Office of the Child Advocate Annual Report 2009

The Commonwealth of Massachusetts
One Ashburton Place, 5th Floor
Boston, MA 02108
Gail Garinger, The Child Advocate

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE CHILD ADVOCATE
ONE ASHBURTON PLACE, 5TH FLOOR • BOSTON, MA 02108
WWW.MASS.GOV/CHILDADVOCATE
(617) 979-8360 • TOLL FREE: (866) 790-3690 FAX: (617) 979-8379

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GAIL GARINGER
THE CHILD ADVOCATE

June 30, 2010

Dear Governor Patrick, Legislative Leaders, and
Citizens of the Commonwealth:

I am pleased to submit the annual report of the Office of the Child Advocate (OCA) for Calendar Year 2009 covering the activities of our office and offering recommendations for your consideration.

During the past year, the OCA has worked continuously to carry out its legislative mandates set forth in the Child Welfare Law (Chapter 176 of the Acts of 2008). This work has taken place in the context of a child welfare system in transition. The Department of Children and Families (DCF) has implemented a new Integrated Casework Practice Model (ICPM), which includes differential response and a family-strengthening casework approach. The Children's Behavioral Health Initiative (CBHI) has expanded programs providing in-home supports and community-based wraparound services to children with behavioral health needs. Both initiatives focus on keeping families together safely so that fewer children and youth are placed out of their homes in foster care, group homes, or residential facilities.

I believe that the Commonwealth's child welfare system is on the right track as it moves to maintain children safely within their families by focusing on the provision of home- and community-based services. The success of this model, however, depends in part on the availability of a robust and well-coordinated array of services. Though the economy appears to be rebounding, DCF and other child-serving agencies still face significant budget constraints that dramatically restrict their ability to provide services. It will take time to develop family-strengthening services to full capacity in all communities throughout the state and to educate providers and the public about those services. While these services are being developed and directed toward the "front end" of the child welfare system, the needs of children and youth in out-of-home placements are the focus of a lawsuit recently filed by Children's Rights, Inc., a New York-based advocacy group. Our agencies and providers will be challenged with fully implementing the new family strengthening models while directing additional resources to children and youth already in care, and both during a time of economic duress. This work requires all of our state's best efforts to devise solutions that employ existing resources whenever possible.

As we improve our child welfare system, we must always consider the system as a whole, and remain mindful that our first priority is the safety and well-being of our children. Child protection services remain critical to child welfare in the Commonwealth. When fully implemented and

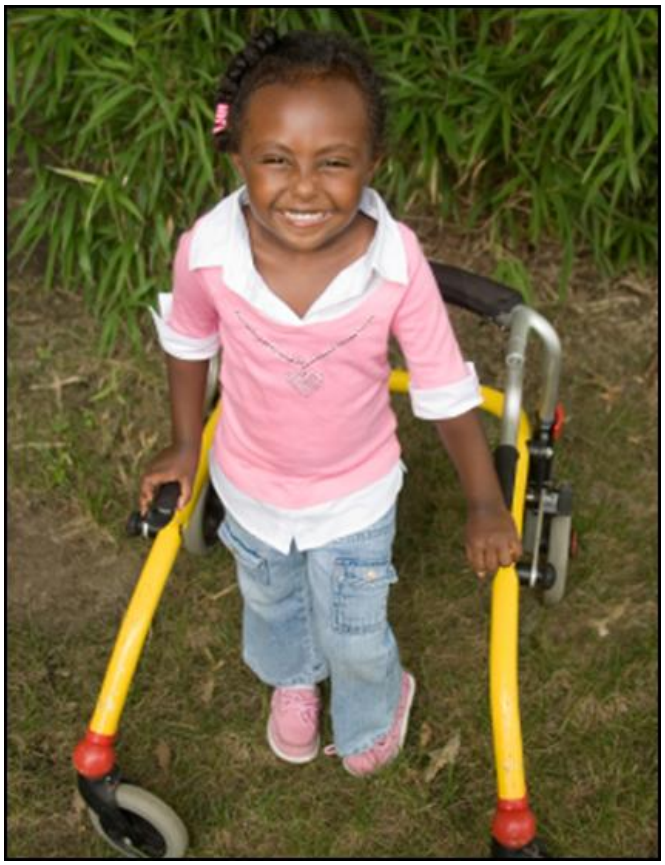
funded, the new casework practice model and home- and community-based services have great potential for reducing the number of children in need of state protection, but even the most comprehensive system of prevention efforts and family supports will not eliminate child abuse and neglect entirely. For these reasons, the OCA will continue to advocate for both prevention of child maltreatment and protection for all Massachusetts infants, children and youth.

