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

April 2017

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE CHILD ADVOCATE
ONE ASHBURTON PLACE, 5TH FLOOR • BOSTON, MA 02108
WWW.MASS.GOV/CHILDADVOCATE
(617) 979-8374 • TOLL FREE: (866) 790-3690 • FAX: (617) 979-8379

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

MARIA Z. MOSSAIDES
THE CHILD ADVOCATE

April 2017

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

As a result of allegations of maltreatment of children with disabilities at the Eagleton School and the Peck School, in the spring of 2016 Governor Charlie Baker asked the Office of the Child Advocate (OCA) to guide and coordinate a review of public and private residential and day programs that provide educational services to children who require a residential or substantially separate educational setting to meet their needs. For the past year, the OCA has led an Interagency Working Group composed of representatives from the state agencies responsible for the oversight of residential schools: the Department of Early Education and Care (EEC), the Department of Elementary and Secondary Education (ESE), the Department of Children and Families (DCF), the Department of Mental Health (DMH), and the Disabled Persons Protection Commission (DPPC). The Working Group was guided by a Steering Committee comprised of the Child Advocate, Undersecretaries of the Executive Office of Education and Health and Human Services, and a representative from the Governor's Office.

The Interagency Working Group's review concentrated on improving the Commonwealth's systemic capacity to prevent harm to children by more quickly identifying programs that are at risk of experiencing operational challenges, and how to provide appropriate support and technical assistance to these programs to ensure their safe operation. This report details the results of this examination, and outlines a series of

recommendations that should improve the oversight of services to children in residential schools. The residential school providers share our mutual goal of ensuring the well-being of and the best outcomes for the Commonwealth's children.

The initial meetings of the Working Group reviewed the risk factors the agencies use to fulfill their statutory functions. As a result of these initial meetings, the agencies agreed to make immediate changes. ESE and DPPC information sharing is now integrated more closely with DCF and ESE. ESE also made several policy changes increasing the scope of reporting of incidents and special education needs to include all students enrolled in the program (Massachusetts, out-of-state, and privately-funded). Policies regarding student and staff restraints and injuries, behavioral supports and restraints, program change requests, and staffing documentation were updated. Quarterly interagency meetings are taking place with ESE, EEC and DCF to discuss residential programs under review, and identify patterns, trends, or areas of concern.

Immediately following the initial meetings, the Working Group then engaged the Public Consulting Group (PCG) to conduct best practices research in oversight of residential schools, review current oversight processes and procedures in Massachusetts, and identify key safety and risk factors that would inform recommendations for improvements. In the Commonwealth, services to children with disabilities are overseen by highly specialized agencies by statutory design. The licensure of child-serving programs, such as foster care, child care and other out-of-home placement is conducted by the EEC, an agency independent of the agencies that obtain these services. Similarly, the investigations of abuse or neglect in institutional settings are conducted by independent agencies or units within the child-serving agency, such as DPPC or the Special Investigations Unit of DCF. Although there is very limited statutorily mandated information sharing among these oversight agencies, the agencies have sought ways to share critical information. This interagency review documents the complex licensing and approval, contract monitoring, and incident investigation processes of all of the agencies. Ensuring timely and coordinated information sharing and response is one of the challenges we must address.

The report that follows, prepared by PCG in consultation with the Interagency Working Group, identifies key risk and safety factors for residential schools While the majority of these indicators are already being collected and reviewed by EEC, ESE, DCF, or DPPC, the review makes recommendations for ensuring that this information can be collected, shared and used more effectively to improve oversight, align monitoring, and streamline incident notification and response.

Four immediate recommendations were identified to support this overall goal:

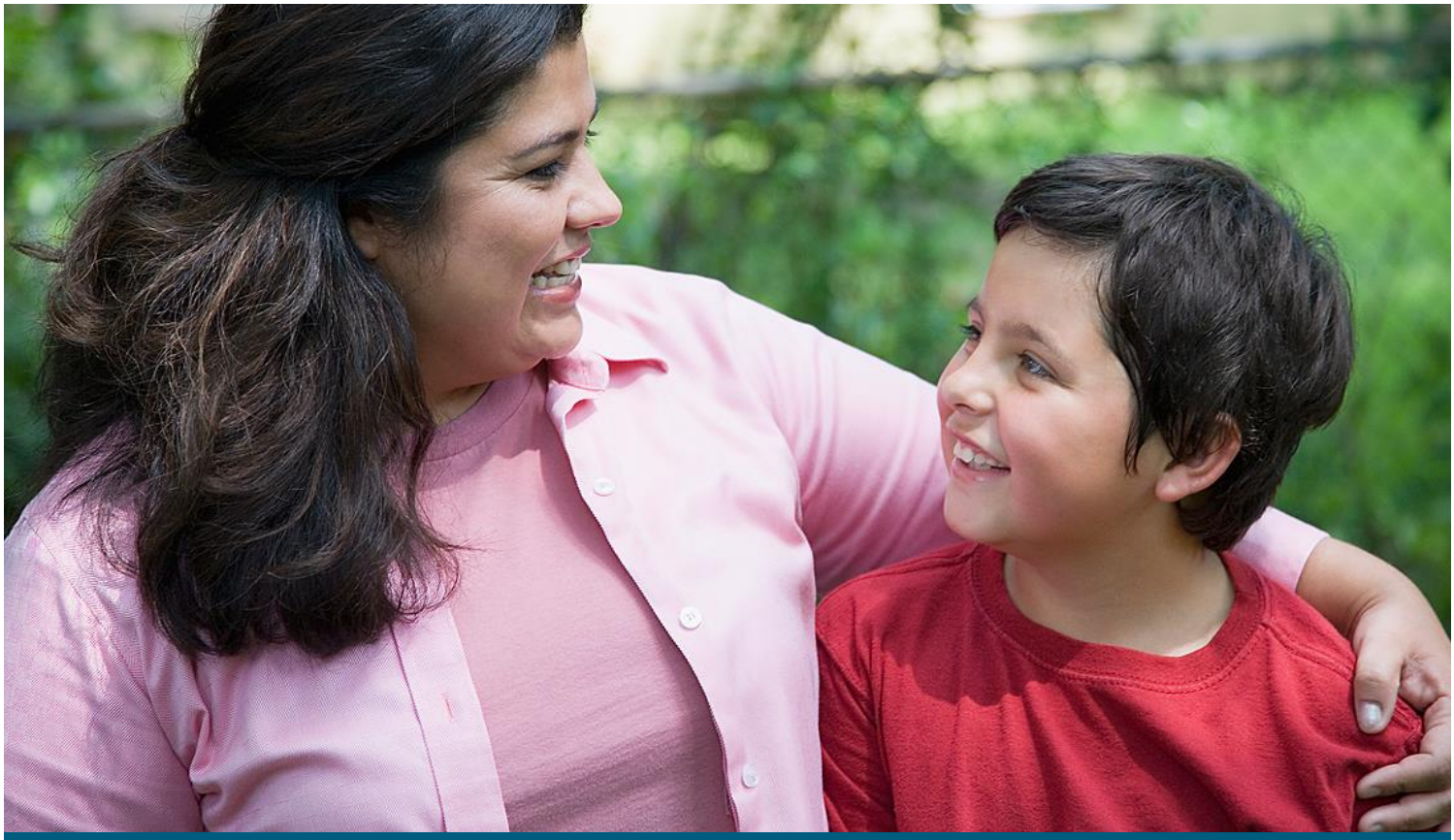
- Coordinate activities and data related to the initial licensing and approval processes of EEC and ESE, as well as DCF monitoring activities, to better align requirements and reduce duplication of efforts.
- Develop a process for sharing data regarding identified safety factors across oversight agencies as an early warning system to proactively identify possible risk and provide training and technical assistance as needed.
- Streamline and clarify incident notification and response protocols among the agencies and providers to reduce duplication and coordinate response protocols for allegations of abuse and neglect or serious incidents
- Review and clarify the circumstances warranting a report of abuse and neglect be filed with the DCF and when a coordinated response is appropriate to ensure improved communication and collaboration during the investigation process.

The Working Group is currently planning for the implementation of the recommendations outlined in this report and the OCA continues to lead this effort. We expect that this next phase will result in the reengineering of our current practices so that information about critical safety and risk factors will be routinely collected and timely shared across all agencies as appropriate, and our monitoring and response activities will be better coordinated. We plan to pilot these changes before proposing any needed statutory or regulatory changes. We also intend to continue to make interim improvements as we redesign our processes.

Once the above recommendations are underway the Working Group will turn its attention to several identified areas warranting further review. These include:

- Workforce issues impacting quality and safety at the schools, including turnover, clinical oversight and program administration;
- Referral practices for placement of children and youth at residential education programs, to better understand how enrollment decisions impact safety, and strengthen improvements that have already been made to ensure that schools are equipped to serve children with complex needs.
- Monitoring and oversight practices at other schools that provide services to children with complex needs, such as substantially separate public school setting and other day programs.

The severity of the substantiated abuse at the Eagleton School resulted in the extraordinary action of the revocation of its residential license and the closure of the program. Despite what occurred at the Eagleton School and Peck School, this review has provided reassurance that there is a resolute commitment to the health, safety and well-being of children placed in residential schools. The Steering Committee and Working Group members are committed to the recommendations that resulted from this review, and will continue to collaborate to improve the coordination and oversight of licensing, monitoring and evaluation of these programs to ensure the best outcomes for children.



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

Final Report

March 31, 2017

PCG | Human Services

Public Focus. Proven Results.™

Table of Contents

Executive Summary

As a result of allegations of abuse and neglect at two Massachusetts schools, Governor Baker requested that the Office of the Child Advocate (OCA) guide and coordinate a review of programs that provide educational services to children and youth whose special education needs require that they be served in a residential or substantially separate[1] educational setting. The OCA convened a steering committee comprised of the Child Advocate, the Undersecretaries of the Executive Office of Education (EOE) and the Executive Office of Health and Human Services (EOHHS), and a representative from the Governor's Office to plan this work. The steering committee decided to focus its initial work on private residential schools with approved special educational programs (hereafter referred to as residential schools) because they serve particularly vulnerable children and youth. These schools serve children and youth with diverse and complex needs in an out-of-home setting. A larger working group was formed to advise and inform this work and includes steering committee members, as well as key staff from the following state agencies involved in oversight of residential schools:

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

Residential schools are comprised of both a licensed residential program(s) and an approved special education school.

[1] A substantially separate school is a school or classroom environment outside of the general education setting for children with significant special education needs.

Oversight of these schools is spread across multiple agencies, each with their own specific mandate and areas of focus:

- **ESE** approves the educational component of residential schools and monitors the schools for ongoing regulatory compliance.
- **EEC** licenses the residential component of residential schools and monitors the programs for ongoing regulatory compliance.

Approval and licensing activities conducted by ESE and EEC require compliance with health, safety and program standards.

- **DCF** and **DMH** procure and monitor residential school services delivered through EOHHS contractual agreements. DMH and DCF also oversee individual client services through ongoing case management. Oversight focuses on program performance, clinical quality, and contract compliance. Today, of the 53 ESE approved in-state residential education schools, 42 hold contracts to provide services through EOHHS contractual agreements- a 79% coverage rate.

In addition to the activities above,

- **DCF**, **DPPC**, and **DMH**[2] investigate[3] allegations of abuse or neglect on behalf of individuals in residential schools.
- **ESE and EEC** respond to notification of incidents[4] and/or complaints as required as part of their regulatory compliance oversight functions. For allegations of abuse, neglect, or other serious incidents or complaints, **EEC** will conduct investigations to review regulatory compliance.
- **DCF and DMH** respond to notification of incidents and/or complaints as required as part of their contract management and client services oversight functions.

The goal of this review is to examine how current state oversight practices could be improved to more quickly identify programs at risk of operational issues. PCG was hired to conduct a detailed business process assessment of current oversight practices, to identify opportunities for better coordination of oversight and monitoring activities across agencies, and to identify opportunities for better coordination of data collection, analysis, and sharing. The assessment and recommendations were informed by best practices research and research on factors associated with safety and positive outcomes in residential programs (see **Appendix C** – Best Practices Research). Specifically, PCG was asked to:

1. Conduct best practices research in oversight of residential schools, including research on safety factors, risk factors, and inter-agency data sharing;
2. Review current oversight processes and procedures;
3. Identify key safety and risk factors to drive recommendations for process and data enhancements; and

[2] DPPC can assign abuse investigations to DMH investigators.
[3] An investigation is an activity conducted by one or more oversight agencies as a response to incident notification or a report of abuse or neglect to review the circumstances and make findings.
[4] An event which may require documentation and notification to licensing, approval, or oversight agencies. Incidents include allegations of abuse and neglect at a residential school.

4. Identify areas for improved data collection and recommend areas of opportunity where coordinated practices, processes, and information sharing will improve business process and oversight.

Methodology

This was a highly collaborative project with significant engagement from numerous stakeholders. Key activities included:

Draft versions of the report underwent several rounds of review and revisions by the entire working group to ensure the accuracy and clarity of PCG's review, findings, and recommendations.

Other Issues Related to Quality and Safety at Residential Schools

The focus of this review was limited to identifying opportunities for better coordination of state agency oversight activities and improvements to organizational level data collection and sharing activities. However, other factors that affect safety and quality at residential schools were highlighted during the review. Key issues include:

- Significant workforce challenges, most notably issues of adequately retaining, supporting, and training program and management staff at residential schools. Workforce issues such as these are correlated with safety and quality in residential programs (see **Appendix C**- Best Practice Research and **page 23** of this report).

- The needs of children and youth are diverse and complex and finding programs specifically aligned with their needs can be challenging due to:
  - Increases in the number of students with disabilities, and children in out-of-home care in general in Massachusetts, which is stretching overall capacity; and
  - Varying placement needs and drivers of multiple state agencies and school districts across the Commonwealth, each of which have their own placement policies[5] and are trying to balance numerous factors including the child's clinical and educational needs, proximity to home, and budgetary and other administrative realities.

- Child-specific oversight is varied across state agencies and local education agencies, although it is a critical component of keeping children and youth safe and ensuring that a program is meeting individual needs. While this review was limited to organizational level oversight, there may be potential for improved child level coordination and monitoring between DCF, DMH, sending school districts, and possibly other placement agencies.

This report does not directly address solutions to these issues; however, additional work will follow this initial assessment to address these challenges. The OCA and the working group will make a plan to review substantially separate schools, and may want to consider looking further into options to address the potential oversight gaps associated with schools that are authorized to operate by their local school committee but not approved by ESE.

Summary of key findings

Oversight of residential schools is complicated and requires significant effort on the part of state agency personnel and providers; state agencies often undertake activities concurrently or within similar timeframes, although they have unique areas of focus depending on their individual agency mandates. Below is a summary of key findings, which are presented in more detail on the pages that follow:

- Oversight processes have evolved in response to each state agency's regulatory or statutory requirements. There is little regulatory or statutory direction on collaborating or

[5] The no refusal policy included as part of the EOHHS contractual agreements is one example of a policy that could be reviewed for its impact on placement decision making.

communicating with each other, but the agencies have found ways to work together to improve coordination and program oversight, particularly when a crisis occurs.

- State oversight agencies are collecting data on most programmatic factors that research shows are most closely associated with safety.

- ESE and EEC conduct separate pre-approval and pre-licensure activities and separate monitoring visits, although they review and collect much of the same information. For the 79% of residential schools' subject to DMH and DCF oversight and quality assurance activities, much of the same information is also collected and reviewed.

- There may be instances where the service populations documented in ESE school approval, EEC license, and the EOHHS contractual agreement are not precisely aligned.

- Oversight agencies have different incident notification standards and submission processes. Multiple agencies must often be notified of the same incident and may launch corresponding response protocols.

- In rare instances, programs with serious program issues have not come to the attention of oversight agencies because instances of suspected abuse or neglect, or other incidents, were not reported.

- Currently, DCF can substantiate an allegation of abuse or neglect against a person but there is no option to create a finding against a program. Provider information is entered into the abuse/neglect report as narrative, making it difficult to aggregate and monitor program administration issues.

Summary of Changes Already Underway

Before this project even began, numerous process improvement changes were already underway and significant progress has been made since. Below is a summary of some of the key changes already underway:

- ESE, EEC, and DCF meet quarterly to share information, questions, and concerns about residential school programs.

- Both EEC and ESE are strengthening their monitoring and streamlining:

    - ESE and EEC are attending some monitoring visits together so that they can begin to see areas for potential collaboration going forward.

    - Beginning in the 2017-2018 school year, for any program that has a finding during their review, ESE will follow up with unannounced visits to verify implementation of the corrective action plan and/or progress reports.

    - Beginning in 2017, EEC is transitioning to a differential licensing process; whereby the program's compliance history will determine the frequency and/or depth of subsequent monitoring. Differential licensing will allow EEC to increase monitoring of

high risk programs. Also, by tailoring the depth of their monitoring, they hope to visit all programs each year. EEC visits, whether monitoring or enhanced will be unannounced. It is only when a residential program is undergoing a full licensing renewal study that a visit will be announced.

- DCF is making changes to i-Family Net so that incidents, allegations of abuse or neglect, and other data that DCF collects will link to providers. This will allow DCF to track performance and other data at the provider level.

- Improvements are underway at EEC and ESE to clarify incident notification requirements, and to collect and monitor restraint data. ESE and EEC have also been working to better operationally define what constitutes a school incident versus a residential incident to reduce notification duplication.

- The working group has flagged confusion about what constitutes the filing of 51As, particularly around medication errors, which will require additional review and technical assistance with providers.

- The Governor's Office is in the process of convening a statewide Data Governance Group, which can assist with the implementation of data sharing improvements.

Recommendations

Based on the findings above, the following steps are recommended to improve coordination of oversight and monitoring activities across agencies. Each of these recommendations will require a more in-depth implementation plan, which should be grounded in and guided by the safety factors identified in this review.

1

Define, align, and consolidate ESE and EEC initial licensing and approval processes, and ESE, EEC, and DCF monitoring activities to improve coordination, data sharing, and monitoring of safety factors and reduce the need for providers to submit duplicative documentation.

- **Next steps:** align the timing of monitoring visits, determine how to review safety factors that are not currently reviewed, monitor and communicate safety factors in between visits, formalize communication practices, and align language on formal documentation (license, approval, and documents related to services purchased under the EOHHS contracts) to communicate uniform expectations about service populations, service specifications, and expected outcomes.
- **Longer term steps**: Create a more centralized residential school application process, determine potential for joint pre-approval and pre-licensing visits, and further streamline monitoring between ESE and EEC.

