors, discussing the needs of youth in the care/custody of DCF
- Advocated with local cities/towns for summer jobs and internships for foster youth; and
- Board members have spoken at Area Office legislative breakfasts to present the youth's perspective on the DCF foster care program

It is the belief of both DCF and members of this Advisory Board, that, at a minimum, an opportunity now exists to strengthen the current Board structure, expand the scope of work, and broaden the membership base. Our plan to assist the Board in taking its work to the next level, and ultimately become a viable Citizen Review Panel includes the following activities:

- Identifying and assessing the strengths and challenges of the current Board, in terms of what is currently in place that can become a viable part of a newly created CRP, what components are missing, and the challenges that need to be addressed in the near future to begin this process. The DCF Director of Adolescent Services and her staff began discussions the fall of FY2018 and will be a partner in developing a plan of action to achieve the goal of becoming a fully-functioning CRP.
- Convening focus groups with the current Youth Advisory Board Membership to hear how they would like to expand their current roles and responsibilities, the obstacles they face, goals they would like to achieve as a group, etc.
- Exploring development of more structured partnerships with the DCF Area Boards and the statewide network of Family Resource Centers.
- Creating a robust membership recruitment plan, to include concerned/involved citizen advocates, former foster youth, adult adoptees, educators, attorneys, leader of child welfare agencies/organization, behavioral health practitioners, social workers, etc.

In a separate document, the Department has submitted a formal Program Improvement Plan (PIP) to support full compliance with the CRP requirements under CAPTA by June 30, 2018.

**CAPTA Coordinator (State Liaison Officer):**

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