This year's report contains a number of discussions and recommendations pertaining to juvenile justice. I am so often saddened to learn of the violent death of another youth in his or her neighborhood. As the OCA reviews fatalities through our critical incident review process and by participation in Child Fatality Review Teams, we are confronted again and again with the question of how to protect our young from the violence that claims so many of their lives.

I want to acknowledge the dedication and hard work of the Governor, legislators, commissioners and managers in executive agencies, and other child welfare and juvenile justice leaders who have devoted their careers to improving the well-being of children and families in the Commonwealth. I am honored to serve as The Child Advocate, and I look forward to working with all of you in the coming year.

Sincerely,

Gail Garinger
The Child Advocate



Office of the Child Advocate

Our Mission is to improve the safety, health and well-being of Massachusetts children by promoting positive change in public policy and practice.

Our Vision is that every child is safe and nurtured in a permanent home and that every family is supported and strengthened within the community.

Our Focus is on at-risk children who are served by the Commonwealth's child welfare and juvenile justice systems.

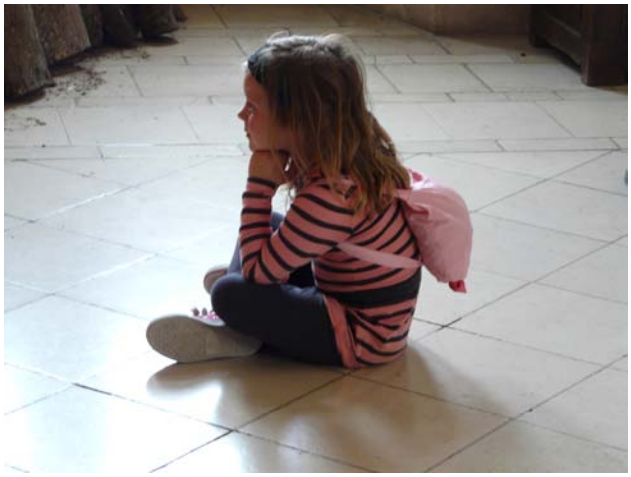
OCA Staff

Gail Garinger
The Child Advocate

Elizabeth Armstrong
Deputy Director

Susan Cummings
Clinical Specialist

Julianna Brody-Fialkin
Program Assistant



2009 Interns:
Johanes Maliza, JD, Harvard Law School '10
Samuel Edandison, BA, Dartmouth College '10
Olivia Grant, Boston Latin School '10
Judith Anne Iglehart, Boston College School of Law '12
Max Iglehart, Benjamin Franklin Institute of Technology '10

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Report of the Office of the Child Advocate for Calendar Year 2009

M.G.L. Chapter 18C, Section 10. The child advocate shall report annually to the governor, the president of the senate, the speaker of the house, the senate and the house committees on ways and means, and the chairs of the joint committee on children, families and persons with disabilities on the activities of the office, including an analysis of activities undertaken to implement subsection (d) of section 5, recommendations for changes in agency procedures which would enable the commonwealth to better provide services to and for children and their families and priorities for implementation of those changes to services. The report shall be made public.

Chapter 18C is included in Appendix A.

Office Administration and Budget

Gail Garinger was appointed by Governor Deval Patrick as the first Child Advocate for the Commonwealth in April 2008. Before her appointment, she served as a juvenile court judge for thirteen years, eight of them as the First Justice of the Middlesex County Division of the Juvenile Court Department. She has also served as General Counsel at Children's Hospital Boston, directed an NIMH-funded research project at The Judge Baker Guidance Center investigating decision-making in the handling of child abuse and neglect cases, and has experience in private practice, specializing in children's health and welfare law and representing providers, parents and children.

The Child Advocate is assisted in her duties by a staff of three employees with collective experience in social work, nursing, law, and human services. Throughout the year, the office was fortunate to have interns from local law schools, colleges, and high schools to help with office activities and specific projects, such as researching competency issues in juvenile delinquency hearings, reviewing Massachusetts law covering emotional abuse and neglect, and examining youth aging out of the care of executive agencies.

The initial appropriation for the OCA for fiscal year 2009 was $300,000, which was reduced by Section 9C adjustments. In fiscal year 2010, the legislature appropriated $244,000 for the OCA in a dedicated line-item. This amount did not fully support the salaries for our 3.5 full-time employees. Additional expenses were absorbed by the Governor's Office. The proposed FY11 budget again appropriates $244,000 for the Office.