2	**Across all oversight agencies, as part of a larger statewide Data Governance Group Review, there should be a process to consistently share information with each other and with residential school providers to improve monitoring of safety factors across all of the oversight agencies, identify programs that may be at risk more proactively, and provide training and technical assistance to providers as needed.** ➢ **Next Steps:** The oversight agencies should coordinate with the Data Governance Group to identify safety factors to track, define, and align data collection and elements across agencies; develop a process for sharing safety factor data; and identify the data sharing agreements, memoranda of understanding, or statutory changes that are needed. ➢ **Longer term steps:** Develop a process to share information with providers, and review the need for and feasibility of software or system changes to streamline form submission and share and track data across agencies, including software or data warehouse options that would allow for more automated identification of programs that may need review.
3	**Streamline and clarify incident notification and response protocols to reduce duplicative or unnecessary notifications and identify the best way for oversight agencies to coordinate responses to allegations of abuse or neglect or other serious incidents.** ➢ **Next steps:** Develop standard definitions of the types of incidents that require notification across agencies, define how notifications should be submitted and the kind of incidents that warrant state agency response, and identify what that response will entail. Also, develop joint communication material to distribute to providers, and develop written communication protocols between the state agencies. ➢ **Longer term steps:** Conduct a business process redesign assessment of current notification submission processes to identify potential for a more centralized notification submission process that would only require providers to submit to one centralized location.
4	**Review DCF's 51A institutional abuse policy to continue to improve the ability to collect and analyze data on programmatic issues, improve communication of program issues to other oversight agencies, and hold providers accountable for programmatic issues.** ➢ N**ext steps**: Clarify for providers the rules around staff that will be flagged as part of an employment background check, develop a process whereby DCF notifies ESE, as well as EEC, of 51Bs, and continue to enhance the capacity of i-Family Net to capture programmatic information in a way that can be analyzed and tracked by provider and program. ➢ **Longer term steps**: Review other state policies and current MA statutes to determine if greater flexibility should be given to DCF for a broader set of dispositions (than supported or unsupported against an individual) in institutional abuse cases and review the benefits of having all institutional abuse cases, including schools, handled by one unit at DCF (the SIU).

5

Review and analyze other factors to better understand and support residential school quality and safety. These issues were outside of the scope of this review, but warrant additional follow-up.

- **Next steps:** Review and analyze workforce issues related to quality and safety at schools, challenges meeting the placement needs of children due to capacity issues and other placement decision making factors and drivers, potential for child level coordination and monitoring by placement agencies, and potential gaps in oversight at schools that are authorized to operate by local school committee, but not approved by ESE, and substantially separate schools.

I. Project Background

As a result of allegations of abuse and neglect at two Massachusetts schools, Governor Baker requested that the Office of the Child Advocate (OCA) guide and coordinate a review of public and private residential and day programs that provide educational services to children and young adults whose special education needs require that they be served in a residential or substantially[6] separate educational setting.

The OCA convened a steering committee comprised of the Child Advocate, the Undersecretaries of the Executive Office of Education (EOE) and the Executive Office of Health and Human Services (EOHHS), and a representative from the Governor's Office to plan this work. The steering committee focused its initial work on private residential schools with approved educational programs (hereafter referred to as residential schools) because they serve particularly vulnerable children and youth. These schools serve a diverse and wide range of children and youth with complex needs including emotional, psychological, or behavior issues, as well as neurodevelopmental disorders, such as autism in an out-of-home setting.

A larger working group was formed to advise and inform this work and includes steering committee members, as well as key staff from the following state agencies responsible for regulating, licensing, approving, reviewing, and/or investigating residential schools:

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

The goal of this review is to examine how current state oversight practices can be improved to more quickly identify programs at risk of operational challenges. During the initial internal working group discussions, as well as in discussions with residential school providers and trade organizations, some common themes emerged about challenges related to oversight, quality, and safety at residential schools:

- Oversight functions related to residential schools are shared by several state agencies. The working group believed there were opportunities for better coordination of oversight and monitoring activities across agencies and opportunities for better coordination of data collection, analysis, and sharing.

- Residential schools are facing workforce challenges, most notably issues of adequately retaining, supporting, and training program and management staff at residential schools. Workforce issues

[6] A substantially separate school is a school or classroom environment outside of the general education setting for children with significant special education needs.

such as these are correlated with safety and quality in residential programs (see **Appendix C**- Best Practice Research and **page 23** of this report).

- The needs of children and youth are diverse and complex and finding programs that are specifically aligned with their needs can be challenging due to:
    - Increases in the number of students with disabilities, and children in out of home care in general in Massachusetts, which is stretching overall capacity; and
    - Varying placement needs and drivers of multiple state agencies and school districts across the Commonwealth, each of which have their own placement policies[7] and are trying to balance numerous factors including the child's clinical and educational needs, proximity to home, and budgetary and other administrative realities.

- Child-specific oversight is varied across state agencies and local education agencies, although it is a critical component of keeping children and youth safe and ensuring that a program is meeting individual needs. While this review was limited to organizational level oversight, there may be potential for improved child level coordination and monitoring between DCF, DMH, sending school districts, and possibly other placement agencies.

The working group decided to address the first bullet above as the first order of priority. Public Consulting Group (PCG) was engaged to conduct an in-depth business process review to identify opportunities for better coordination, data collection, and data sharing between oversight agencies. The working group asked PCG to ground the review and analysis with research about best practices, and use this research to identify factors associated with safety or risk in residential programs (see **Appendix C** – Best Practices Research).

Specifically, PCG was asked to:

- Conduct best practices research in oversight of residential schools, including research on safety factors, risk factors, and inter-agency data sharing;
- Meet with state agency personnel, sending school districts, and residential school leaders to review oversight processes and procedures;
- Identify key safety and risk factors to drive recommendations around process and data enhancements;
- Identify areas for improved data collection; and
- Recommend areas of opportunity where coordinated practices, processes, and information sharing will improve business process and oversight.

Following this review, the working group will address the workforce, placement, and child level data coordination issues noted above, as well as review substantially separate schools.

[7] The no refusal policy included as part of the EOHHS contract agreements is one example of a policy that could be reviewed for its impact on placement decision making.

III. Methodology

Project Organization

PCG kicked off the project with the steering committee on June 15th, 2016. This was followed by meetings with the full working group to further develop and refine the project scope and plan. PCG participated in the steering committee and working group meetings throughout this engagement to review progress and findings and keep the project moving forward.

Best Practice Research and Review

Best practice research was performed by accessing and reviewing articles in academic databases, such as the Psychology and Behavioral Sciences Collection, Legal Source, and the SocINDEX, as well as reviewing publicly available resources, including state oversight agency websites in Massachusetts and other states. PCG also reached out to representatives from the State of Connecticut, Allegheny County, Pennsylvania, and Harris County, Texas to obtain information specific to initiatives in those states, and interviewed Massachusetts state personnel with national expertise in best practice such as DMH Director of System Transformation, Janice LeBel, and DCF Commissioner, Linda Spears. See **Appendix C** for the full Best Practices document.

A key aspect of the research was to identify programmatic factors correlated to safety and risk in residential programs. These safety factors were presented to the Working Group, along with the best practices research, on October 6th, 2016.

Data Collection

PCG utilized two primary information collection methods to document the current oversight processes: (1) individual interviews with personnel at state oversight agencies and sending school districts, and (2) focus group interviews with personnel from residential schools in Massachusetts and DCF staff responsible for residential school placement decisions.

Individual Interviews with Agencies and Sending School Districts

PCG conducted interviews with seven different Massachusetts state agencies, as well as sending school districts. Prior to the interviews, PCG reviewed state agency websites and applicable laws and regulations to better understand each agency's scope of responsibility with respect to oversight of residential schools and programs. During agency interviews, PCG obtained additional information about policies, procedures, and contractual requirements, and reviewed current practices.

Interviews included meetings with state agency information technology (IT) and program personnel, as well as commissioners, directors, and other leadership. Interview questions were tailored specifically to each agency. The chart below displays the number of people and roles of staff interviewed at each agency.

Interview Participants

Agency	Participants
Disabled Persons Protection Commission (DPPC)	**Total Participants: 2** • Deputy Executive Director • General Counsel
Department of Mental Health (DMH)	**Total Participants: 7** • Quality and Risk Manager for Child/Adolescent Division • Assistant Commissioner for Quality, Utilization and Analysis • Director of System Transformation • Child/Adolescent Directors in Area Offices
Department of Children and Families (DCF)	**Total Participants: 8** • Commissioner • Deputy Commissioner of Clinical Services and Program Operations • Assistant Director, Caring Together • Director of Program Operations • Director of Procurement • Director of Special Investigation Unit • General Counsel • Assistant Commissioner, Continuous Quality Improvement
Department of Elementary and Secondary Education (ESE)	**Total Participants: 2** • Senior Associate Commissioner for Accountability, Partnerships and Technical Assistance • Director, Office of Approved Special Education Schools
Executive Office of Education (EOE)	**Total Participants: 3** • Undersecretary of Massachusetts Executive Office of Education • IT Staff
Department of Early Education and Care (EEC)	**Total Participants: 3** • Deputy Commissioner for Field Operations • Residential and Placement Supervisors
Executive Office of Health and Human Services (EOHHS)	**Total Participants: 1** • Undersecretary of Human Services
Sending School Districts	**Total Participants: 3** • Special Education Directors and Administrators

Table 1: Interview participants

Focus Groups

PCG conducted focus groups with residential school providers and DCF placement staff. Providers selected served as a representation for a collection of programs with different sizes and different patient populations from across the state. During the focus groups, PCG sought insight into the current program challenges and root causes for those challenges.

Development of Findings and Recommendations

In mid-November PCG documented and shared an early draft of the "as-is" assessment and report with findings and recommendations. This report was shared with the full working group and initial feedback and edits were recorded. At that time, the working group agreed that more time was needed to further discuss and refine the recommendations. PCG facilitated two extended working group meetings in late November and mid-December to develop and refine recommendations. Draft versions of the report underwent several rounds of review and revisions by the entire working group to ensure the accuracy and clarity of PCG's review, findings, and recommendations.

III. Current State

Landscape

The private and approved residential special education school landscape has origins dating back to 1974, when Massachusetts passed the first special education law in the nation, M.G.L. c.766- known as Chapter 766- which guaranteed all students with disabilities get an education that meets their unique needs. Modeled after this law, the federal Education of All Handicapped Children Act (EHA) was signed into law so that all children with disabilities nationwide would "have a right to education, and to establish a process by which State and local educational agencies may be held accountable for providing educational services for all handicapped children."

These two pieces of legislation guided the formation of schools that created inclusive learning spaces designed to meet the needs of students with special needs. These included day programs, summer programs, and residential programs.

Since then, both state and federal law has evolved. The EHA has been reauthorized several times and is currently named the Individuals with Disabilities Education Act (IDEA). It is the current law governing the provision of special education services to the nation's eligible students[8]. In Massachusetts, the special education law was transferred to M.G.L. c. 71(b) with regulations found under 603 C.M.R. 28.00. Despite the codification change, private residential special education schools are still referred to as Chapter 766 schools today.

There is significant complexity in segmenting the entire population of Chapter 766 schools. During the 2015-2016 school year, 5,764 students from Massachusetts were placed in special education schools, both day and residential. This accounts for approximately 3.5% of all students with disabilities statewide, but does not include students placed in those schools by out-of-state agencies, nor does it include students whose placements are privately funded. As of November 9, 2016, ESE oversees the special education services for the above students in 164 approved day and residential programs operated at 85 agencies.

Of those 164 programs approved by ESE, 53 (32%) run residential programs licensed by EEC; ***these 53 programs are the subject of this review.*** Of the 5,764 Massachusetts publicly funded students attending approved private special education schools, close to 900 (16%) are in residential programs. The remainder are in approved private day special education schools. These numbers do not include students with special

[8] http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2C

needs attending unapproved[9] Massachusetts special education schools, nor do they include students in out-of-state approved special education programs[10]. Schools not approved by ESE must be authorized to operate by the local school committee. If there is a residential component to the program, then the residential program must be licensed by EEC and will be subject to ongoing monitoring by EEC. However, the school portion of the program would not be subject to ESE's oversight, leaving a potential gap in oversight. These schools are outside of the scope of this report, which focuses on approved private special schools, but this is an area that could be flagged for further review. Massachusetts regulations allow for the placement of individual students in unapproved in-state and out-of-state programs at public expense, after review by ESE and the Commonwealth's Operational Services Division through a distinct, individual student approval method.

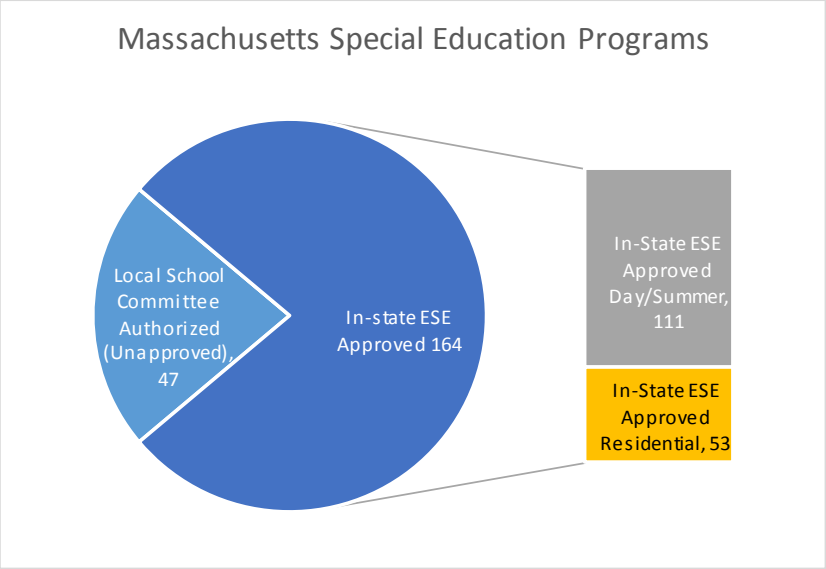


Figure 1: Breakdown of Special Education Schools: There are 164 ESE approved in- state day and residential schools; of which 53 are residential programs. Those 53 programs are the subject of this review.

[9] These programs might not be approved private schools for several reasons: They may not have applied for approval; they may not usually serve students with special education needs; they may be located out of state; or they may lack elements required for approval such as having a certain number of teachers with special education licensure. Despite lack of approval, however, a particular school may offer just the right kind of program, peer group, and related services to meet a particular child's special education needs. Placement at these schools can be paid for with public funds when the school system agrees that an out-of-district placement is necessary and there are no appropriate approved programs in the state available to meet the student's needs, and, if the school district can demonstrate that (1) it first sought placement in an approved program and (2) that preference was given to approved programs in the Commonwealth of Massachusetts. See 603 CMR 28.06(3)(e)(4).

[10] Students may also be placed at public expense in out-of-state schools if an out-of-state program seeks approval from the Department of Elementary and Secondary Education. In consultation with the district, and with documentation of host state approval or accreditation, these programs may accept Massachusetts students who would be best served across state lines.

Current Oversight Activities

Residential schools are comprised of both a licensed residential program(s) and an approved special education school.

Figure 2: The scope of this report includes only residential schools, which are comprised of both a licensed residential component and an approved special education school.

Oversight of residential schools is spread across multiple agencies, each with their own specific mandate and areas of focus:

- **ESE** approves the educational component of residential schools and monitors the schools for ongoing regulatory compliance;
- **EEC** licenses the residential component of residential schools and monitors the residential programs for ongoing regulatory compliance; and
- **DCF** and **DMH** procure and monitor residential school services delivered through EOHHS contractual agreements. DMH and DCF also oversee individual client services through ongoing case management.

The licensing and approval activities conducted by EEC and ESE require compliance with health, safety and program standards. DCF/DMH oversight focuses on program performance, clinical quality, and contract compliance. However, not all children and youth in residential schools are there under an EOHHS contract; some are there through a district placement, Bureau of Special Education Appeals order, Settlement Agreement, or private pay through a parent or guardian. Today, of the 53 ESE approved in-state residential education schools, 42 hold contracts to provide services through an EOHHS contractual agreement- a 79% coverage rate. The diagram below illustrates this dynamic.

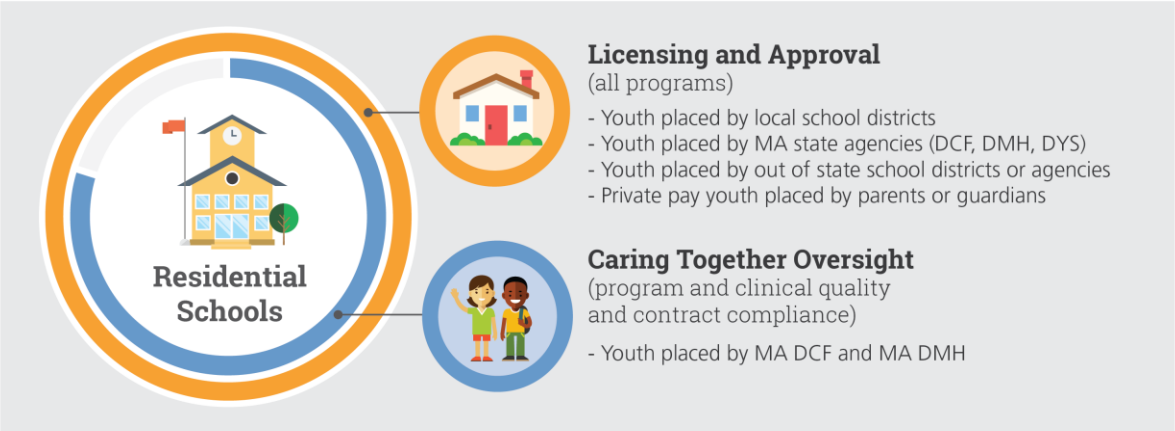


Figure 3: Licensing and approval activities cover all children/youth served including all residential schools and programs. DMH and DCF oversight applies to 79% of programs; those contracted by DMH and DCF.

In addition to the activities above,

- **DCF**, **DPPC**, and **DMH**[11] investigate[12] allegations of abuse or neglect on behalf of individuals in residential schools.
- **ESE and EEC** respond to notification of incidents[13] and/or complaints as required as part of their regulatory compliance oversight functions. For allegations of abuse or neglect, or other serious incidents or complaints, **EEC** will conduct investigations to review regulatory compliance.
- **DCF, and DMH** respond to notification of incidents and/or complaints as required as part of their contract management and client services oversight functions.

The chart below provides a more detailed account of the oversight activities, along with the areas of focus for the different agencies involved in the activities.

Oversight Activities

Agencies Involved	Oversight Activity[14]	Frequency	Area of Focus
EEC	Residential license initial application and approval	One time	Regulatory compliance
ESE	Special education program initial application and approval	One time	Regulatory compliance

[11] DPPC can assign abuse investigations to DMH investigators.
[12] An investigation is an activity conducted by one or more agencies as a response to incident notification or a report of abuse or neglect to review the circumstances and make findings.
[13] An event which may require documentation and notification to licensing, approval, or oversight agencies. Incidents include allegations of abuse and neglect at a residential school.
[14] This chart is intended to show functions at a high level and does not reflect every activity that the agencies conduct related to monitoring, such as regulatory waivers or requests for program changes to name just a couple. Deeper understanding of those activities may be helpful going forward as the agencies work to streamline oversight processes.