OCA Advisory Board

Twenty-three *ex-officio* members, including Secretaries and Commissioners from child-serving agencies and offices, and three governor's appointees sit on the Child Advocate Advisory Board. The appointees include an advocate, a former foster youth, and a grandmother raising her grandchildren. Chaired by The Child Advocate, the Board meets semiannually. OCA staff utilize these meetings to update Board members on their activities and to present on topics such as Guardianships and Kinship Care, and Psychoactive Medications for Children. The Child Advocate will consult with the Board in the creation of the comprehensive plan as described in M.G.L. Chapter 18C, Section 11. Board members are listed in Appendix B and board meeting minutes are posted on the OCA website at www.mass.gov/childadvocatemeetings/meetings.htm.

Activities Mandated by Statute

Complaint Process

In fulfilling Sections 5(c) and (d) of its mandate, the OCA receives complaints regarding child-serving state agencies. The toll-free number, 1-800-970-3690, and designated email address, childadvocate@state.ma.us, facilitate this process. The OCA refers the majority of callers to appropriate resources, such as the involved agency's ombudsperson or quality assurance office, attorneys, or suitable services. Staff direct all complainants to contact the OCA again if the caller is dissatisfied with the agency response or is unable to resolve the complaint directly through the agency. If the OCA staff believe that a child receiving services from a state agency may be in need of assistance, they monitor the matter until it is resolved. The OCA also collects data on these calls to help identify trends, and The Child Advocate uses the reported experiences to inform her systemic and policy work.

The number of complaints has increased steadily over the past year, demonstrating the expanded public awareness of the office. The intake coordinator and clinical specialist respond to complaints from parents and other family members, foster and pre-adoptive families, advocates and attorneys, and children in care or receiving services from the Commonwealth. In calendar year 2009, the Office received 234 complaints regarding executive agencies, compared to 64 complaints received between May 2008, when The Child Advocate took office, and December of 2008. These agencies include the Departments of Children and Families (DCF), Mental Health (DMH), and Transitional Assistance (DTA). The callers also registered complaints regarding elementary and secondary schools, as well as probate and family and juvenile court issues. Many children and youth receiving services from executive agencies are also involved with the courts, and OCA staff field complaints with a perspective that recognizes this involvement. The Child Advocate then addresses identified system problems with liaisons to the juvenile and probate and family courts. Callers most commonly expressed concerns about placement, medical care and education. In order to better respond to concerns about education, staff members consulted with counsel from Massachusetts Advocates for Children and attended a training session offered by the Special Education Surrogate Parent Program.

Through the complaint process, the OCA was contacted when parties in a juvenile court case addressed for the first time whether the 2008 amendment to M.G.L. Chapter 119 to include Section 38A required judicial hearings if a child has been declared brain dead by physicians for children in the custody of DCF. The Child Advocate heard from a number of judges and a state senator concerning this issue, and met with representatives from Children's Hospital Boston, including legal counsel, the director of a critical care unit, an ethicist, and several members of the child protection program, to discuss brain death and the issue of judicial review. Following this work, the OCA developed the position that brain death **is** death under Massachusetts law, and not a condition that requires judicial review of withdrawal of life-sustaining medical treatment under Section 38A, and OCA staff recommended no legislative action to amend Section 38A. The OCA has offered and stands willing to work with Children's Hospital Boston to convene an educational forum with pediatric critical care specialists and ethicists around this issue, if legislators or judges would find it useful. This is one example of how the complaint process leads to policy development by the OCA in child welfare and juvenile justice.

Institutional 51As and 51Bs
Pursuant to M.G.L. Chapter 119, Section 51B, the OCA receives from DCF copies of substantiated reports and investigations that relate to abuse and neglect occurring in institutional settings, including licensed facilities such as residential programs, foster care, day care, public and private schools and after school programs. The child-serving agencies involved in these reports include DCF and the Departments of Youth Services (DYS), Early Education and Care (DEEC), and Elementary and Secondary Education (DESE). OCA staff identified categories of maltreatment most commonly occurring in institutional settings, including lack of supervision, improper use of restraints, physical abuse, sexual abuse including inappropriate personal boundaries on the part of caretakers, and neglect and emotional maltreatment. These issues may occur in different settings. For example, inadequate supervision by staff may occur in a child care program, resulting in a child being left behind on a playground, or in a residential program, resulting in a youth being assaulted by another youth.

Initially, the OCA received a substantial quantity of reports, and many hours were required to review these reports, summarize them, and log them into a database. With the help of two volunteers, the OCA is now current in this process. After processing each report, staff determine whether any further action is required; in appropriate cases, staff contact an agency or program to inquire about actions taken after the date of the report. Reviewing and categorizing the substantiated institutional 51B reports has allowed the OCA to identify systemic problems that exist in out-of-home care. Recognition of these issues assists the OCA in formulating its view of the child welfare system and in making policy recommendations.