Agencies Involved	Oversight Activity[14]	Frequency	Area of Focus
EEC	Residential license monitoring	Annually[15]	Regulatory compliance
EEC	Residential license renewal	Every 2 years	Regulatory compliance
ESE	Special education program review	Every 3 years	Regulatory compliance
DCF	Quality assurance reviews[16]	Annually	Program and clinical quality and contract compliance
DCF, DMH	Rehabilitation Services reviews	Annually	Compliance with federal regulations and Medicaid state plan
EEC	Incident[17] notification response, follow-up, and regulatory investigations	As required	Regulatory compliance and corrective action
ESE	Incident notification response and follow-up	As required	Regulatory compliance and corrective action
DCF, DMH	Incident notification response and follow up	As required	Contract compliance and individual client services oversight
DCF	Investigations of abuse or neglect allegations on behalf of individuals under age 18	As required	Abuse and/or neglect determination and corrective action
DPPC, DMH	Investigations of abuse or neglect allegations on behalf of individuals age 18 and older[18]	As required	Abuse and/or neglect determination and corrective action
ESE	Student/staff restraint injury report and restraint database	As needed	Regulatory Compliance
EEC	LEAD restraint reporting	Quarterly	Regulatory Compliance

Table 2: Overview of state agency roles and responsibilities for oversight of residential schools.

Below the activities associated with initial licensure and approval, ongoing monitoring and quality assurance, and investigations and incident response are illustrated in more detail

[15] Starting spring 2017.
[16] Approximately 79% of approved private residential schools operate under an EOHHS Contractual agreement and are subject to DCF and DMH reviews.
[17] Incidents include, but are not limited to, allegations of abuse or neglect at a residential school.
[18] Up to age 22 at residential schools.

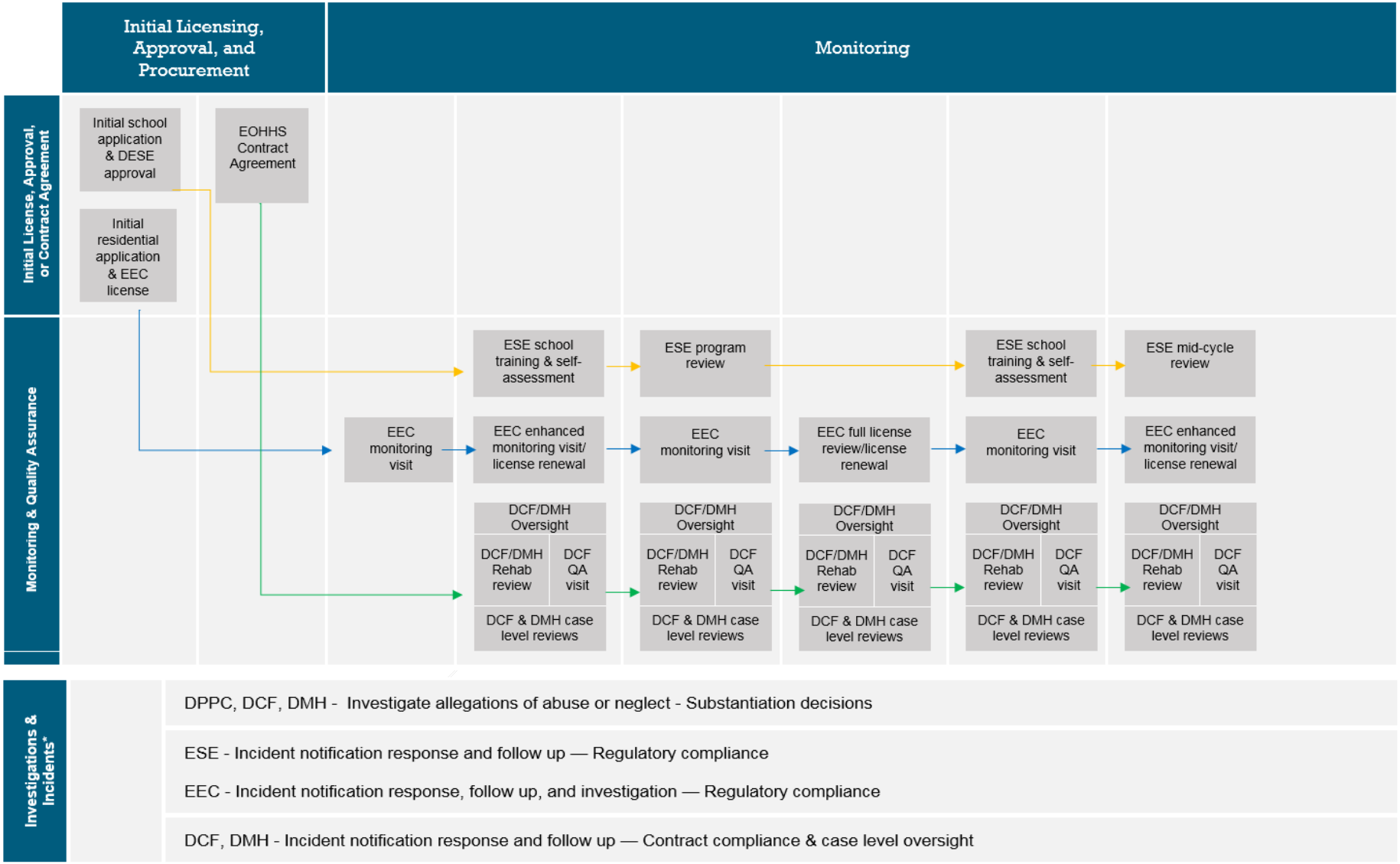


Figure 4: Overview of state agency roles and responsibilities for oversight of residential schools, * incidents include, but are not limited to, allegations of abuse or neglect

As the diagram above illustrates, oversight of residential schools is complicated and requires significant effort on the part of state agency personnel and providers; state agencies are often undertaking activities concurrently or within similar timeframes, although they have unique areas of focus depending on their individual agency mandates. These processes have evolved over time largely in response to each state agency's regulatory or statutory requirements. While there is little regulatory or statutory direction on collaborating or communicating with each other, the agencies have found ways to work together in order to improve coordination and program oversight. Numerous process improvements are already underway.

As previously noted, the focus of this analysis is largely on organizational oversight rather than how agencies conduct child-level oversight and assessment. Child-specific case management oversight provided by DMH and DCF includes case assessment, service planning, monthly visits with children and youth, progress checks on treatment plans, health care oversight, family and sibling visits, and additional activities. Local school districts also oversee student individual education plans (IEPs) as well as student progress. These measures contribute significantly to keeping children/youth safe and assuring that a program is meeting individual needs. While addressing ways that the state agencies can share all of the information they collect and monitor, including child-level data and information, which will be critical for ongoing monitoring going forward, the focus of this report is on how the state agencies currently conduct organizational level oversight. Another area for potential follow-up work would be to address child-level data coordination between placement agencies.

Throughout this engagement, several key challenges to quality and safety of residential schools were highlighted, including:

- Residential schools are facing workforce challenges, most notably issues of adequately retaining, supporting, and training program and management staff at residential schools. Workforce issues such as these are correlated with safety and quality in residential programs (see **Appendix C**- Best Practice Research and **page 23** of this report).

- Similarly, programs should be well suited to the clinical and developmental needs of the children and youth in their care. Matching the right child with the right placement at the right time is a challenge in Massachusetts, as it is in other states. The needs of children and youth are diverse and complex and finding programs that are specifically aligned with their needs can be challenging due to:
    - Increases in the number of students with disabilities, and children in out of home care in general in Massachusetts, which is stretching overall capacity; and
    - The various placement needs and drivers of multiple state agencies and school districts across the Commonwealth, each of which have their own placement policies[19] and are trying to balance numerous factors including the child's clinical and educational needs, proximity to home, and budgetary and other administrative realities.

[19] The no refusal policy included as part of the EOHHS contract agreements is one example of a policy that could be reviewed for its impact on placement decision making.

This report does not directly address solutions to these issues; however, additional work will follow this initial assessment to address these challenges. In addition, the OCA and the working group will make a plan to review substantially separate schools, and should consider looking further into options to address the potential oversight gaps associated with unapproved schools.

Organizational Factors that Promote Safety and Positive Outcomes for Children and Youth

One of the goals of this project was to identify programmatic factors that correlated to safety or risk in residential programs so that issues of safety can be more proactively monitored. Given the nature of services provided by residential schools and the populations served, risk can't be entirely eliminated. However, if safety factors are understood, then risk can be tracked, managed, and mitigated.

The working group wanted to understand which programmatic factors were most closely associated with safety and risk in order to ground the review of current practices and recommendations with this information. Collectively, these state oversight agencies collect a tremendous amount of information in their oversight of residential schools. A number of key factors aligned with safety and positive outcomes emerged in the research[20,21,22] (see **Appendix C**- Best Practice Research). Below is a list of these factors, along with a corresponding list of primary indicators (directly observable evidence of the factor) and secondary indicators (outcomes or events that may indicate the presence of certain safety factors). Looking at both primary and secondary indicators is important because they include a mix of directly observable evidence, as well as case outcomes or events that would be consistent with their presence.

The list of safety factors below drove data collection activities conducted by PCG, particularly shaping the kinds of questions asked about the data collected and shared by the agencies, and were critical for shaping the findings and recommendations throughout the report. This research allowed the project team and the working group to develop recommendations that are focused on the data elements that are most critical to monitor and make the best use of available data.

[20] Organizational Toxicity in Children's Treatment Facilities that Leads to Violence and Maltreatment (Nunno), Presentation to the Restraint Reduction Network Conference, 2015
[21] Huckshorn, Kevin Ann. "Six Core Strategies for Reducing Seclusion and Restraint Use©." November 20, 2006.
[22] Child Welfare League of America, "Achieving Better Outcomes for Children and Families REDUCING RESTRAINT AND SECLUSION", 2004.

Indicators of Safety/Positive Outcomes in Residential Programs

Safety Factor	Primary Indicators	Secondary Indicators
Program: • developmentally appropriate treatment model • clinical involvement in program	• Developmentally appropriate behavior management policies and procedures • Consistent implementation of behavior management policies and procedures • Documentation of clinical protocols • Consistent implementation of treatment and clinical plans • Staff at all levels can articulate the treatment model • Sufficient clinical documentation (assessments and treatment plans) • Stability of key executive positions (positions filled, tenure) • Stability of clinical staff (positions filled, tenure)	• Clients discharged to lower levels of care (e.g. home) • Low rates of re-entry to congregate care or other 24-hour level of care • Lower rates of psychotropic medication use, reduction in use during care or at discharge[23] • "typical" rates of incident reports (51As, other incidents), consistent trends • Low to no restraints • Average or low recurrence of incidents/51As • Length of stay (may vary based on needs of child and their diagnoses)
Workforce: • Stable and engaged leadership • well trained staff • adequate staffing levels • staff supported by regular supervision	• Supervision of staff • Record / evidence of staff training • Low overtime utilization • Average or low direct care and supervisory staff turnover rate • Most direct care and supervisor positions filled • Average or higher tenure of direct care and supervisory staff	
Culture: • learning environment	• Evidence of data collection and usage related to performance • Implementation of corrective action plans	

Table 3: Safety factors and indicators at residential education facilities.

The degree to which agencies currently collect and share this data is included in the analysis that follows.

[23] The Commonwealth has a psychopharmacological committee which stays closely connected to the issue of medication administration, as an oversight mechanism.

Initial Licensing, Approval, and Monitoring

In order to operate as a residential school in Massachusetts, the provider must seek licensure for the residential component through EEC and approval for the day time educational component through ESE.

Residential Licensing and Monitoring

EEC will soon implement a "Differential Licensing" process, an emerging best practice in residential licensing, which conducts monitoring based directly on the provider's history of regulatory compliance with regulations. The program's level of compliance is used to determine the level of health and safety risks to the children. Licensors use this to determine the frequency and/or depth of monitoring needed for each respective provider. This process of differential licensing allows EEC to identify and increase monitoring of high risk programs, as well as tailor technical assistance to providers in need of improvement. Differential licensing uses "key indicators" in its monitoring tools, which are the regulations that would pose the highest probability of harm to children if found to be in non-compliance. The EEC Residential and Placement licensing unit, worked together to review the aggregate history of most cited regulations and best practices related to residential licensing and identified those regulations that were identified as most important for child safety. Over time, these key indicators are monitored and adjusted as needed. In Massachusetts, one key goal for differential licensing is for licensors to be able to visit programs annually for monitoring (outside of investigation visits). The key indicators identified for Massachusetts residential programs are:

Massachusetts EEC Key Indicators of Risk

Domain	Key Indicators of Risk
Care of Children	• Adequate staffing • Appropriate supervision • Daily routine and structured activities • Administrator or designee on shift
Behavior Support	• Positive interactions with children • Crisis prevention/de-escalation techniques/physical intervention techniques • Staff knowledge and use of behavioral plans • Children aware of expectations
Facility/Environment	• Indoors clean, safe, good repair, appropriately furnished • Medications and hazards secured • Current building, fire, and health certificates • Outdoor area clean and free of hazards • Evidence of emergency preparedness
Documentation	• Functional communication log • Accurate medication log • Review of incident reports

Table 4: MA EEC key residential program Indicators. EEC uses these indicators to determine providers that need additional levels of monitoring and oversight.

Note that there are many similarities between EEC's key indicators of risk and the safety factors on page 23. EEC will use a cloud-based system called LEAD (Licensing Education Analytic Database) to conduct licensing visits and store relevant data. The software is being rolled out in phases, the first of which occurred in June of 2016, with a "soft" roll-out of the "Provider Portal." This allows licensees to submit corrective action plans in response to findings of non-compliance, file incident reports, and perform other functions electronically as they relate to the licensing process. Residential licenses must be renewed every two years.

School Approval and Monitoring

In Massachusetts, ESE approves the schools – deeming them fit for programming through evaluating a series of regulations. Following an initial approval process that investigates the full suite of required regulations and standards, the procedure continually monitors progress through a quality assurance process called a "program review" that occurs in six-year cycles, with a mid-cycle review at three years. The program and mid-cycle reviews consist of an online component, completed by school staff, called a self-assessment, followed by a desk review of the agency's self-assessment conducted by ESE staff. The elements of the onsite portion of the program review are determined by ESE's desk review in conjunction with any patterns identified through the review of incident reports, complaints or requests for changes from the school, and subsequent follow up with the programs 6-8 weeks ahead of the onsite visit.

Mid-cycle reviews vary based on areas of concern as identified in a web-based self-assessment, and are designed to target areas where the school previously needed improvement. ESE staff refer to their data system as "WBMS" (for Web Based Monitoring System), which automatically carries over deficient findings from both previous reviews and the current desk review. ESE recognizes categories of residential students in three classifications – Massachusetts students, privately-funded students, and out-of-state students. Program reviews include a review of documentation; staff and parent/guardian interviews; a review of staff records; a review of student records; a tour of facilities used by the students; and surveys sent to parents/guardians for students placed and funded by a Massachusetts school district, a Massachusetts state agency, or a combination of both. While ESE now requires schools to submit serious incident reports for all students enrolled in the program during school hours, ESE can only review MA student records during the program and mid-cycle reviews. The program is required to submit a corrective action plan and/or progress reports to address any areas of noncompliance identified during a program or mid-cycle review.

ESE's approval and monitoring processes are consistent with other states. Many states have similarly moved toward a practice of focused monitoring, which includes periodic program reviews but focuses the review based on the findings of the desk audit, and/or performance or other data. The review is then focused on particular areas of compliance rather than the full list of program requirements. Many states also have targeted monitoring reviews, which use trend data annually (such as from dispute resolutions, state complaints, etc.) to identify Local Educational Agencies (LEA)[24] that require more in-depth analysis and onsite review.

[24] A Local educational agency is more often referred to as a school district.

Process and Data Collected

The picture below illustrates the Massachusetts state agencies' processes for initial licensing and approval and monitoring. Both EEC and ESE also have processes for notification whenever there are incidents that include threats to safety and well-being of students at the residential schools, which inform the monitoring and approval process. These incident response activities will be discussed in the later section, Investigations and Incident Response.

Note that in the diagram below, EEC and ESE communicate regularly during the pre-licensing and pre-approval processes with both agencies looking for assurance from the other that they will license or approve. Communication is less proactive during ongoing monitoring activities.

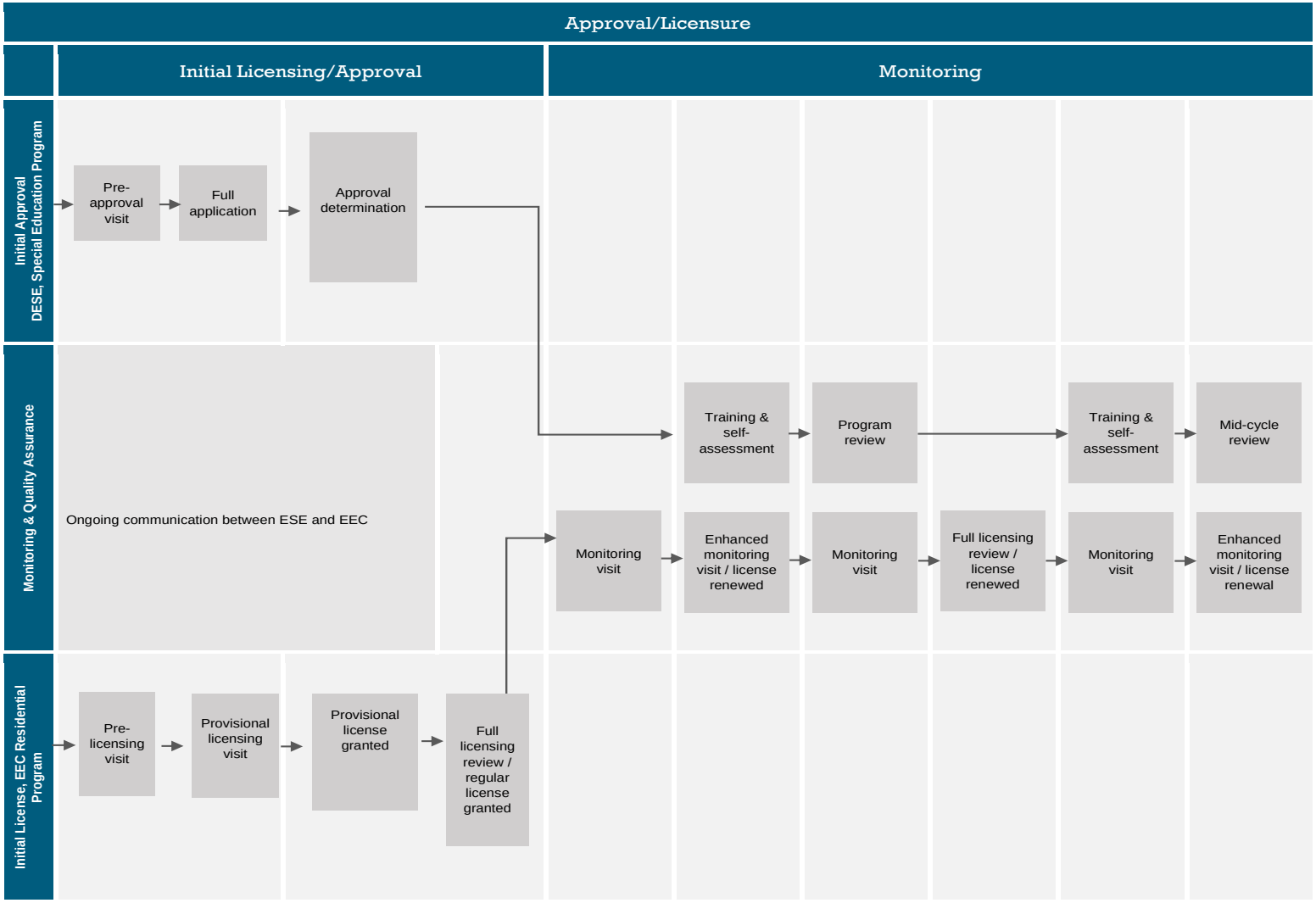


Figure 5: Initial licensure, approval, and ongoing monitoring. Beginning in the 2017-2018 school year, ESE will conduct unannounced visits to programs that have any findings of noncompliance in their reviews.

The crosswalk chart below summarizes data collection relative to key safety factors during licensing and approval activities. A check in the cells below indicates that the data is collected; a blank cell indicates that the data is not collected.

Safety Factor Collection: Licensing/Approval and Monitoring

Agency and System	ESE	EEC
	WBMS	LEAD
Frequency	3 years	1 year
Process	School Approval and Monitoring	Res License and Monitoring
Primary Safety Indicators		
Behavior management policies and procedures	✓	✓
Clinical protocol documentation	✓	✓
Staff can articulate treatment model	✓	
Clinical documentation of treatment plans and assessments	✓	✓
Key executive staff positions filled	✓	✓
Key executive staff positions with sufficient tenure		
Clinical staff positions filled	✓	✓
Clinical staff positions filled with sufficient tenure		
Evidence of staff training	✓	✓
Overtime utilization		
Direct care turnover rate		
Supervisory staff turnover rate		
Direct care positions filled	✓	✓
Supervisor positions filled	✓	✓
Direct care staff tenure		
Supervisory staff tenure		
Evidence of performance-based data collection	✓	✓
Evidence of data usage	✓	✓
Implementation of corrective action plans	✓	✓
Secondary Safety Indicators		
Youth discharge data (discharged to home, other 24 hour setting) by program		
Youth rates of re-entry to program or other similar program by program		
Rates of psychotropic medication use and/or practice by program		✓
Number of restraints/seclusions by program*	✓	✓
Number of incidents reported by program*	✓	✓
Number of 51A reports by program*	✓	✓
Youth length of stay by program		✓

Table 5: Safety factor data collected by ESE and EEC. *While EEC and ESE collect the number of incidents and restraints by program, they do not collect the number of those events per child per program, which provides important context.

Key Findings

Changes Already Underway

Contract Compliance and Program Performance

DCF and DMH procure residential services under the EOHHS services procurement. As of today, 42 of the 53 (79%) approved in-state residential schools in Massachusetts provide services as an approved provider under the EOHHS Contracts. In order to be an approved program, the residential school program must be consistent with the program's residential license with respect to the age, disabilities, and other characteristics of the children/youth served. These programs provide services to DCF and DMH involved children/youth, however there may also be children/youth in the program who are not there under the EOHHS contractual agreement such as: if they were referred solely by the LEA, are from out of state, or are private pay.

DCF and DMH quality assurance activities are intended to look beyond basic safety and program standards to review program performance, compliance with contract specifications, clinical appropriateness and effectiveness, client services and safety, and whether services meet federal Medicaid requirements. These activities are layered on top of licensing and approval activities. The table below describes the quality assurance activities undertaken by DMH and DCF. In addition to these quality assurance activities, DMH and DCF also follow up on complaints, incidents, and other program or client matters as needed. These activities will be discussed in more detail later in the Investigations and Incident Response section of this report.

DMH and DCF Oversight Activities Related to Services purchased under EOHHS Contract

Activity	Description	Frequency
DCF -Quality Assurance Program Reviews	DCF assigned staff visits each program to review many quality factors, and have developed a checklist as a guide for this review. Factors include, but are not limited to, such things as general performance, management practice, including staff development and training and organization operations, and clinical practice including the effectiveness of the clinical approach, permanency, well-being, and safety.	Annual
Medicaid Rehabilitation Option Reviews	Per the service requirements, residential schools provide Rehabilitation Services. DCF and DMH staff conducts case reviews at each provider to confirm that sufficient documentation exists to demonstrate that services meet the definition of Rehabilitation. The team reviews a sample of 10 cases at each program looking for documentation of various functional assessments, a treatment plan, progress notes, and periodic review of the treatment plan.	Annual
Ongoing Quality Assurance	The DMH/DCF team regularly monitors the performance of residential schools and assists DCF and DMH area and regional staff to find appropriate programs for children/youth, review quality indicators such as length of stay, and connect with providers when needed. Staff participate in area and regional office meetings on a regular basis.	Ongoing

Process and Data Collected

The process map below illustrates how the DCF and DMH oversight layers in with the regular and recurring monitoring and quality assurance conducted by EEC and ESE.

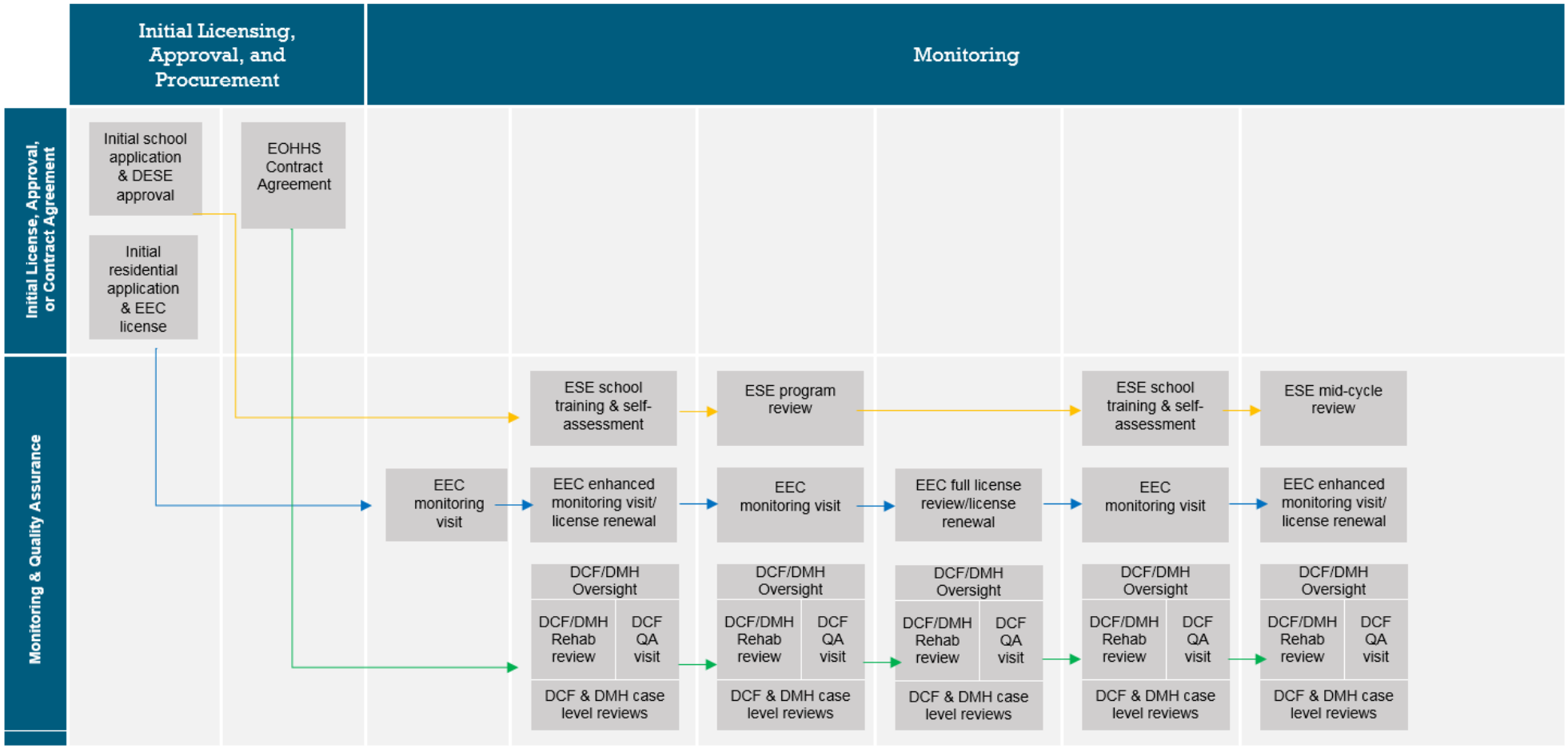


Figure 6: Quality assurance and monitoring activities conducted by DMH/DCF, EEC, and ESE.

While the agencies communicate and collaborate when there are program concerns or issues, they generally undertake the activities in the figure above separately. Although the quality assurance reviews have a different focus than EEC's and ESE's monitoring activities, the team reviews some of the same information and materials during its program reviews that EEC and ESE review. Below is a list of the areas of overlap between information reviewed/collected by ESE and EEC for approval and licensing and the program oversight. The chart is not a full list of requirements for each agency, only an overview of where there is overlap between two or more requirements. One important note about the chart below is that both EEC and ESE target their reviews, and so they may not ask for all of the materials below at every review. However, there is clearly overlap between all three agencies, which presents potential opportunity for collaboration.

Areas of Overlap in Information Reviewed

Requirement	EEC	ESE	DCF and DMH
EEC License		X	X
Staff training	X	X	X
Runaway procedures	X	X	X
Staff qualifications	X	X	X
Procedure for investigation of child abuse and neglect	X	X	X
Rules for behavioral support	X	X	X
Plan for Health Services	X	X	X
Financial Solvency	X	X	X
Child-student ratios	X	X	X
Mental health needs of children/youth	X	X	X
How the social/emotional skills of children/youth will be met	X	X	X
Safety inspection	X	X	
Rules for behavioral management	X	X	X
Policies and procedures on registering complaints and grievances	X	X	X
Purpose of the program documented	X	X	X
Visiting policies	X	X	
Children/youth are provided opportunities to learn and practice nutrition and exercise skills	X	X	X
CORI information	X	X	
Organizational structure	X	X	X
Medication administration	X	X	X
Physical restraint policies-including reduction	X	X	X

Table 7: Overlap in program oversight between EEC, ESE, and DCF/DMH

The crosswalk chart below summarizes which safety factor indicators are currently collected during DCF and DMH program quality assurance activities. A check in the cells below indicate that the data is collected; a blank cell indicates that the data is not collected.

Safety Indicators Collected Annually During DCF/DMH Oversight Reviews (stored in a DCF shared drive)		
Process	Medicaid Rehab Review (DCF/DMH)	DCF Program Review[25]
Primary Safety Indicators		
Behavior management policies and procedures	✓	✓
Clinical protocol documentation	✓	✓
Staff can articulate treatment model	✓	✓
Clinical documentation of treatment plans and assessments	✓	✓
Key executive staff positions filled		✓
Key executive staff positions with sufficient tenure		
Clinical staff positions filled		✓
Clinical staff positions filled with sufficient tenure		
Evidence of staff training	✓	✓
Overtime utilization		
Direct care turnover rate		
Supervisory staff turnover rate		
Direct care positions filled		✓
Supervisor positions filled		✓
Direct care staff tenure		
Supervisory staff tenure		
Evidence of performance-based data collection	✓	✓
Evidence of data usage	✓	✓
Implementation of corrective action plans	✓	✓
Secondary Safety Indicators		
Youth discharge data (discharged to home, other 24 hour setting) by program	✓	✓
Youth rates of re-entry to program or other similar program by program	✓	✓
Rates of psychotropic medication use and/or practice by program[26]	✓	✓
Number of restraints/seclusions by program	✓	✓
Number of incidents reported by program		✓
Number of 51A reports by program		✓
Youth length of stay by program		✓

Table 8: Safety indicators collected during DMH and DCF oversight

[25] DCF program review
[26] The Commonwealth has a psychopharmacological committee which stays closely connected to the issue of medication administration, as an oversight mechanism.

DCF and DMH also provide case management services and collect the following additional information as part of those functions. DCF is building the functionality to collect this information by provider as well, so that they will be able to track client level outcomes and events by program.

Timeframe	Current	Current
Agency	DCF	DMH
Secondary Indicators		
Youth discharge data (discharged to home, other 24 hour setting)	✓	✓
Rates of youth re-entry to congregate care or other 24 hour level of care	✓	✓
Number of restraints/seclusions per youth	✓	
Number of reported incidents per youth	✓	✓
Number of 51A reports per youth	✓	
Youth length of stay	✓	✓

Table 9: Data collected by DCF and DMH case management

Key Findings

- Approximately 80% of approved in-state residential schools are subject to DCF/DMH oversight and quality assurance activities.
- The DCF/DMH team collects some of the same information and materials during their program reviews that EEC and ESE review, although all three agencies conduct monitoring separately.
- Feedback from provider focus groups indicate that the DCF/DMH quality assurance can come across as another compliance function, rather than one that is focused on quality improvement and technical assistance.
- There may be instances where the ESE school approval, EEC license, and EOHHS contract agreement are not precisely aligned with respect to the characteristics of the children the program can serve. This can create confusion about appropriate placements.
- DCF and DMH collect a lot of provider level and client level data, but aggregating it is challenging. i-Family Net (DCF's case management system) currently only collects provider information in narrative form, which makes it difficult to track child outcomes by program. Similarly, DMH has separate datasets and data systems for incidents (acuity/critical incident and investigations) and case management. Information gathered during the quality assurance activities described above are stored on shared drives, rather than in systems.
- As a new approach to service delivery and oversight, additional written information about DCF and DMH roles and functions would be useful to providers and other stakeholders.

Changes Already Underway

- Changes to i-Family Net to better capture provider level information are underway as part of revisions to DCF's Institutional Abuse policy. Going forward, 51As, incident reports, and other data that DCF collects (such as length of stay, placement moves, etc.) will link to providers. Medication errors, recorded as either 51As or incident reports, will also link to providers (if the error happens outside of the school day).
- DCF and DMH are in the process of clarifying roles and responsibilities of DCF and DMH in contract monitoring and oversight.

Investigations of Abuse or Neglect and Incident Response

Allegations of abuse or neglect must be reported to DCF or DPPC for review and disposition.

DCF investigates allegations of abuse or neglect against children/youth (individuals under age 18) when the allegation involves their parent or caretaker. The Special Investigations Unit[27] (SIU) investigates allegations of abuse or neglect in out-of-home care, including institutional and residential settings, although allegations that occur at school (including residential schools) are investigated by DCF area office investigators. For very severe cases, DCF may coordinate with law enforcement throughout the investigation. DCF records information about the investigation in i-Family Net and information about any confirmed perpetrators into the central registry. DCF is legally required to notify the appropriate District Attorney for death, sexual abuse, and serious injury. DCF's regulations state that they may notify other state agencies when they have received and screened in a report alleging that abuse or neglect of a child has occurred at a facility owned, operated, or funded, in whole or in part, by any of said departments or office, or at a facility operated by a person or entity subject to licensure or approval by any of said departments or office[28]. Pursuant to a memorandum of understanding between DCF and EEC, the DCF SIU notifies EEC of all 51A reports involving a residential program licensed by EEC. **EEC** then conducts an investigation concurrently or jointly with DCF for regulatory compliance. DCF's General Counsel notifies ESE of abuse allegations/investigations involving schools via a monthly report.

DPPC investigates cases of abuse or neglect for individuals with a disability between the ages of 18-59, when the abuse is alleged against a caretaker. As authorized by statute, DPPC may assign the investigation to the Massachusetts Rehabilitation Commission (MRC), the Department of Developmental Services (DDS), or DMH to be investigated under the authority and oversight of DPPC. The State Police Detective Unit assigned to DPPC (SPDU) reviews every report of abuse made to the DPPC hotline and when there is an appearance of a crime a copy of the report is sent to the District Attorney's Office and/or to the local law enforcement agency in the jurisdiction where the alleged abuse occurred for consideration and investigation when appropriate. DPPC must adhere to strict privacy laws, and their regulations say, "…regardless of whether abuse is substantiated or not, the designated investigator may make a conclusion based on the findings as to whether a violation of other state statutes and regulations exists and whether such violation poses a risk of harm to persons with disabilities. If such a violation is determined to exist,

[27] The Special Investigation Unit investigates allegations of abuse or neglect concerning certain kinds of caretakers, such as those who work in institutions.
[28] 110 CMR 4.43

the investigator may make recommendations regarding actions needed to remedy the identified violation including, but not limited to, referral of the matter to the appropriate agency of the Commonwealth that has jurisdiction over the violation and recommendations for remedial actions based upon the statutory and regulatory authority of the agency conducting the investigation for the Commission"[29]. Therefore, in instances where DPPC believes that EEC, DCF, or ESE should be involved due to their licensing/approval or other authority, DPPC can send a copy of the findings to them.

When an allegation of abuse or neglect is made to DCF or DPPC involving a residential school, the program must also notify ESE if the incident occurred at the school, EEC if the incident occurred in the residence, and DCF or DMH if the child/youth was placed by one of those agencies. For any allegation of abuse or neglect, EEC will immediately launch a regulatory investigation either concurrently or jointly with DPPC or DCF. More information is presented below about how the various agencies receive notification of incidents, including allegations of abuse or neglect, and how they respond.

Incident Notification and Response

EEC, ESE, DMH, and DCF have unique processes for responding to reports of abuse/neglect, complaints, or incidents, depending on their respective roles in the oversight of schools and residential programs. They also have different incident notification requirements. For example, DCF defines a restraint as a reportable incident, while DMH does not require notification unless the restraint resulted in the need for medical intervention (though DMH has different reporting requirements for facilities). Providers are required to self-report this data whenever they experience a qualifying incident or event during their school or program hours, and the agencies follow up to review regulatory compliance, contract and program compliance, and/or client services depending on the agency's mandate and specific area of focus.

Often, providers may have to report the same incident to one or more entity and there is similarity in the information requested by each agency. This similarity can be seen in the table below, which provides a crosswalk of information that providers may need to submit during incident notification or when reporting suspected instances of abuse or neglect.

[29] 118 CMR 5.02

Information Collected	Incident Notification or Abuse/Neglect Report Form Requirements[30]				
	DMH	DCF		ESE	DPPC
	Incident Report	51A	Incident Report[31]	Form 2	Intake Form
Demographic Information	✓	✓	✓	✓	✓
Parent / Guardian Information	No	✓	No	No	✓
Commitment Status	✓	No	No	No	No
Disability	✓	No	No	No	✓
Description of Incident	✓	✓	✓	✓	✓
Current level of agency involvement	✓	No	No	No	✓
Provider / School Name	✓	No	✓	✓	✓
Program Name	✓	No	✓	✓	✓
Program Address	✓	No	✓	✓	✓
Medications	✓	No	No	No	No
External Notifications	✓	No	✓	✓	✓
Follow Up Decision Required	✓	No	No	✓	✓
Reporter	✓	✓	✓	✓	✓
Staff Involved	✓	No	✓	✓	✓
Previous Allegations	No	No	No	No	✓
Screening Decision	No	No	No	No	✓
Type of Program	No	No	No	✓	✓

Table 10: Notification of incidents and abuse/neglect across the oversight agencies. Areas of overlap often require providers to supply the same information multiple times.