Critical Incident Reports
Pursuant to M.G.L. Chapter 18C, Section 5 (a) and (b), agencies under the Executive Offices of Health and Human Services (EOHHS) and Education (EOE) report to the OCA when a child receiving services dies or is seriously injured. These are called critical incident reports. Staff carefully review each report and the involved agency's response, and when indicated, follow up to confirm that the agency took appropriate steps and provided suitable services to families.

The OCA received 116 critical incident reports between January and December 2009 from 16 state agencies and offices. DCF filed 36% of the reports, 23% came from DYS, and DMH and DTA filed 14% and 12% respectively. The remaining 25% were submitted by other agencies, such as DEEC, DESE, and the Department of Developmental Services (DDS). In addition to fatalities, reports documented medical emergencies, child maltreatment by biological and foster parents and at residential facilities, and youth violence in the community.

Twenty-seven of the critical incident reports submitted to the OCA during calendar year 2009 involved the death of a child. In the event of a fatality, the OCA communicated with the involved agency to gather further information. If the agency conducted an investigation that generated a written report, the OCA requested and reviewed the report. In certain instances, the OCA contacted providers to ascertain what actions they had taken to address problems. In one instance, OCA staff filed motions and appeared in juvenile court in order to obtain court records for review.

Medically-related deaths accounted for ten of the critical incident reports pertaining to deaths. In many of these situations, the families' involvement with state agencies revolved around the chronic medical conditions of the children. Other deaths involved issues of abuse or neglect intertwined

with medical disabilities. For example, the OCA received a critical incident report regarding the physical abuse of a three-month old with a pre-existing medical condition. Six months later, the OCA received a second report on this child's death after many surgeries and medical complications.

Four critical incident reports involved unexplained infant deaths. Of these, two infants died from Sudden and Unexplained Infant and Toddler Death Syndrome, commonly referred to as SIDS. The two other infants died suddenly and unexpectedly, one from a virus, and another whose cause of death has not been determined yet.

Reports also included the following: A toddler, age two, died after falling from a second story window. A 15-year old receiving mental health services from DCF committed suicide unexpectedly. At the end of June, a one-year old with no prior involvement with DCF died from an abusive head trauma; the hospital filed a report of abuse or neglect with DCF who alerted the OCA by filing a critical incident report.

Six critical incident reports pertained to the violent deaths in their communities of state agency-involved youth. Four of these youth were involved with DYS. All four of these young men died in violent altercations in their communities after being released on conditional liberty by DYS. Three of these four teens were engaging in services and had returned to school at the time of their deaths. The other two reports regarded a 17-year old girl with an active Child In Need of Services (CHINS) case, and a young woman who had just turned 18 whose CHINS case had just been closed. Both were murdered after they had run away from their parents or placements. The OCA is extremely concerned about the number of fatalities and serious injuries caused by violence and suffered by youth of color in their communities.

The OCA learned of three cases in which child fatalities were caused by serious physical abuse in the home, and in which the families were receiving state agency services:

- In March, an 18-month old was brought to the Emergency Department with flu-like symptoms. She died from internal injuries and abusive head trauma, and her mother's boyfriend was charged with murder.
- Two reports involved school-age girls dying from knife wounds inflicted while in the care of their parents. In each case, the parent had mental health issues and the local District Attorney brought homicide charges against the parent.

The final critical incident report pertained to a teen suicide cluster in Barnstable County. Two suicides within one month brought to light five more that had occurred over the past two years, and several more teens committed suicide after the critical incident report was filed. None of these teens had been involved with executive agencies. DPH and DMH partnered with local school and law enforcement personnel to provide outreach and suicide prevention efforts to the community. The OCA applauds this proactive interagency response and encourages similar endeavors in the future.

The OCA continues to work with state agencies, EOHHS, and the Executive Office of Education (EOE) to develop the best method to monitor critical incidents that will lead to the identification of systemic concerns and improve services to children, youth and families.

Comprehensive Plan
M.G.L. Chapter 18C, Section 11, requires that "The child advocate, in consultation with the advisory board and the interagency child welfare task force…shall formulate a comprehensive plan, with periodic benchmarks and cost estimates, to recommend a coordinated, system-wide response to child abuse and neglect, including related mental health, substance abuse, and domestic violence issues." The Child Advocate has met with the interagency child welfare task force on two occasions, and work on the comprehensive plan is in progress. In April 2010 OCA staff learned that several interns would work in the office over the summer, including two law students, and a determination was made that the quality of the plan could be enhanced by taking additional time with additional staff resources in the summer months. Accordingly, The Child Advocate advised Governor Patrick and the legislature of her intention to file the comprehensive plan on September 1, 2010, rather than June 30, 2010.