In response to growing concern about restraint and seclusion use in child-serving settings, the Commonwealth organized a cross-secretariat effort to reduce and prevent their use in 2009. The initiative brought together agencies to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing, and ensure that treatment and educational settings employ behavior support methods that reflect current knowledge about the developmental impacts of early traumatic experiences.

EEC and ESE collect restraint data as follows:

[30] EEC does require incident notification under specific circumstances, but does not have a standard incident report form, except for suspected incidents of abuse or neglect which can be reported through LEAD. Many of the same elements are captured but are not noted here as this functionality became operational after data collection.
[31] DCF incidents are reported by type with specific questions for each type of incident.

Restraint Reporting

Licensing and Approval Agency	Type of Data	Description
ESE	Residential schools must report any restraint that causes injury. Data includes student level data including the persons involved in the restraint for public and private day or residential schools program, for Massachusetts Students, or out-of-state students.	Approved private special education schools are required to submit the data within three days. Data is submitted through a web based application and the data is "live". As of January 1st, 2016, school principals are required to conduct weekly reviews of individual restraint data to identify students who have been restrained multiple times during the week. During program and mid-cycle reviews, ESE will review weekly logs, notes from principals, and review documentation in student records specific to restraint data.
EEC	Aggregate, provider level data	Data is submitted quarterly to LEAD.

Table 11: Restraint reporting activities across the Executive Office of Education.

When incidents require response or follow-up, the oversight agencies often launch parallel response activities, which can be seen in the illustration below.

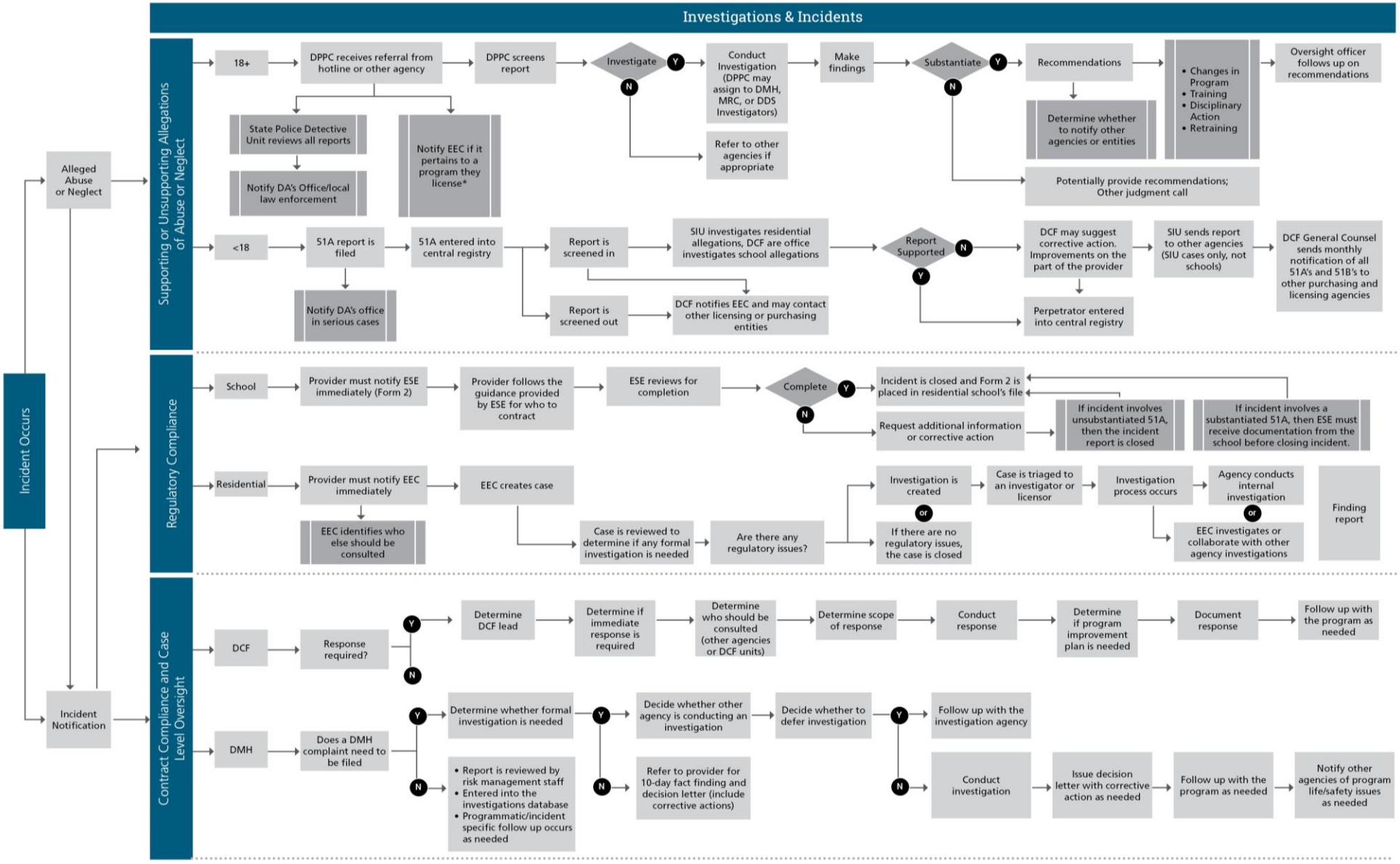


Figure 7 – Investigations and Incident Notification: EEC launches a regulatory investigation in response to any serious incident, including allegations of abuse or neglect as displayed in regulatory compliance pathway.

Key Findings:

- The complexity of differing incident notification requirements between agencies may lead to providers filing reports unnecessarily as a means of ensuring consistent compliance across all agencies.
- Providers may have to submit multiple notifications to different agencies for the same incident, and multiple agencies often follow up on the same incident.
- A lot of communication and collaboration occurs between agencies during incident response activities, so while the agencies' notification requirements are separate, their response is coordinated.
- Personnel from some of the state oversight agencies noted that it would be helpful if they could get more information about the disposition of incident response and investigation activities undertaken by DMH.
- DPPC notifies EEC of allegations of abuse or neglect related to residential schools, but does not routinely notify ESE.
- EEC is notified of 51A reports by DCF very timely, but ESE is not. Allegations of abuse or neglect that occur at residential programs are investigated by the DCF Special Investigations Unit. The SIU will immediately notify EEC of such reports. However, allegations of abuse or neglect that occur at schools are investigated by DCF area office investigators. ESE is notified of these reports and investigations via a monthly report from the DCF Office of the General Counsel.
- Providers noted that staff have concerns about the personal accountability associated with 51A reports, which may be a deterrent to staff retention. Some of this anxiety may be due to misunderstanding about what is recorded in the registry. Currently, individuals involved with cases that are not substantiated would not be flagged during a background check. It is also not widely understood that DCF does consider programmatic issues when determining whether an individual should be held accountable or not.
- Currently, DCF can substantiate an allegation against a person but there is no option to create a finding against a program. 51As are attached to people, not programs, which makes it hard to aggregate the number of 51As by provider. Provider information is generally entered into the abuse/neglect report as narrative, making it difficult to run a provider history check. The reporting format does not provide information in a way that can be aggregated and analyzed to identify issues with program administration (e.g. staffing plan, training, oversight) versus individual staff liability.
- SIU is supposed to complete investigations within 15 days, but this is often not possible for cases occurring within institutions due to the time it takes to talk to everyone, obtain records, and coordinate with other state agencies. Often times children/youth involved in allegations of abuse or neglect have been moved to different programs throughout the state.

- In rare instances, programs with serious program issues have not come to the attention of oversight agencies because allegations of abuse or neglect, and/or other incidents, were not reported when they should have been. The Eagleton School, for example, was closed last spring after an investigation conducted by several law enforcement agencies found "a pattern of violence against students by some employees". Complaints against one staff person indicated that he intimidated students with threats if they told on him and accused students of lying to clinicians about him. Thus, inappropriate staff conduct went unreported.
- Similarly, programs that serve children who are non-verbal, very young, or medically fragile may also need to be monitored more frequently or differently than other programs as these children are particularly vulnerable and may not be able to communicate programmatic issues.

Changes Already Underway:

- Revisions to DCF's Institutional abuse policy are underway including modifications to i-Family Net to link provider information to 51As.
- Confusion about what constitutes the filing of 51As, particularly around medication errors, is an area that the working group has flagged for additional review and technical assistance with providers. An agency workgroup comprised of DCF, EEC, DMH, and DPH have been meeting to clarify processes and reporting requirements for medication errors to provide more specific guidance to residential schools related to what warrants a 51A to be filed to reduce misunderstanding in this area.
- ESE and DPPC have begun to develop a process for DPPC to notify ESE when they receive a report of suspected abuse or neglect involving a residential school.
- ESE and EEC have been working to better define what constitutes a school incident versus a residential incident to reduce duplication.
- Revisions to ESE's Form 2 incident report were implemented October 17, 2016. Programs are now required to report specified incidents for all students enrolled in the program, including Massachusetts students, out-of-state students and privately placed students during school hours. Programs must also notify ESE of any student (day or residential) who is being terminated on an emergency basis. Additional changes to ESE's Form 2 include reporting notification confirmation charts for other agencies, and a checklist to ensure providers submit notification to appropriate agencies;
- ESE's WBMS system integration is in production so that programs can upload serious incidents (Form 2's) and notifications or prior approval requests (Form 1's) into WBMS;
- Residential schools must submit required restraint notifications within 3 days. Data is submitted through a web based application and the data is "live". Restraint data was collected and reviewed from all programs from January-June 2016. As a result of the data, ESE will conduct onsite visits to three schools to provide technical assistance and will provide telephone technical assistance to two others.

IV. Recommendations

Based on the findings above, the following steps are recommended to improve coordination of oversight and monitoring activities across agencies. Each of these recommendations will require a more in-depth implementation plan, which should be grounded in and guided by the factors associated with safety and positive outcomes for children in residential programs in **Appendix C** – Best Practice Research and reiterated on **page 23** of this report.

In the process of discussing the current state analysis and key findings, the working group identified key guiding principles that must be considered as the recommendations below are implemented. These generally apply to every recommendation that follows.

- Implementation plans will need to consider the recommendations below in the context of a child service system that is much larger than just residential schools. While these recommendations are specific to residential schools, they may be relevant more broadly across the child service system.
- Stay focused on the goal of improving the business process to address the key safety factors identified in this report, not just layering on additional requirements or aligning unnecessary processes or data collection activities.
- Statutory, regulatory, and policy changes will need to occur in order to implement and maintain changes. As recommendations are moved forward, early identification of those changes as well as follow through, will be critical. In addition, it must be noted that many of these recommendations would require additional resources, such as additional staff or technological changes in order to implement them.
- Ongoing involvement of multiple stakeholders in the design and implementation of changes will be critical for success, including the involvement of families and consumers where appropriate and possible.
- Consistent feedback on the plans and progress related to the recommendations below should be provided to providers, schools, the Massachusetts Association of Approved Private Schools (MAAPS), and other stakeholders so that there is universal understanding of changes to practice, policy, and oversight activities.

Each recommendation below is divided into changes already underway, proposed next steps (within the next 12-18 months), and further work (steps that would need to be taken after the initial 12-18 months or where further research is needed). Sub-recommendations are presented sequentially under each recommendation.

LICENSING, APPROVAL AND MONITORING

1. Define, align, and consolidate ESE and EEC initial licensing and approval processes and ESE, EEC, and DCF monitoring activities to improve coordination, data sharing, and monitoring of safety factors and reduce the need for providers to submit duplicative documentation.

Changes already underway:

- EEC staff will observe ESE residential school monitoring visit(s) and ESE staff have participated on EEC residential school monitoring visit(s). The purpose is for each agency to learn more about each other's processes, including identifying opportunities for more shared activities.
- Both EEC and ESE are strengthening their monitoring and making their monitoring more focused:
    - Beginning in the 2017-2018 school year, ESE will make unannounced visits as a follow up to any programs that have a finding during their review, to verify implementation of the corrective action plan and/or progress reports.
    - Also beginning this year, EEC is transitioning to a differential licensing process; the program's compliance history will determine the frequency and/or depth of subsequent monitoring. Differential licensing will allow EEC to increase monitoring of high risk programs. Also by tailoring the depth of their monitoring, they hope to visit all programs each year. EEC visits, whether monitoring or enhanced will be unannounced. It is only when a residential program is undergoing a full licensing renewal study that a visit will be announced.
- ESE, EEC, and DCF are meeting quarterly to share information, questions, and concerns.

Next Steps:

1.1. Agree on specific safety factors to monitor across all agencies, and establish common cross-agency data definitions and analytical reports, so that agencies can review information uniformly.

1.2. Align the timing of ESE's periodic monitoring with EEC's annual monitoring visits and clarify the specialized monitoring roles of the two agencies (health and safety versus educational) and what monitoring activities are specific to each.

1.3. Monitor safety factors in between scheduled monitoring activities (in coordination with activities conducted in **recommendation 2),** by developing and/or sharing reports between and among ESE, EEC, and DCF.

1.4. Determine how to identify programs that may be under-reporting incidents or instances of abuse/neglect.

1.5. Determine whether programs that serve children/youth whose disabilities (or other characteristics) make them more vulnerable, such as non-verbal children/youth, very young children, or medically fragile children/youth, may need to be monitored more frequently or differently than other programs, and if so, how.

1.6. Continue improving ESE approval processes to ensure that residential schools are equipped to work effectively with the children they accept.

1.7. Develop protocols, including how the oversight agencies will coordinate and what steps with be undertaken, for circumstances of extraordinary program non-compliance.

1.8. Formalize communication practices via written policy or agreement (what should be communicated, when, and how) between EEC, ESE, DCF and other state oversight agencies.
1.9. Identify any necessary regulatory or statutory changes required to streamline initial licensing/approval and monitoring activities.

Further Work:

1.10. Review EEC licenses, ESE school approvals, and EOHHS contractual agreements for residential schools to ensure that they convey the same expectations, terms, and language about program requirements, populations, and outcomes. Develop a shared language for describing children and their disabilities and characteristics, program specifications, and outcomes for inclusion in formal documentation going forward so that schools see the same messages across EEC, ESE, and EOHHS contractual documents. Correct any documents that are out of alignment.
1.11. Determine how ESE and EEC will review the safety factors that are not currently reviewed or collected by either agency (refer to chart on **page 23** of this report).
1.12. Create an integrated residential school application process including a uniform application for EEC license and ESE approval for residential schools and a centralized location for submission.
1.13. Determine potential for joint pre-licensing and pre-approval visits.
1.14. Further streamline monitoring between ESE and EEC (such as through joint monitoring visits or a joint monitoring checklist that staff at both agencies are trained to review). Review and revise procedures, forms, training procedures, and monitoring requirements as appropriate.

DATA COLLECTION AND DATA SHARING

2. Develop a process for sharing the safety factors across oversight agencies and identify the data sharing agreements, MOUs, or statutory changes that are needed. Across all oversight agencies, there should be a process to consistently share information with each other and with residential school providers to improve monitoring of safety factors across all of the oversight agencies, identify programs that may be at risk more proactively, and provide training and technical assistance to providers as needed.

Changes Already Underway:

- The Governor's Office is in the process of convening a cross-secretariat working group to review cross-agency data sharing processes.
- DCF is modifying I-Family Net to allow data aggregation by provider.
- ESE is currently conducting a pilot to receive information about all 51As and 51Bs[32] that occurred in schools in one city. Upon completion of the pilot, lessons learned can be utilized to maintain and expand the current pilot into a larger engagement and can also inform future data sharing arrangements between multiple oversight agencies.

[32] A 51B report is a report of substantiated abuse or neglect perpetrated against an individual under the age of 18. Its name references the Massachusetts General Law that governs its practice.

- Language was included in the Governor's Fiscal Year 2018 Budget Recommendation to allow data sharing between ESE and EEC.

Further Work:

2.1. Define and align data collection and data elements across agencies for prioritized safety factors.
2.2. Develop a process to share information with providers. Convene a meeting with the providers to tell them what information is available and ask providers what information would be helpful to share (individual and in aggregate). Agree on format and frequency. Conduct periodic meetings with the providers to share information and provide technical assistance
2.3. Review the need for and feasibility of software or system changes to streamline form submission and share and track data across agencies, including software or data warehouse options that would allow for more automated identification, using the safety factors identified in **Appendix C** and on **page 23** of this report, of programs that may need review.

INCIDENT NOTIFICATION AND RESPONSE

3. Streamline and clarify incident notification and response protocols to reduce duplicative or unnecessary notifications and identify the best way for oversight agencies to coordinate responses to allegations of abuse or neglect or other serious incidents.

Changes already underway:

- Improvements are underway at EEC and ESE to clarify incident notification requirements, and to collect and monitor restraint data. ESE and EEC have also been working to better operationally define what constitutes a school incident versus a residential incident to reduce notification duplication.
- Revisions to ESE's Form 2 incident report were implemented October 17, 2016. Programs are now required to report specified incidents for all students enrolled in the program, including Massachusetts students, out-of-state students and privately placed students during school hours. Programs must also notify ESE of any student (day or residential) who is being terminated on an emergency basis. Additional changes to ESE's Form 2 include reporting notification confirmation charts for other agencies, and a checklist to ensure providers submit notification to appropriate agencies. Notifications can be uploaded directly into WBMS.
- Required restraint notifications must now be submitted to ESE within 3 days and are submitted via a web based application so that restraint data is now "live".

Next Steps:

3.1. Create standard definitions, across agencies, about the types of incidents or occurrences that require notification and which agencies require notification under which circumstances. Determine whether restraint reporting could also be incorporated.
3.2. Define how the oversight agencies will respond to different kinds of incident notifications, based on the safety factors identified in Recommendation 1, including the kinds of incidents that will

warrant a joint response and what the joint response will entail (refer to the factors associated with safety and positive outcomes in **Appendix C** and on **page 23** of this report). Formalize informal communication protocols between the state agencies, and make recommendations for regulation changes if needed.

Further Work:

3.3 Conduct business process redesign assessment of current notification submission processes to identify potential for a more centralized notification submission process[33] that would only require providers to submit to one centralized location and notification would be forwarded to appropriate agencies. ESE and EEC explore possibility and feasibility of creating a centralized approach for screening, decision making, and response based on urgency of incident and agency of purview (ESE and EEC).

51A REVIEW AND COMMUNICATION

4. Review DCF's 51A institutional abuse policy to continue to improve the ability to collect and analyze data on programmatic issues, improve communication of program issues to other oversight agencies, and hold providers accountable for programmatic issues.

Changes already underway:

- Revisions to DCF's Institutional abuse policy are underway including modifications to i-Family Net to link provider information to 51As.
- Confusion about what constitutes the filing of 51As, particularly around medication errors, is an area that the working group has flagged for additional review and technical assistance with providers. An agency workgroup comprised of DCF, EEC, DMH, and DPH have been meeting to clarify processes and reporting requirements for medication errors to provide more specific guidance to residential schools related to what warrants a 51A to be filed to reduce misunderstanding in this area.

[33] Related work has been led by other Commonwealth agencies (such as the Executive Office of Elder Affairs and the Governor's Office). The implementation team should connect with these entities prior to implementation to ensure consistency.

Next Steps:

4.1 EEC and DCF should finalize policy and changes to EEC's background check consent form, which will allow EEC to receive records of substantiated concern, in addition to actual substantiated allegations.

4.2 Develop a process whereby DCF notifies ESE and DPPC, as well as EEC, of 51As to ensure that program concerns are raised to the appropriate oversight agencies.

4.3 Continue to enhance the capacity of i-Family Net to capture programmatic concerns that come to light during investigations in a way that can be analyzed and tracked by provider and program.

Further Work:

4.4 Review other state policies and current MA statutes to determine if greater flexibility should be given to DCF for a broader set of dispositions (than support or unsupported against an individual) in institutional abuse cases and review the typical amount of time allowed for other states to complete institutional abuse cases and how it compares to the 15 days allowed in Massachusetts.

4.5 Review the benefits of having all institutional abuse cases, including schools, handled by one unit at DCF (the SIU) to improve consistency of practice and communication.

AREAS FOR FURTHER REVIEW

5. Review and analyze other factors to better understand and support residential school quality and safety. These factors were outside the scope of this review but are worthy of additional study:

5.1. Workforce issues such as program administration, turnover, leadership, clinical oversight, supervision, and training are correlated with safety and quality in residential programs (see **Appendix C**- Best Practice Research and **page 23** of this report). The working group should identify which workforce issues are associated with the safety factors identified, and continue working with the major trade organizations representing providers to explore how the Commonwealth can better support the residential school workforce in order to maintain high quality programs.

5.1.1. As the report recommendations are implemented, agencies should develop joint training and communication materials with providers to clarify:

- the types of incidents that require notification;
- which agency(ies) to notify;
- the process for submitting notifications to oversight agencies;
- how the oversight agencies will respond;
- how data should be submitted; and
- what the rules are around staff that will be flagged as part of an employment background check.

5.2. There are numerous entities placing children in residential schools including several state agencies, school districts across the Commonwealth, and out of state agencies. All of these

entities have their own placement policies[34], practices, and factors that drive their placement decision making and are trying to balance numerous factors including the child's clinical and educational needs, proximity to home, placement capacity issues, and budgetary and other administrative realities. They also have their own child level oversight practices, with varying levels of capacity. The working group should conduct a review of residential school placement practices and drivers, as well as the child level oversight conducted by placement entities, in order to assess current practice, understand how enrollment decisions can impact identified safety factors, make recommendations for improvements to child level data coordination, and ensure that children's needs are being met.

5.3. A review of other types of schools that provide services to children with complex needs is needed to ensure that there are sufficient oversight practices in place. These schools include:

- Substantially separate programs in public schools – these include school or classroom environments outside of the general education setting for children with significant special education needs; and
- Locally approved schools - schools not approved by ESE must be authorized to operate by the local school committee. If there is a residential component to the program, then the residential program must be licensed by EEC and will be subject to ongoing monitoring by EEC.

[34] The no refusal policy included as part of EOHHS contractual agreements is one example of a policy that could be reviewed for its impact on placement decision making.

Appendix A:

Agency Mission Statements:

Department of Elementary and Secondary Education: To strengthen the Commonwealth's public education system so that every student is prepared to succeed in postsecondary education, compete in the global economy, and understand the rights and responsibilities of American citizens, and in so doing, to close all proficiency gaps.

Department of Early Education and Care: To provide the foundation that supports all children in their development as lifelong learners and contributing members of the community, and support families in their essential work as parents and caregivers.

Department of Children and Families: Strive to protect children from abuse and neglect and, in partnership with families and communities, ensure children are able to grow and thrive in a safe and nurturing environment.

Disabled Persons Protection Commission: To protect adults with disabilities from the abusive acts or omissions of their caregivers through investigation, oversight, public awareness, and prevention.

Department of Mental Health: As the State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities. The Department establishes standards to ensure effective and culturally competent care to promote recovery. The Department sets policy, promotes self-determination, protects human rights and supports mental health training and research. This critical mission is accomplished by working in partnership with other state agencies, individuals, families, providers and communities.

Appendix B

Applicable Agency Legislation, Statutes, and Regulations

Applicable Statutes and Regulations	
Department of Elementary and Secondary Education (ESE)	Every Student Succeeds Act (ESSA); Individuals with Disabilities Education Act (IDEA); Massachusetts General Law c. 15, c. 69, c. 71; 603 CMR[35];
Department of Early Education and Care (EEC)	Massachusetts General Law c. 15D; 102 CMR; 606 CMR
Department of Children and Families (DCF)	Massachusetts General Law c. 18B; 110 CMR
Disabled Persons Protection Commission (DPPC)	Massachusetts General Law c. 19C; 118 CMR
Department of Mental Health (DMH)	Massachusetts General Law c. 19; 104 CMR

[35] Code of Massachusetts Regulations (CMR)

Appendix C – Best Practices

Table of Contents

1. INTRODUCTION AND BACKGROUND

The term "residential school" refers to programs that provide both a residential component as well as an approved special education program on-site.

Figure 1: Massachusetts residential school components- These components include both an approved special education program and a licensed residential program.

Across the nation, these programs have different names including residential treatment centers, academies, and therapeutic boarding schools. Children and youth can be referred to residential schools through the mental health system, the child welfare system, or the school system. Residential schools tend to serve more adolescent age youth than younger children.

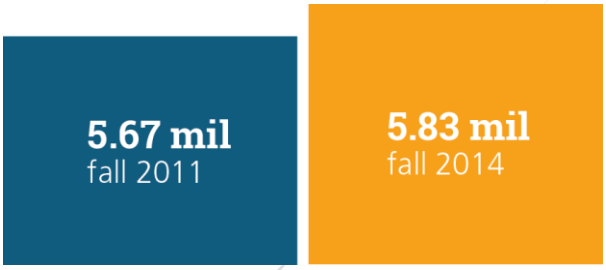


Figure 2: Total number of students nationally with disabilities- The rate of students with disabilities has risen 2.39% between 2011 and 2014.

Nationwide, from 2011 to 2014, the number of children in foster care who have been placed in a group home or institution has remained relatively flat from 56,120 to 56,188, respectively. Over the same time the number of students ages 6-21 with disabilities fell to a low of 5.67 million in fall 2011, but rose to 5.83 million by fall 2014.[36] When children with complex disabilities cannot be adequately educated in public schools, the school district must fund appropriate education elsewhere, such as in a residential school. However, the Individuals with Disabilities Education Act (IDEA) contains provisions encouraging the least restrictive placement "...to the maximum extent appropriate, children with disabilities including children in public or private institutions or care facilities, are educated with children who are *non*disabled; and special classes, separate schooling or other removal of children with disabilities from regular educational environment occurs only if the nature or severity of the disability is such that

[36] Samuels, Christina A. "Number of U.S. Students in Special Education Ticks Upward." Education Week. April 19, 2016. Accessed September 22, 2016. http://www.edweek.org/ew/articles/2016/04/20/number-of-us-students-in-special-education.html. Vol. 35, Issue 28, Pages 1,12

education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."[37]

Mental health and child welfare experts have also been encouraging more limited use of residential or congregate care. According to the American Orthopsychiatric Association, "group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting"[38]. Secure attachments to consistent caregivers are critical for the healthy development of children and youth, especially for very young children. Youth who live in institutional settings are at greater risk of developing physical, emotional and behavioral problems.[39]

As noted by the Association for Children's Residential Centers, 'it is important to shift the culture and perception in the youth-serving arena so that residential is not seen as a placement of last resort, but rather as a specialized opportunity—an intervention or a tool—to help with a specific set of needs and circumstances. In the current typical scenario, a youth must fail repeatedly prior to referral and admission to residential, when a shorter stay earlier in the youth's trajectory may have helped establish a stronger foundation for system of care supports and interventions."[40]

This shift in the role of group care services is further reinforced nationwide in shifting state and federal emphasis towards redesigning how child welfare services are funded, by focusing resources more towards preventive services and encouraging more limited use of congregate care. Numerous states were granted Title IV-E waivers[41] aimed at reducing the use of congregate care. Before the waivers expire in 2019, Congress is expected to pass new federal financing legislation, which will likely reinforce these aims.

But many states are struggling. Texas, for example, describes a perfect storm of issues such as insufficient foster family homes, reduction in the use of smaller group homes, and the closure of two residential treatment programs due to safety concerns as having significantly strained their residential treatment capacity, especially for children with disabilities[42]. Illinois is also currently under scrutiny due to harsh treatment of children in residential treatment, as well as children lingering in shelters and psychiatric hospitals largely due to insufficient placement capacity[43]. One reason for the strain on residential treatment is a shortage of foster family homes. In addition to Texas and Illinois, Georgia, Mississippi, Oklahoma, Arkansas, Alabama, Florida and numerous other states have publicly acknowledged family foster home shortages in the past couple of months. When there are not enough family foster homes for children, children who may not require a residential level of service may be placed in a residential program anyway, straining the capacity of the system.

[37] IDEA - Building the Legacy of IDEA 2004. http://idea.ed.gov/explore/view/p/,root,statute,I,B,612,a,5,

[38] Dozier, Mary, Roger Kobak, and Abraham Sagi-Schwartz et al. Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association. American Journal of Orthopsychiatry. American Orthopsychiatry Association. February 25, 2014. https://www.apa.org/pubs/journals/features/ort-0000005.pdf.

[39] "CONGREGATE CARE, RESIDENTIAL TREATMENT AND GROUP HOME STATE LEGISLATIVE ENACTMENTS 2009—2013." NCSL. October 26, 2015. http://www.ncsl.org/research/human-services/congregate-care-and-group-home-state-legislative-enactments.aspx.

[40] Sisson, Kari. "REDEFINING THE ROLE OF RESIDENTIAL TREATMENT." Association of Children's Residential Centers.

[36] Texas foster care-crisis: Children sleeping in CPS offices again as more removed from homes but state out of places to care for them, Dallas News, March 17, 2016

[41] Title IV-E waivers allow states to waive certain requirements related to the use of Title IV-E funds to fund child welfare demonstration projects aimed at reducing reliance on out of home care.

[43] DCF Wards Languish in Psych Hospitals, Shelters, Detention, September 9, 2016, Chicago Tribune

A study conducted in 2014 found that approximately six million children in the US were disabled, an increase of 16% from a decade earlier, driven entirely by increases in neurodevelopmental or mental health conditions[44]. This may be one reason why many states report that the acuity level of children in their care is rising. These increases in acuity manifest into challenges for both clinicians and providers through increased numbers of physical assaults, psychological screenings, police arrests, and "absent without leave" (AWOL) status of children in placement, all of which have increased over the last three years[45].

Increases in acuity manifest as challenges for providers through increases in physical assaults, increases in psychological screenings, police arrests, and AWOLs

Nationwide state oversight agencies face challenges in adequately overseeing these facilities for various reasons: programs are often provided by numerous private agencies across the state, youth within the facilities may have disabilities that interfere with their ability to adequately communicate problems or mistreatment at the facility, there may be multiple state agencies responsible for oversight leaving room for potential gaps or miscommunication between them, and there may be confusion in the provider and caregiver community about the kinds of incidents that need to be reported as incidents, abuse, or neglect.

In 2008, the GAO conducted a comprehensive study that highlighted the challenges of state and federal oversight practices related to residential programs. Though older, this reflects a nationwide trend where facilities have been investigated for failing to adequately meet or supervise the needs of children and youth in their care. Facilities in Illinois, Texas, New Hampshire, Massachusetts, Florida, and West Virginia, to name just a few, have made headlines in recent years. The GAO survey respondents from 28 states reported at least one death in a residential facility in 2006, some of them accidents or suicides that may have been attributable to a lack of supervision by staff. Key findings from the study included:

- Gaps in oversight often come from missing licensing requirements (such as some measures of youth well-being like suicide prevention plans), lack of compliance monitoring, exemptions for certain facilities, and lack of communication between agencies.
- Almost all states reported that their licensing requirements (if they had them) included standards related to the physical plant, proper use of seclusion and restraint techniques, reporting of adverse incidents, and staff qualification requirements and background checks. However, other risks to youth were not always addressed. For example, most of the agencies included in the survey did not require private agencies to have written suicide prevention plans.
- Certain aspects of youth well-being were not included in all monitoring activities. The quality of educational programming and use of psychotropic medications were most likely to be reviewed at only some, or none, of the facilities monitored by child welfare, health and mental health, and juvenile justice agencies.

[44] What's Behind the Stark Rise in Children's Disabilities, August 19th, 2014, http://www.npr.org/2014/08/19/341674577/whats-behind-the-stark-rise-in-childrens-disabilities
[45] Placement and Procurement Focus Group Session. The Department of Children and Families (DCF). September 2016.

- Many state agencies reported they did not routinely share information with others regarding negative findings from monitoring reviews
- Some states require accreditation instead of licensure for certain types of programs, but accrediting organizations do not always inform the state if a facility's accreditation status has been suspended or limited
- Some states admitted being hesitant to close programs or program intakes if there is a shortage of placement facilities[46]

Numerous states have passed legislation since this study was conducted to enhance laws related to the oversight of residential facilities, including residential schools. Between 2009 and 2013, eight (8) states have passed laws related to oversight and/or licensing of residential facilities, ten (10) protection from abuse, and two (2) oversight of psychotropic medications.[47]

The purpose of this document is to present best practices in oversight of residential schools including:

- An overview of organizational factors that promote safety and positive outcome for children and youth;
- Information about state oversight practices including the kinds of data collected for licensing, contract and program management, and investigations/incidents; and
- Information about best practices in the development and implementation of inter-agency data management systems.

2. ORGANIZATIONAL FACTORS THAT PROMOTE SAFETY AND POSITIVE OUTCOMES FOR CHILDREN AND YOUTH

Residential Facilities

> Researchers have noted that the majority of institutional abuse reports occur during moments of crisis.

While the incidence and severity of challenges in the residential education population is naturally higher given the clinical complexity of the populations, researchers have noted that the majority of institutional abuse reports occur during moments of crisis, such as when children are threatening harm to themselves or others[48]. Faculty at the Residential Child Care Project within the College of Ecology at Cornell University conducted a research study of 45 child and adolescent fatalities related to restraint in residential (institutional) placements in the

[46] "Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges." United States Government Accountability Office, May 2008. http://www.gao.gov/new.items/d08346.pdf
[47] "CONGREGATE CARE, RESIDENTIAL TREATMENT AND GROUP HOME STATE LEGISLATIVE ENACTMENTS 2009—2013." NCSL. October 26, 2015. http://www.ncsl.org/research/human-services/congregate-care-and-group-home-state-legislative-enactments.aspx.
[48] The Institutional Child Abuse Project. http://rccp.cornell.edu/iab/iab-techasst.html.

United States. Researchers noted a variety of organizational practices, policies, and cultures that contributed to the overuse of restraints and ultimately the fatalities. The causes noted included[49]:

- lack of training in crisis management;
- insufficient staff supervision;
- inadequate monitoring of restraints, and dependence on restraints for reasons other than safety, for example to enforce compliance with program rules or staff requests;
- inappropriate placement;
- inadequate or non-existent treatment philosophy;
- non-compliance with regulations;
- children's rights ignored;
- inadequate staffing or resources; and a
- lack of a learning or reflective environment.

Researchers have noted specific organizational factors that contribute to the culture of a residential facility, and the likelihood of abuse. Healthy organizations exhibit organizational structures and processes that produce safety, positive developmental outcomes & well-being[50]. On the opposite end of the spectrum, toxic organizations are a combination of organizational structures or processes that product risk, negative developmental outcomes and maltreatment[51] Differences between the kinds of activities that make a facility healthy versus toxic are included in the table below[52].

Category	Healthy Facilities	Toxic Facilities
Program	✓ Alignment between the organization's mission and program model ✓ Programs governed by best practices and best interests of children in a trauma-focused context ✓ Staff are trained on and are aware of the organizational mission and program model and how they align. Staff at all levels of the organization can articulate the program model	✓ Theory of change inconsistent with research and developmental principles ✓ Lack of training for new staff ✓ Inconsistent articulation of the program model throughout the organization

[49] Nunno, Michael A., D.S.W., and Martha Holden. "Learning From Tragedy: Restraint Fatalities in Child Welfare, Mental Health and Juvenile Corrections Facilities." Family Life Development Center at the College of Human Ecology, Cornell University. http://rccp.cornell.edu/_assets/Learning_From_Tragedy.pdf.
[50] Nunn, Michael A., D.S.W. Organizational Toxicity in Children's Treatment Facilities That Leads to Violence and Maltreatment. Presentation at the Restraint Reduction Network. 2015.
[51] Nunno, Michael A., D.S.W. Organizational Toxicity in Children's Treatment Facilities That Leads to Violence and Maltreatment. Presentation at the Restraint Reduction Network. 2015.
[52] Nunno, Michael A., D.S.W. Organizational Toxicity in Children's Treatment Facilities That Leads to Violence and Maltreatment. Presentation at the Restraint Reduction Network. 2015.

Category	Healthy Facilities	Toxic Facilities
Admission	✓ Admission criteria matches organizational mission	✓ Lack of control over intake and/or admission linked to need to maintain bed census
Clinical Participation	✓ Clinical participation embedded in the daily life of the facility. Clinical staff in proximity to children and direct care staff. ✓ Weight given to clinical expertise and consequences for deviating from clinical protocols, such as child safety plans or individual crisis management plans	✓ Little to no clinical participation in the daily life of the facility. Clinical staff removed from direct care staff and children ✓ Insufficient clinical monitoring ✓ Lack of consequences for deviating from clinical protocols
Documentation	✓ Culture encourages risk identification, learning, and self- assessment ✓ Documentation is complete and current and is reviewed and analyzed to inform treatment, supervision, daily routine, risk management and ultimately child outcomes ✓ Active use of data for organizational and professional learning. All levels of the organization involved in learning/risk management	✓ Insufficient data (either too little, too much, or not current) ✓ Data is used as way to defend the organization, rather than for learning ✓ No formal method for assessing and reviewing adverse events at the organization
Supervision	✓ Supervisors integrated into the daily life of the facility ✓ Frequent supervision focused on professional growth, self-reflection, and learning and linked to risk management ✓ Supervision is connected to training	✓ Supervision is infrequent or unavailable for all shifts ✓ Supervision is used to enforce agency rules and policies ✓ Supervision is disconnected from training
Fear	✓ Little or no expression of fear for safety amongst staff or children	✓ Fear expressed by staff or children is minimized, ignored, or suppressed
Aggression	✓ No aggression amongst staff and children (minimal or no restraints, reports of abuse)	✓ Multiple police report, reports of abuse, restraints, etc. ✓ High numbers of staff or child injuries

Figure 3: Organizational factors associated with safe facilities and positive developmental outcomes

The six core strategies to reduce restraint and seclusion, developed by the National Association of State Mental Health Program Directors, echo similar themes[53]:

- **Leadership toward Organizational Change:** Consistent and ongoing involvement of senior leadership to define and articulate a vision and philosophy toward restraint/seclusion reduction, develop a plan to reduce seclusion and restrain and hold people accountable to the plan

[53] Huckshorn, Kevin Ann. "Six Core Strategies for Reducing Seclusion and Restraint Use©." November 20, 2006. http://www.nasmhpd.org/sites/default/files/Consolidated Six Core Strategies Document.pdf.