Outreach
The Child Advocate "shall undertake activities designed to educate the public regarding the services of the office and of the mission of the executive agencies in providing services to children and families." M.G.L. Ch. 18C, Sec. 5(g). Throughout the year, The Child Advocate and her staff attended and presented at meetings and conferences across the state with various stakeholders. Of note over the past year, The Child Advocate presented to classes at Western New England College, Suffolk Law School, and Harvard Law School. She spoke at conferences hosted by support groups, such as Parents Helping Parents; funders like United Way, Casey Foundation, and the Blue Cross/Blue Shield Foundation; and legal services and other bar organizations like Massachusetts Continuing Legal Education, Inc., the Boston Bar Association, and the Massachusetts Association of Women Lawyers. She also addressed attendees at conferences hosted by state agencies, such as the Department of Youth Services – Annie E. Casey Foundation Juvenile Detention Alternatives Initiative Statewide Conference in September. Other staff members presented information related to kinship guardianships at a national conference and at the Grandparents Raising Grandchildren Commission.

The OCA serves as a bridge between the state child-serving agencies, the legislature, and outside stakeholders, including advocacy groups, unions, service providers, and consumers. The Child Advocate meets often with individuals across the state involved with the child welfare and juvenile justice systems. Interest groups, such as parent support groups and attorneys, communicate their experiences with state agencies and their needs and suggestions to improve services for youth. In her attempt to ensure adequate medical oversight for children receiving services from the state, The Child Advocate has met with hospital-based child protection teams and other healthcare professionals and has coordinated with agencies to facilitate collaboration. As a former juvenile court justice, she is aware of the need for members of executive agencies and the courts to learn about one another's work directed at children and families. Through outreach to advocates, consumers, and children, The Child Advocate expands the public's knowledge of the office, while receiving from stakeholders suggestions for improvements in the child welfare and juvenile justice systems.

The OCA continued to reach out to agency-involved youth in 2009. Staff visited residential programs operated by DYS and spoke to youth about their experiences there. They presented to youth at a DMH-affiliated program for transition-age youth and participated in meetings for young adults needing services. The Child Advocate helped facilitate the Restraints and Seclusion Youth Policy Conference, which was the first in a series led by DMH. The OCA collaborated with state

agencies, advocacy groups, and other stakeholders to distribute the OCA Youth in Care Outreach Cards. Working with the Committee for Public Counsel Services (CPCS), the OCA provided cards to children's counsels across the state to dispense to their clients. Massachusetts Continuing Legal Education, Inc. supplied the cards at their 11th Annual Juvenile Delinquency and Child Welfare Law Conference in May. And OCA staff were able to circulate cards through their attendance at meetings and conferences, such as the Kids in Crisis: Courts, Corrections & Confinement conference at Suffolk Law School. Through these efforts, the OCA hopes to not only inform youth of resources and their rights, but also to ensure that they and other stakeholders learn about the OCA and the assistance OCA staff may be able to provide.

Additional Activities of the OCA

Child Fatality Review Team

The statewide child fatality review team was created by legislation in 2000 with the goal of decreasing the occurrence of preventable childhood deaths and injuries. The state team was directed to develop an understanding of the causes and incidence of childhood death and advise the governor, the legislature, and the public by recommending changes in law, policy, and practice to decrease child death. The state team is chaired by the Office of the Chief Medical Examiner (OCME) and advises eleven local teams, constituted within each of the elected district attorneys' offices. The local teams gather records and information and conduct reviews of individual cases, and submit recommendations to the state team.

The OCA participates in the state team as an *ex officio* member. During the last year, representatives from the Department of Public Health (DPH) partnered with OCME to provide leadership for the state team. The state team has met bimonthly rather than quarterly, and two working groups have provided guidance for enhanced communication between the state and local teams. The OCA convened one of these working groups and visited the local teams in Suffolk, Essex, Norfolk, Middlesex, and Hampden Counties during the last year.

The OCA receives reports of critical incidents from executive agencies, described in the previous section, which include reports of fatalities of children in the custody of or receiving services from EOHHS or one of its constituent agencies. Some child fatalities meet the definition of a critical incident and are also reviewed by local child fatality review teams. In those circumstances, the OCA seeks to attend the local team meetings in order to participate in the review of those fatalities. The case review, multi-disciplinary representation, and discussion provide critical information to the OCA's understanding of the circumstances surrounding each child's death, as well as the OCA's consideration of policy.