- **Use of Data to Inform Practice:** Regular and ongoing review of data related to use of seclusion/restraint, including the development of organizational goals and tracking

- **Workforce Development:** Development of a treatment environment based on the knowledge and principles of recovery and trauma informed systems of care and individualized, person-centered treatment planning activities. This is implemented through staff development training, job descriptions, performance evaluations, new employee orientation, and other similar activities

- **Use of Seclusion/Restraint Prevention Tools**: Use of assessment tools to identify risk for violence and seclusion/restraint history, universal trauma assessments, tools to identify persons with high risk factors for death and injury, environmental changes, sensory modulation interventions, and other treatment activities designed to teach people emotional self-management skills

- **Consumer Roles**: Full and formal inclusion of consumers, children, families and external advocates to assist in the reduction of seclusion and restraint

- **Debriefing Techniques**: Reducing the use of seclusion/restraint relies on analysis of seclusion/restraint events and the use of this knowledge to inform policy, procedures, and practices. A secondary goal of debriefing is to minimize trauma to staff and consumers involved or other witnesses to the event

Similar research conducted by CWLA, regarding facilities that had successfully reduced their use of seclusion and restraints, noted the following factors as critical to their success[54]:

- Strong leadership
- Person-centered organizational culture
- Policies and procedures include practices that assist with the reduction of restraint and seclusion, such as assessments, individualized behavior support planning, monitoring, and debriefing
- Regular staff training
- Relationship-based treatment milieu
- Use of data to track and monitor restraint/seclusion

RESIDENTIAL STAFF TURNOVER

One impediment to a well trained workforce is the high rate of staff turnover in residential facilities. In one study of three residential treatment centers for children and adolescents in Virginia, turnover rates for psychiatric nurses was 45% and residential counselors was about 75%[55]. There are numerous reasons for this turnover including low pay, difficult hours, and a challenging population but the effects are concerning. For one thing, staff vacancies may result in fatigue for remaining staff, as they may need to work longer hours to cover shifts, and fatigue can impair a person's ability to effectively manage

[54] Welfare League of America, "Achieving Better Outcomes for Children and Families REDUCING RESTRAINT AND SECLUSION", 2004.
[55] Fish, Teresa. "Burnout of direct care staff and leadership practices in residential treatment centers for children and adolescents" (PhD diss., The George Washington University, 2007).

challenges. Secondly, it is a direct impediment to developing a well-trained workforce, well prepared to handle a wide range of potential crises.

Effective Educational Practices for Students with Emotional or Behavioral Disorders

Researchers have noted that certain factors are important for the engagement of students with emotional or behavioral disorders (EBD), and the themes are consistent with those above[56]:

- Zero tolerance policies, such as those that automatically expel or suspend students for certain infractions, are not very effective. Removing troubled children and youth puts them out of reach of educators who could help them.
- So called "tiered programs" such as Response to Intervention and School Wide Positive Behavior Supports show good results for supporting and reaching children and youth with EBD. These approaches promote positive social behaviors, in three tiers: 1. school wide, 2. students who do not respond to primary interventions, and 3. students with persistent problem behavior and disciplinary issues.
- Professional development is critical and teachers need more support and training to effectively select and implement intervention programs.

Some of the Special Education Professional Practice Standards laid out by the Council on Exceptional children include[57]:

- **Teaching and Assessment:** Provide individualized instruction techniques, use evidence based practices where possible, conduct periodic assessments to measure progress, create safe and culturally responsive learning environments, support the use of positive behavior supports, report unethical behavior

- **Professional Credentials and Employment:** Ensure credentials, ensure that staff are working within their professional skill and knowledge, provide clear communication of duties and expectations, provide adequate supervision

- **Professional Development:** Individual professional development plans, continuous evaluation

- **Paraeducators:** Ensure appropriate training, only assign tasks for which they are trained, provide regular performance feedback

- **Parents and Families:** Engage families, communicate regularly, inform parents of educational rights and safeguards

In summary, key organizational safety elements include: a therapeutic program model that aligns with the organization's mission, leadership and management engagement, understanding of the program model

[56] Hanover Research. "Effective Programs for Emotional and Behavioral Disorders". January 2013.
[57] "Ethical Principles and Professional Practice Standards for Special Educators,"
Council on Exceptional Children Special Education Professional Practice Standards, https://www.cec.sped.org/Standards/Ethical-Principles-and-Practice-Standards.

at all levels of the organization, relationship-based and client-centered interventions, a well trained workforce supported by regular supervision and clinical expertise, effective use of data in a culture that encourages learning and accountability, and family engagement.

3. OVERSIGHT PRACTICES

Nationally, there is no single or standard oversight process for residential schools. Residential schools are consequentially overseen through a variety of mechanisms, including licensing and approval, program and contract management, and incident reporting and investigation. Information gathered through any one element of the oversight process, should inform the other phases. For example, as states have begun to collect data on restraints and seclusions, they have modified licensing standards to include provisions for behavior management policies that limit the use of restrain/seclusion and they have modified provider contracts and performance expectations to minimize use of restraints and seclusion.

Figure 4: Typical components of licensed and approved residential education facilities - The interaction between the components leads to continued comprehensive monitoring and oversight.

**Not all programs are contracted*

Licensing/Approval Processes

Although licensing standards for residential facilities and private special education schools vary across states, most states have standard licensing regulations. These licensing regulations establish standards for licensing that include individualization to meet resident's needs, while also ensuring their right to

decisions making, and living in a safe environment. Standard license residential regulations typically include the following:

Category:	Includes:
Physical Plant/Building & Grounds	✓ Facility ✓ Exit (doors and lights) ✓ Food service/nutrition ✓ Sanitation; Safety
Staffing & Training	✓ Staff ratios/levels ✓ Qualifications ✓ Background checks ✓ Training
Administration/Operating Policies	✓ Personnel records ✓ Children's records ✓ Grievances ✓ Incident reporting ✓ Admission and discharge policies ✓ Family involvement and visitation ✓ Mandated reporting ✓ Emergency preparedness ✓ Communication
Health and Medication	✓ Medication management ✓ Medication logs ✓ Medical/dental treatment
Program Policies and Procedures	✓ Developmentally appropriate program ✓ Behavior management ✓ Children's rights ✓ Assessment and service planning

Figure 5: residential licensure requirements- The licensure requirements often focus on basic facility health and safety standards.

The approval process for private special education schools includes a review of similar elements including administrative policies and procedures, program policies and behavior management, student records, adequacy of and qualifications of teaching staff, facility and safety requirements, and of course, a focus on educational programs and progress.

TIMING OF REVIEWS

Residential Licensing

An emerging best practice in residential licensing is differential licensing. Twenty-six (26) states report "having a method for determining the frequency and/or depth of monitoring based on an assessment of a facility's level of compliance with regulations," also known as differential monitoring, although not all of these states apply this approach to residential licenses.[58] The differential monitoring model is a risk-based assessment model which focuses on provider's compliance history and program changes to determine the level of health and safety risks to children. The model assists licensors in determining the frequency and/or depth of monitoring needed for any residential, placement or child care provider. The number of states using differential monitoring for at least a portion of child care facilities has increased significantly from 11 states in 2005 to 26 states in 2011, and 27 states report having abbreviated licensing forms that shorten the list of requirements checked during inspections.[59] State have different motivations and purpose for implementation of differential licensing or differential monitoring models, however, the outcomes are often the same: identification and increased monitoring for high-risk programs, tailored technical assistance for improvement of health and safety compliance, and efficiencies in monitoring processes to allow licensor to visit programs more frequently. Massachusetts is one state implementing this method of licensing. In Massachusetts, one key impetus of implementation is for licensors to visit programs annually for monitoring (outside of investigation visits). Differential Licensing uses regulations that would pose the highest probability and severity of harm to children if found to be in non-compliance. These high risk items are called "key indicators". In Massachusetts, key indicators on the monitoring tools for residential providers include adequate staffing and administrator or designee on shift, functional communication logs, review of incident reports, and evidence of emergency preparedness.[60] Over time, data collected on key indicators will help inform on-going analysis on key indicators. Best practices indicate that key indicators should be reviewed frequently and revised as needed every 3-5 years.

Residential license and renewal standards are similar across states nationally; however, frequency varies. Some states only require license renewals every few years, and will conduct onsite licensing review only during that period. Some states have unannounced visits, while others notify their facilities. Each state has a process in place for receiving and investigating complaints. In many states, residential licensing activities are within the purview of the state child welfare agency.

Examples of the variance in compliance monitoring across neighboring states are displayed in the table below. Under differential licensing, EEC plans to visit programs annually, as well as continuing to conduct investigations and follow up on complaints and incidents as needed.

[58] Fifty State Child Care Licensing Study, 2011-2013. Principle Investigators: Sheri Fischer, US DHHS, ACF, National Child Care Information and TA Center; Jana Martella, National Association for Regulatory Administration. http://www.naralicensing.org/Resources/Documents/2011-2013_CCLS.pdf (p.18).

[60] "Residential Regulations", http://www.eec.state.ma.us/docs/residential_regs.pdf.

State	Frequency of Monitoring
Connecticut[61]	• Residential facilities are visited on at least a quarterly basis for compliance monitoring • In addition, unscheduled or follow-up visits occur when issues arise, to address suspected reports of abuse or neglect, critical incidents, and the monitoring of corrective action plans • Licenses renewed every two years – an inspection site visits shall be scheduled no less than three months prior to the license expiration date
New Hampshire[62]	• Mandate to complete at least 2 monitoring visits during each 3- year licensing period, with at least one of them being unannounced • Renewal Visit • Additional visits as deemed necessary (in response to complaints, infractions, etc)
Rhode Island[63]	• Annual license renewal required • Additional visits as deemed necessary (in response to complaints, infractions, etc)
Vermont[64]	• Initial license term for new program is 1 year • Standard licenses must be renewed every 2 years • Additional visits as deemed necessary (in response to complaints, infractions, etc)

Special Education Reviews

The majority of states maintain a monitoring system comprised of cyclical, focused, and targeted reviews for special education programs. With cyclical monitoring states conduct a program review through a desk audit and onsite review on a multi-year (most commonly every five to six years) cycle. This program review is generally compliance oriented, requires submission of student files to be audited, and is designed to assure the fidelity of IDEA implementation. Student file checklists can range from a low of 30 to over 100 compliance indicators to be verified. State officials then conduct onsite reviews to verify, through interviews and further document review, the findings from the documents previously submitted.

This approach has been the standard baseline for state monitoring systems, predating IDEA 2004. However, as states have become more focused on student outcomes and required to report publicly on the student performance indicators, these approaches have changed. Some states have maintained this traditional approach, but many have chosen to move toward focused and targeted monitoring methods instead.

Focused monitoring includes periodic program reviews but focuses the review based on the findings of the desk audit, and/or performance or other data. The review is then focused on particular areas of compliance rather than the full list of program requirements. The National Center for Special Education Accountability Monitoring (NCSEAM) describes focused monitoring as "a process that purposefully selects priority areas to examine for compliance/results while not specifically examining other areas for

[61] http://www.ct.gov/dcf/lib/dcf/policy/pdf/Licensing_PG_amendment.pdf
[62] http://www.dhhs.nh.gov/oos/cclu/faq.htm#visit
[63] http://www.dcyf.ri.gov/docs/dcyf_residential_child_care_regulations.pdf
[64] http://dcf.vermont.gov/sites/dcf/files/FSD/Policies/241.pdf

compliance to maximize resources, emphasize important variables, and increase the probability of improved results."65 In nearly all states using this framework, Focused Monitoring is driven by the performance on some or all of the student performance indicators and other key performance indicators and conducted annually. Many states also have Targeted Monitoring reviews, which use trend data annually (such as from dispute resolutions, state complaints, etc.) to identify programs that require more in depth analysis and onsite review.

ACCREDITATION

Various other third-party organizations also perform evaluations of residential facilities and special education programs for accreditation. Some states may require programs to be accredited, and accreditation standards are usually more comprehensive than state licensing standards. Accreditation evaluations include on-site visits, record review, and interviews with children and staff. Accreditation associations overwhelmingly look for staff that are sufficient and trained to handle the specific number and needs of the students in the facility, safety of actual physical plant, and assurance that appropriate services are being offered to children, as well as risk and operational strategies that are tailored for the specific features of the facility and the children there. There are numerous organizations that offer accreditation. Three examples are below:

The Council on Accreditation, which is a nonprofit accreditor of human services since 1977, believes specific administration, management, and service standards promote sound operations and management. These standards include building healthy, supportive relationships with personnel, program activities that provide opportunities to experience a sense of self-efficacy and belonging, safe indoor and outdoor environments, and sports/fitness programs. The standards also speak to connections with families and community involvement, appropriate supervision, and personnel that respond to the needs of children with behavioral needs appropriately[66].

(NCASES) provides an accreditation process for private special education providers. For an organization to achieve accreditation status with (NCASES), standards include requirements for educational program staff, clinical staff, and residential staff meeting regularly to review their clients' treatment plans for compatibility, as well as educational and residential programs collaboration to address the extracurricular needs of clients/students.

The Joint Commission also has certain standards for accreditation. These standards include ensuring that the facility has a framework for organizational structure and management, strengthens community confidence in the quality and safety of care, treatment and services, and is recognized by state authorities as fulfilling regulatory requirements67. The Joint Commission also looks for risk management strategies and customized processes of review grounded in the mission of the facility. Other features

[65] Connecticut's System of General Supervision and Focused Monitoring for Continuous Improvement for Students with Disabilities Manual, 2006

[66] "Council on Accreditation after School and Youth Development -Definition", http://coanet.org/standard/cyd-ayd/.

[67] "The Joint Commission Behavioral Health Care Accreditation," https://www.jointcommission.org/assets/1/18/BHC_Toolkit.pdf, 2007.

taken into account are staff-level interaction, and policies and procedures as needed to determine whether a residential facility is fit.

Incident Reports and Investigations

All states have reporting requirements related to allegations of abuse or neglect and many states also have reporting requirements related to restraints/seclusions or other incidents.

- **Abuse/neglect allegations** -definitions of abuse and neglect are governed by federal and state law. At residential schools, events such as medication errors, runaways, or injuries incurred during a restraint/seclusion may need to be reported. Many states have special investigation units that investigate institutional abuse/neglect allegations. Whether or not the allegation meets the threshold for substantiated abuse or neglect, the investigating entity may make recommendations for corrective actions, which should then be factored into program oversight mechanisms and licensing reviews. Investigations may also trigger an immediate review by licensing authorities as well as contracting entities.

- **Restraints/Seclusions** – many states now require facilities to report occurrences of restraint/seclusion. The purpose of the data collection is largely to conduct reviews so that restraints can be minimized in the future. As of 2013, 17 states, including Florida, Texas, Connecticut, and California, collect minimal state level data on restraint/seclusion use each year. 28 states require that data be kept at the state, local, or school level[68]. Reports often include information about the name of the student, events that directly preceded the restraint including other attempted de-escalation techniques, type of restraint, duration of restraint, condition of child following restraint including any injuries incurred, names of staff who conducted the restraint and witnessed the restraint, and who was notified.

- **Incidents** – in addition to events that meet the criteria above, programs are also often required to report other kinds of incidents to the state. These may include psychiatric hospitalizations, client arrests, and minor accidental injuries.

Given the nature of the services provided at residential schools, some degree of incident occurrence and reporting is expected. Tracking and reviewing the frequency of incidents, severity of incidents, and the degree to which incidents re-occur should offer useful information about the quality and safety of the programs. One limitation is that many state and local agencies may only have access to the information contained within their own data systems, which limits their ability to comprehensively evaluate a program.

Contract/Program Management

In addition to licensing requirements and processes, many states also collect additional data related to provider performance either for the purposes of responding to federal requirements or for managing contracts and services. These efforts tend to focus more on assessing the quality and effectiveness of

[68] "MY STATE'S SECLUSION & RESTRAINT LAWS BRIEF SUMMARIES OF STATE SECLUSION AND RESTRAINT LAWS AND POLICIES," August 4, 2013, http://www.autcom.org/pdf/MyStateRestraintSeclusionLaws.pdf.

services, rather than more strictly on issues of health and safety, which is the focus of licensing. Ideally, the information is used to provide support to providers where needed and to inform purchasing and contracting practices going forward.

The American Association of Children's Residential Centers recommends the framework below for provider performance measures:[69]

- **Practice/Process Indicators** – such as seclusion and restraint, medication management, elopements, incidents and injuries, family inclusion in the milieu, youth participation in treatment, parent contact, access to services and supports, participation of community partners, continuity of care, timeliness and comprehensiveness of diagnostic assessments, and discharge planning; and/or activities/practices sub-grouped by life domains (i.e. emotional, psychological, physical, social, academic, medical, nutritional, legal, spiritual, cultural, vocational).

- **Functional Outcomes** – changes in the child's level of functioning as a result of the treatment intervention, as measured through valid instrumentation and processes. Examples could include restrictiveness of living environment, school performance, legal involvement, peer relationships, and severity of illness.

- **Perception of Care** – response and satisfaction of children, families, and the community regarding the services provided, using surveys or other instruments.

- **Organizational Indicators** – staff retention, job satisfaction, work environment, fiscal performance, safety programs, etc.

The Building Bridges Initiative (BBI), which was originally developed by Dr. Gary Blau, the chief of the child, adolescent and family branch of the federal Substance Abuse and Mental Health Services Administration, also developed a list of suggested provider level performance measures. The mission of the Building Bridges Initiative is "to identify and promote practice and policy initiatives that will create strong and closely coordinated partnerships and collaborations between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes"[70] Provider level performance measures recommended by the BBI are[71]:

- ✓ Average length of stay in residential for discharges
- ✓ Re-admissions to 24-hour level of care 1-year post-discharge
- ✓ Number of restraints/seclusions divided by the number of youth in residential, per year

[69] American Association of Children's Residential Centers, "Redefining Residential: Performance Indicators and Outcomes", October 2007, http://togetherthevoice.org/sites/default/files/paper_4_final_acrc.pdf

[70]The National Building Bridges Initiative, Advancing Partnerships. Improving Lives. IARCCA 66th Annual Conference – September 21, 2010 Presented by: Jody Levison-Johnson, LCSW, Vice President, Coordinated Care Services, Inc., Rochester, NY Raquel Hatter, President/CEO, Family & Children's Service, Nashville, TN.