The OCA will continue to work with DPH, OCME, and other stakeholders to improve the consistency and engagement of the state child fatality review team**.** Child fatality review is, at its core, a public health function which is enabled by the multi-disciplinary membership of the teams. Massachusetts is fortunate to have interested and committed leadership coming from DPH, OCME, and most of the District Attorneys' Offices for this important work. As a long-term strategy, sustainable funding options for both the state and local teams need to be explored, as the Commonwealth's child fatality review program cannot develop and mature without assistance or resources.

Committees and Hearings
The Child Advocate sits as an *ex officio* member on many boards and councils, including the Governor's Child and Youth Readiness Cabinet, the Child Abuse Prevention Board (usually referred to as the Children's Trust Fund), the Children's Behavioral Health Advisory Council, the Department of Elementary and Secondary Education (DESE) Task Force on Behavioral Health and the Public Schools, and the Shaken Baby Prevention Initiative. Staff also attend meetings of the Juvenile Justice Advisory Committee, the Juvenile Detention Alternatives Initiative, the Massachusetts Interagency Restraint and Seclusion Prevention Initiative, the Governor's Council on Sexual and Domestic Violence, the Professional Advisory Committee for Child and Adolescent Services, and other interagency projects. Involvement with these groups helps to inform and educate staff, so that the OCA can act as a clearinghouse for child welfare and juvenile justice policy. As OCA staff attend these meetings, they are always looking for ways to share information and synchronize policy concerning child welfare and juvenile justice. During the last year, The Child Advocate focused especially on implementation of services and the interface between the Children's Behavioral Health Initiative (CBHI) and DCF's Integrated Casework Practice Model (ICPM). Recently The Child Advocate participated in the Governor's Human Services Summit and will be part of the Summit's working group focusing on integrating service plans for children involved with multiple state agencies.

Legislation and Regulation
The OCA often is asked to review proposed legislation on topics such as school bullying, the use of aversion therapy, and the CHINS system. The Child Advocate also reviews proposed regulatory changes published for comment by state agencies, with special attention to those promulgated by DCF. She appreciates the opportunity to learn about new initiatives and to evaluate these legislative and regulatory changes with a view toward trauma-informed care and interagency collaboration.

- **Adam Walsh Act/Sexual Offender Registration and Notification Act (SORNA)**

The Child Advocate participates in the Adam Walsh Act/SORNA Working Group convened by Representative Kay Khan, Co-Chair of the Committee on Children, Families and Persons with Disabilities, and attended by public and private stakeholders. This group examines how Massachusetts can achieve "substantial implementation" of the federal Adam Walsh Act and thereby receive federal funds for numerous programs, while maintaining the balance between public safety, concerns related to successful rehabilitation and confidentiality, and existing state statutes. The Child Advocate is especially concerned with how juveniles are treated under the Act and is actively involved with the Working Group in addressing problematic provisions. The Child Advocate also reviewed H2239, An Act Relative to the Creation of a Sex Offender Management Board. This bill would create a Sex Offender Management Board that would seek to introduce evidence-based standardized procedures for the risk assessment, identification, and methods of treatment of sex offenders.

- **Children In Need of Services (CHINS)**

The Child Advocate has been active with ongoing efforts regarding reforming the CHINS system. She has reviewed the recommendations of prior task force reports, reviewed Senate Bill 68 and House Bill 1278, An Act Regarding Families and Children Engaged in Services, and participated in meetings with stakeholders regarding these bills, including a group convened by Senator Karen Spilka.

- **DCF Transition-Age Youth**

The Child Advocate has reviewed and participated in meetings regarding Senate Bill 40, An Act Concerning Foster Youth Who Remain in the Care of the Department of Children and Families after They Attain Eighteen Years of Age. She is a member of a group working to examine the implementation of task force recommendations stemming from the November 2008 report, *Preparing Our Kids for Education, Work and Life: A Report of the Task Force on Youth Aging out of DSS Care.* The OCA continues to work with DCF, providers, and advocates to assure ongoing support for transition-age youth, and encourages funding at both state and federal levels to provide services for this vulnerable population.

- **Data Collection**

The Child Advocate has met with juvenile justice stakeholders to examine how data collection and analysis can be improved. In addition to the merits of using evidence to inform policy, Massachusetts must meet federal requirements to collect and disseminate data in order to comply with federal funding requirements. The Child Advocate has reviewed Senate 940, An Act to Improve Juvenile Justice Data Collection, and has advocated that MassCourts, the new software being phased into the courts, be designed to capture data that will meet federal requirements.

Kin Raising Kin

The OCA hears from many grandparents and other relatives who have taken on the role of caregiver for children in their families, whether close, extended or "fictive" (connected emotionally rather than by blood or marriage). These are kin caregivers, and the amount of information they need to navigate necessary legal, medical, educational, and financial considerations is daunting. During the last year, the OCA staff fielded calls through our complaint process and addressed the needs of kin caregivers for information on obtaining financial assistance such as grantee relative benefits through DTA, information about educational rights for alternative school placement, and information about their role in Care and Protection cases as kin foster placements, to name a few examples. In addition, staff attended support groups for grandparents raising grandchildren in Weymouth, Plymouth, and Jamaica Plain, as well as focus sessions of the Grandparents Raising Grandchildren Listening and Learning Tour. Staff presented information regarding the informational needs of kin caregivers to the Commission on the Status of Grandparents Raising Grandchildren (Commission), and also participated in a presentation at the annual meeting of the National Association of Children's Counsel. The OCA collaborated with the Executive Office of Elder Affairs (EOEA), EOHHS, DCF, and the Commission to produce A Resource Guide for Massachusetts' Grandparents Raising Their Grandchildren, 4th edition, found at: www.mass.gov/Eelders/docs/caregiver/grandparents_raising_grandchildren.pdf. The OCA will continue to work with advocates, agencies, and court administration personnel to address the needs of kin caregivers for information and support.

Online Mandated Reporter Training

In the 2008 Annual Report, the OCA described the statutory requirement and need for mandated reporter training and suggested that online training presented advantages worthy of consideration. Massachusetts law requires persons who come in contact with children while fulfilling their professional responsibilities to report to DCF cases of suspected child abuse or neglect. The Child Welfare Law of 2008 added a requirement, effective January 1, 2010, that all mandated reporters who are professionally licensed by the Commonwealth complete training to recognize and report suspected child abuse or neglect. The law does not specify which, if any, state entity is responsible for

conducting the training program, nor does it provide funding to support this new activity. M.G.L. Ch. 119, Sec. 51A. No standardized curriculum has been agreed upon by all interested agencies and offices.

Following the January 2010 implementation date, the OCA conducted an informal telephone survey of licensing organizations within the state. Staff learned that none of the organizations contacted had begun training mandated reporters, although DPH was developing a curriculum for emergency medical technicians. DCF area offices and the District Attorneys continued to provide in-person training when requested or when a need was identified.

The development of a professional online training tool will require the investment of resources beyond those currently available within EOHHS and DCF. In an effort to address the mandate of implementing a universally available mandated reporter training program, DCF and University of Massachusetts leaders met to determine the feasibility of a web-based mandated reporter system funded through user fees. After consideration and analysis, the proposal was determined not to be fiscally viable. Recently, EOHHS has begun to plan for a pilot online mandated reporter training (OMRT), developed by its human resources training office and based on DCF's mandated reporter training curriculum. This training will be available through EOHHS's intranet for use by EOHHS staff exclusively. Successful implementation of this strategy will provide an opportunity to determine the actual cost of providing online training to a larger audience. The OCA hopes that the pilot will provide an opportunity to document the need for additional financial investment to fulfill this legislative mandate.

The Middlesex Children's Advocacy Center (CAC) established an online mandated reporter training program in April 2010. Although the OCA applauds the initiative shown by the Middlesex CAC, the program does not satisfy the need for a training that presents standardized curriculum for mandated reporters throughout the state. The OCA continues to advocate for a standardized online mandated reporter training, and envisions a system in which an EOHHS-approved curriculum is developed in conjunction with other stakeholders. Mandated reporters should have the opportunity to learn the basic principles involved with reporting suspected abuse and neglect through a free or low-cost OMRT. Additional specialized training within a discipline could then be offered by specific licensing bodies, continuing education foundations, agencies, or other groups.

The need for a standardized curriculum is illustrated by concerns brought to the OCA by advocates, agency representatives, and physicians around the issue of mandatory reporting of consensual sex between minors. School nurses and physicians in the community learn that minors younger than sixteen are engaged in sexual relations when they request health counseling on topics such as contraception. Some personnel from the law enforcement community believe that nurses and doctors must then report these sexual relations to DCF as child abuse, and they teach this course of action in trainings they conduct on mandated reporting. DCF, for its part, will screen out any report that does not involve a caretaker, but will send a copy of the report to law enforcement. Thus this view of the reporting requirements acts to keep law enforcement apprised of the sexual activities of minors through an indirect route, enabling them to conduct their own evaluation of whether the matter merits further investigation by law enforcement.