[71]Dougherty, Richard H., Ph.D., and Deborah Strod, M.S.W. "Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures", March 2014. http://www.buildingbridges4youth.org/sites/default/files/BBI%20Building%20Consensus%20on%20Residential%20Measures%20-%20March%202014.pdf.

- ✓ Number of critical incidents per youth per year in residential
- ✓ Percent of admissions and discharges incorporating comparison of a youth's medication orders during and after the residential episode
- ✓ Percent of youth discharged on multiple psychotropic medications
- ✓ Presence or absence of a child and family team
- ✓ Percent of informal supports on child and family team (CFT) where one is used
- ✓ Percent of youth free from child-to-child injuries while enrolled in residential program, annually
- ✓ Percent of discharge type (Reunification or Goals Met, Against Medical Advice, Runaway, Administrative, Planned, Loss of eligibility, Managed Care Denial) for youth discharged from residential services
- ✓ Percent of youth with a post-discharge continuing care plan created and transmitted to a responsible adult in the post-discharge living environment
- ✓ Restrictiveness of Living Environment Score change between Residential environment and discharge destination
- ✓ Post discharge exposure to maltreatment or abuse in the home, in the periods following discharge: as long as follow-up continues but no less than three months

Figure 6: BBI provider level performance metrics- These measures help to identify and promote practices correlated with positive child well-being and outcomes.

The Alliance for Strong Families and Communities also allows member organizations, including residential schools, to participate in a national benchmarking initiative as a way for individual organizations to understand how they are performing relative to their peers, although individual results are anonymous. Metrics for residential services include[72]:

- ✓ Length of Stay (by Program Type),
- ✓ Occupancy Discharge Status,
- ✓ Use of Restraint (Rate/ Injuries by Program Type),
- ✓ Medication Errors (by Program Type),
- ✓ Violence/Aggression Injuries (Male/Female),
- ✓ Violence Aggression Property Damage (Male/Female),
- ✓ Family Preservation,
- ✓ Residential Self Harm (Male/Female),
- ✓ Client Satisfaction (Adult/Youth),
- ✓ Post-Discharge Outcomes (Stability, Productivity, Risky Behavior, Relationships).
- ✓ Staff Retention

[72] "Alliance for Children and Families National Benchmarking Imitative," 2010, https://www.bpsys.org/retail/brochures/Alliance-Brochure2008-09.pdf.

- ✓ Organizational Climate (staff survey)

Figure 7: Alliance for Strong Families and Communities provider level performance metrics. These measures help to identify and promote practices correlated with positive child well-being and outcomes.

STATE EXAMPLE OF PROVIDER PERFORMANCE MEASURES

Kansas

In 2007, Mental Health office at the Kansas Department of Social Rehabilitation contracted with the University of Kansas to develop a state level performance management system, specifically for psychiatric residential treatment facilities (PRTF)[73]. The focus of the initiative was to track and understand performance levels across all of the state's PRTF facilities.

In collaboration with stakeholders, the researchers developed a PRTF program logic model. The program model outlined the inputs and resources of the system, the associated activities and processes expected of those resources, and ultimately the immediate, mid-term, and longer term outcomes that would be anticipated. The program model is illustrated below[74].

[73] PRTFs provide out-of-home residential psychiatric treatment to children and adolescents whose mental health needs cannot be effectively and safely met in a community setting in Kansas. https://www.kdads.ks.gov/commissions/behavioral-health/consumers-and-families/services-and-programs/prtfs

[74] Kapp, Stephen A., MSW, PhD, et al. Building a Performance Information System for Statewide Residential Treatment Services. Kansas Department Social Rehabilitation Services, Division of Disability and Behavioral Health Services. Routledge Taylor & Francis Group. 2011.

Overall Psychiatric Residential Treatment Facilities (PRTF) Kansas Program Model

1.0 Resources	2.0 Staff Activities	3.0 Program Process	4.0 Immediate Outcomes	5.0 Intermediate Outcomes	6.0 Long-Range Outcomes
• Funding Staff - Leadership - Supervisors ▪ Direct Care Workers - Mental Health Professionals - Drug/Alcohol Counselor - Medical Professionals - Activity Coordinator - Teachers - Chaplain - Support Staff • Clients • Facilities • External Community Agencies • Families • Case workers	• Individual therapy • Group therapy • Family therapy • Expressive therapy • Recreational therapy • Crisis intervention • Psychiatric consultation • Medication management • Medical care • Case management • Community activities • Residential care • Education • Clinical supervision • Staff development • Information collection	• Screening, assessment, diagnosis • Treatment team formation • Treatment planning • Activities coordination • Ongoing treatment interventions • Regular treatment plan reviews • Information collection • Transition planning • Discharge	• Successful completion of treatment plan • Restraint and seclusion-free setting • Safe, secure therapeutic environment • Stabilize and modify behavior • Symptom reduction and management • Skill-building and self-regulation • Medication management • Functioning improvement • Substance abuse recovery • Increase self-efficacy • Secure least restrictive placement	• Maintain less restrictive placement • Maintain connection with community services • Continue to maintain healthy behaviors • Continue to practice pro-social skills • Stabilize and maintain work or education • Maintain positive view of self-concept and abilities • Maintain high level of functioning in family, community, and independent living situation	• Successful reintegration into community • Becoming a healthy and productive member of society that makes a positive contribution

Figure 8: Provider logic model- This model indicates specific measures to collect data on in support of positive outcomes for children in placement.

Working from this program model, and additional stakeholder interviews and benchmarking other state systems, the research team developed a series of performance measures for PRTFs in three broad domains: access, process, and outcomes. The measures are listed in the chart below[75].

Domain	Indicators	Measures
Access	Access to services'	Length of time from referral/acceptance to admission Length of time from screening to admission The ratio of acceptance to denial of referrals The reason of denial by agency
	Follow-up care	Percent of parent or caregiver response to consumer satisfaction survey questions about availability and acceptability of services for child/youth
	Follow-up care	Average length of time for clients between discharge and next face-to face visit at community- based services
Process	Youth and caregiver's participation in treatment	Percent of children/youth with caregivers satisfied with participation in treatment
	Treatment plan completion	Percent of children/youth with treatment plan completed at discharge Reasons for non-completion of treatment plan prior to discharge
	Serious occurrence	Total number of serious occurrences • Number of deaths • Number of injuries requiring medical care • Number of suicide attempts
	Use of restraint and seclusion	Percent of change in use of restraint, seclusion per month
	Length of stay	Length of stay by agency
Client status outcome	Clients' satisfaction with services	Percent of caregivers satisfied with services measured by the Ohio scales Percent of child/youth satisfied with services measured by the Ohio scales
	Improvement in clients' functioning and symptom reduction	Two scores over a period of time (at admission and at discharge) in the Problem Severity domain in Ohio Scales Two scores over a period of time (at admission and at discharge) in the Functioning domain in Ohio Scales

[75] Kapp, Stephen A., MSW, PhD, et al. Building a Performance Information System for Statewide Residential Treatment Services. Kansas Department Social Rehabilitation Services, Division of Disability and Behavioral Health Services. Routledge Taylor & Francis Group. 2011.

Domain	Indicators	Measures
	Restrictiveness of living environment	Percent of child/youth whose primary residence was listed at discharge as their own home or foster care in the FY
		Percent of child/youth who maintained the level of care at 90 days after discharge
	Return to PRTF	Percent of readmission to agency within 90 days

Figure 9: Summary of Outcome Domains and Indicators for Kansas Residential Treatment- Outcomes indicate areas where the provider has identified critical areas of data collection.

4. INTER-AGENCY COLLABORATION AND DATA SHARING

While different states use many unique approaches in overseeing residential schools, it does not appear to be common practice for states to share data across agencies, even though in an ideal system, the practices of licensing, contract management, and investigations should all be informing each other. One reason for this may be that in many states, the functions of licensing, investigations, and contract and program management are contained within the same state oversight organization. For example, in the State of Connecticut licensing, children's behavioral health, and child welfare are all housed within the same umbrella organization: the Department of Children and Families (DCF). Therefore, in states like Connecticut, a single state oversight agency (DCF) will only coordinate externally with the local school districts and education authorities when necessary. In states that do practice inter-agency data sharing related to these schools, there is not easily accessible information about their practices, policies, or procedures.

Since there is not substantive information available about inter-agency data sharing specific to oversight of residential schools, we can look at inter-agency collaboration and data management systems more generally to provide guidance, lessons learned, and best practices.

In general, data sharing across agencies can be very challenging due to several factors, including:

- *Federal and State Privacy Laws:* Privacy laws, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) protect individuals' personal, health, and educational information. While these laws are important, they can make it difficult to share individuals' protected information between organizations.

- *Disparate Information Technology Systems:* While many IT systems are designed to interface and share data with other similar systems, systems that use different operating languages or that use different means to exchange data can create difficult conditions for sharing data.

- *Non-standardized Data Language:* In most states, there is no data dictionary, or "common language", across all agencies. For example, what one oversight agency calls an "investigation", another may call a "review". This inconsistency can create barriers to sharing accurate and meaningful data.

- *Inconsistent Policies, Practices, and Procedures:* Different state agencies have policies, practices, and procedures that may contradict those in another state oversight agency. In addition, each state agency may have IT governance, including security and data sharing standards that are

specific and unique to that agency. These conditions can complicate how data can be shared between agencies.

Despite the aforementioned challenges, there are some successful examples of integrated data management systems within human services.

Allegheny County, Pennsylvania

Allegheny County Department of Human Services developed a data warehouse to store information on DHS clients and the services they receive through DHS, as well as services provided through a number of other outside agencies[76]. The warehouse includes data from external sources such as Pennsylvania DHS, Allegheny County and City of Pittsburgh Housing Authorities, local school districts, the County Medical Examiner, and the criminal justice system. External partners send information to be loaded into the warehouse through a special platform that can accept data in different formats and load them into the warehouse. Each client is assigned a unique identifying number so that all client-specific information can be pulled together. The primary purpose of the warehouse is management decision making; from serving individual clients more effectively to understanding the cost/benefit of certain programs, and understanding the effectiveness of programs.

As one specific example of how the data has been used, personnel were able to identify a discrepancy between the number of children identified as homeless by DHS compared to the number of children identified as having a housing crisis by the schools, largely due to different definitions of homelessness that guide DHS and the school districts[77]. Identifying these additional children allowed the state to leverage more funding because state funding is tied to the definition of homelessness used by the schools, and will allow for earlier intervention. According to Allegheny County leaders, key factors in the successful development and implementation of the warehouse included: leadership, investment, and developing trust with partners[78].

Harris County, Texas

Harris County, Texas was struggling with the real-world implications of limited data and information sharing between their juvenile justice agencies, child protective services, and mental healthcare providers. Children "would have to go through the same intake process over and over at different departments, and caseworkers couldn't easily see where else in the system a child had previously been"[79]. This eventually led to the passage of new legislation that clarified the capabilities of information sharing across agencies, specifically to avoid duplications, like repeating assessments or intake interviews every time a child interacted with a new agency. The new system now integrates data across Harris County Child Protective Services; the Juvenile Probation Department; and the State Department of education.

This county work completed in Texas is reflective of a larger effort to understand systems integration as it relates to juvenile justice and its relationship with other child and adolescent service systems. Since 2014, the Juvenile Justice, Geography, Policy Practice & Statistics organization (JJGPS) has been working to understand how states share information and work constructively together when youth interact with

[76] "The DHS Data Warehouse," http://www.alleghenycounty.us/Human-Services/News-Events/Accomplishments/DHS-Data-Warehouse.aspx.
[77] "Improving Educational and Well-Being Outcomes: School–DHS Data Sharing in Allegheny County", Allegheny County Department of Human Services, http://acdhs.barkandbyte.info/wp-content/uploads/2016/06/Improving-Educational-and-Well-Being-Outcomes-8-19-15.pdf, August 2015.
[78] Feldman, Andy. (2016) *How Allegheny County's Data Warehouse is improving human services through integrated data: An interview with Erin Dalton, Allegheny County Department of Human Services – Episode #110.* Gov Innovator web site: http://govinnovator.com/erin_dalton/
[79] http://urbanedge.blogs.rice.edu/2016/08/03/data-sharing-efforts-aim-to-improve-child-welfare-juvenile-justice-outcomes/#.V-UfefkrJQL

multiple agencies. During the winter of 2013-2014, JJGPS interviewed state officials nationwide to define and uncover themes by which states were attempting to share information. Their research identified five best-practices being leveraged by states, including:

- **Data Sharing:** Facilitated through the use of statewide information systems allowing for consistent data between systems. At least five states, including Delaware, New Hampshire, New Mexico, Rhode Island, and Vermont, have a single automated information system hosting child welfare and juvenile Justice data;

- **Committees or advisory groups:** Multidisciplinary groups have a formal status and mission of improving systems integration on behalf of youth in both the child welfare and Juvenile Justice systems, often more common in decentralized states;

- **Formal interagency Memoranda of Understanding (MOUs)**;

- **Informal agency agreements:** Commonly based on historical practice, mutual trust, and recognition of the need to collaborate; and

- **State and/or Court rules:** These rules mandate systems integration efforts, often more common in decentralized states.

The usage of these strategies correlates to the way states organize the capabilities of the integration. For states with centralized administration through a single state-level department, as in the case for seven states below, structural barriers to coordination may be reduced; however, in almost half the states, core elements of major agencies services are decentralized:

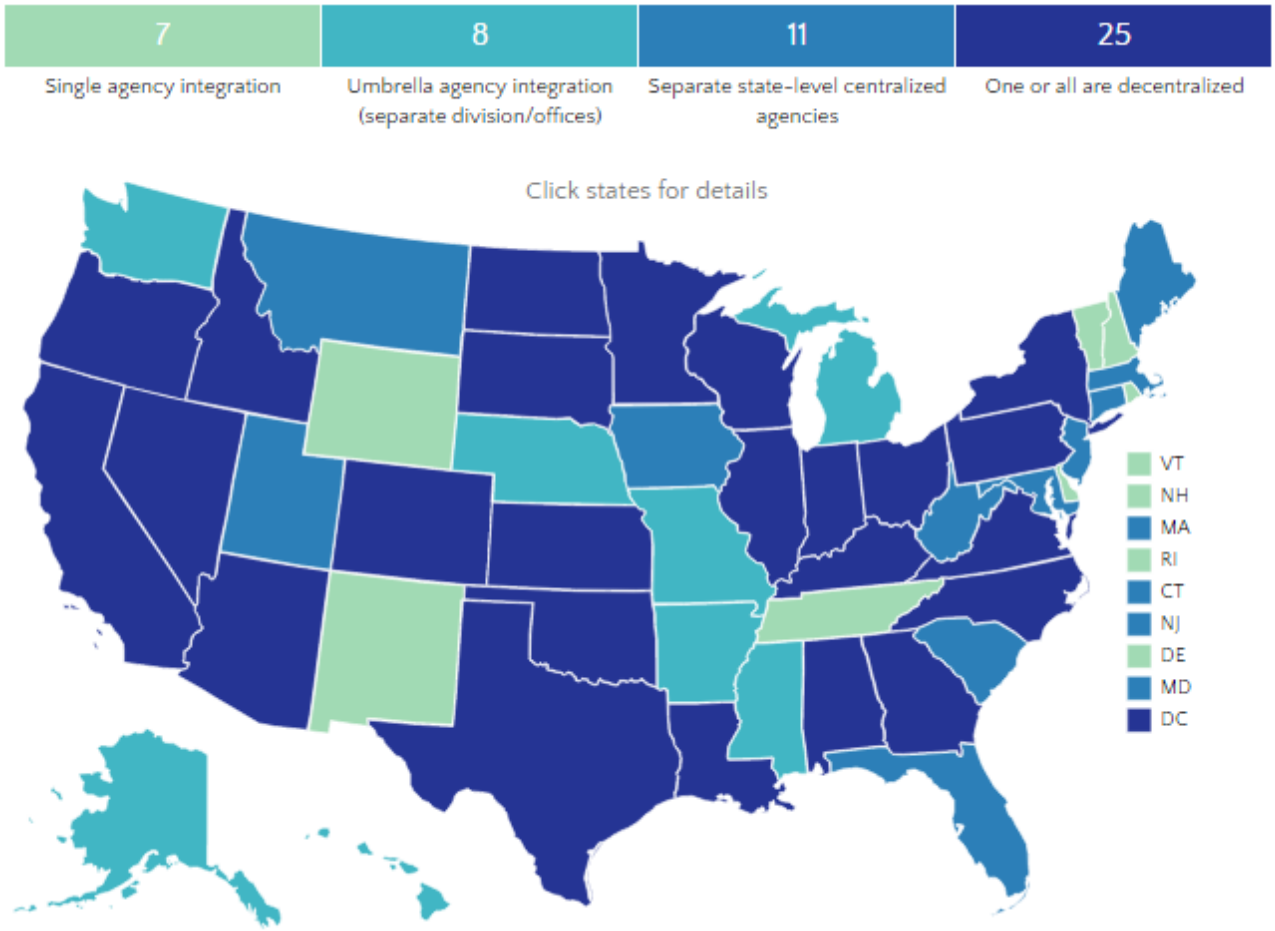


Figure 10: National landscape of states' agency-level integration- 72% of states have some form of decentralized governance, limiting inter-agency data sharing.

Specific to data sharing, there are several key pre-requisites of successful inter-agency collaboration, including:

- Establish a data management and governance structure, including identifying a lead agency or individual[80]
- Complete data definition and clean-up, including inventorying existing data sets, developing a cross-agency data dictionary, and performing automated and manual cleanup
- Develop change management procedures
- Develop business a data dictionary and data model for shared and unique agency processes

[80] DAMA International. *The DAMA Guide to the Data Management Body of Knowledge (DAMA-DMBOK)*, Technics Publications, (Chicago, 2016).

In order for states to develop optimal oversight of residential schools, some inter-agency collaboration and data sharing must occur. According to a study done in 2012 by the GAO on Interagency Collaborative Mechanisms, there are eight key approaches for successful inter-agency collaborations[81]:

- Define and articulate a common outcome;
- Establish mutually reinforcing or joint strategies;
- Identify and address needs by leveraging resources;
- Agree on roles and responsibilities;
- Establish compatible policies, procedures, and other means to operate across agency boundaries;
- Develop mechanisms to monitor, evaluate, and report on results;
- Reinforce agency accountability for collaborative efforts through agency plans and reports; and
- Reinforce individual accountability through performance management systems.

As oversight agencies seek to share data in an accurate, meaningful, and secure way, roles and responsibilities need to be clearly agreed upon between the participating agencies, and there should be a process for making and enforcing decisions. This clarity should be solidified through memoranda of understanding, polices, or other requirements in order to increase the chance that meaningful change and collaboration occurs.

[81] U.S. Government Accountability Office. *Key Considerations for Implementing Interagency Collaborative Mechanisms,* GAO-12-1022 (Washington, DC, 2012), http://www.gao.gov/products/GAO-12-1022.

www.publicconsultinggroup.com