The Child Advocate, most members of the child welfare community, and many from law enforcement take a different view of the reporting requirement. Any sexual relations between a caretaker

and a minor must always be reported to DCF as child abuse. If a mandated reporter is concerned that a non-caregiver adult, or other minor child, has been involved in a coercive sexual relationship with a minor child, the situation should be reported to the police for investigation and appropriate action. Requiring that mandated reporters file a 51A report of abuse or neglect automatically in every instance of a 15-year-old looking for contraception, however, would discourage minors from seeking health care and serves no countervailing purpose. The OCA has spent considerable time discussing this issue with stakeholders, and endorses the view that minors must be able to seek health counseling about sexual relations without fearing that a 51A report will be filed automatically. We reiterate that if anything about the circumstances triggers concern from the health professional or other mandated reporter, she must evaluate the facts and use her best judgment to decide whether to report to DCF or law enforcement. Difficult issues such as this, on which reasonable people can disagree, illustrate the need for a consistent approach and standardized curriculum for mandated reporter training.

Prevention Initiatives and the Children's Trust Fund

Since 1988 the Children's Trust Fund (CTF), a public-private partnership, has led the state's efforts to prevent child abuse and neglect. The Child Advocate is a member of the CTF Advisory Board, and in 2009 also participated in the Shaken Baby Prevention Initiative Advisory Board. In addition to CTF activities, OCA staff spoke at the Middlesex County Shaken Baby Syndrome Prevention Initiative and worked with DPH and other child fatality review team members around prevention efforts like infant safe sleep environment and window safety. In addition to these specific initiatives aimed at prevention, the broader goal of strengthening families has been infused in the work of CTF and the child-serving agencies. Family strengthening values include promoting social connections and resilience in parents and educating them about child development and parenting skills, as well as providing concrete help in difficult times. The OCA believes that prevention is critically important in ensuring the safety and well-being of Massachusetts children, and that programs aimed at prevention should be available in all communities to all families who will benefit from them. However, at present only 38% of qualifying new mothers or fathers applying for a home visitor under the CTF Healthy Families program can be accommodated. Efforts aimed at supporting families with children ages zero to three are especially crucial, given that infants and very young children experience rapid brain development as they are forming attachments to their caregivers. These coincidental developments result in building a neurological foundation for relationships for the remainder of a person's life. DPH received two Substance Abuse and Mental Health Service Administration (SAMHSA) grants to develop programs for promotion of well-being in very young children last year, and The Child Advocate serves on the steering committee for coordination of these grants.

Expert Consultation in the Investigation of Child Abuse

Based on the OCA's review of complaints and critical incident reports and its discussions with health care providers and other stakeholders, OCA staff believe that it is important to strengthen the availability of specialized medical expertise to DCF staff in the investigation of child abuse. It is critical that a coordinated system be in place across the state so that DCF staff can readily obtain expert medical consultation during initial screening of 51A reports, and during initial assessments or investigations.

In recent years DCF has attempted to hire a physician medical director who could oversee the development of a comprehensive system for accessing specialized medical consultation and for

delivering healthcare to DCF-involved children; however this effort has been unsuccessful. The DCF Health and Medical Services Team presently consists of a nurse director, six regional nurses, two part-time nurses based at Children's Hospital Boston, and a medical social worker. While this Team provides valuable educational and consultative services, the Team is not part of a comprehensive system with identified protocols for DCF staff to access child abuse and neglect experts.

To address these concerns, the OCA has begun coordinating with hospital-based child protection teams and other medical professionals in the child welfare field. There have been offers from professionals across the state to collaborate with DCF, and the OCA will continue to assist in establishing these relationships. Recently a medical services focus group was convened by DCF, and the OCA looks forward to participating in the work of that group as it progresses.

Psychoactive Medication and the "Rogers" Process

Across the nation, advocates for children are concerned about the use of psychoactive medication to treat behavioral health issues in children. This issue was brought home to Massachusetts when a young child died from an overdose of multiple psychoactive medications in 2006. In examining the issue of psychoactive medication, and particularly the prescription of psychoactive medication for children in DCF custody, one must think about the quality of the treatment itself as well as the process for obtaining informed consent from parents or from someone standing in the place of a parent.

The OCA attends meetings of a working group convened by medical leadership from MassHealth and DMH, aimed at defining and gathering relevant data to be used to develop methods to monitor and support practice in psychopharmacology for children. The working group plans to develop strategies to promote comprehensive care consistent with best practices. The work of this group is directed at all children covered by MassHealth, not only those in DCF custody.

A second working group is directed toward considering the issue of informed consents for the use of psychoactive medications for children in DCF custody. DCF has taken the position that treatment with certain psychoactive medications, antipsychotics, is tantamount to extraordinary medical treatment, and that DCF social workers cannot give consent to this treatment. Instead, consent is sought from a judge in the court where the child's custody was transferred to DCF. The juvenile court judge appoints a guardian *ad litem*, known as a "Rogers monitor," to collect information, review medical records, conduct interviews, and recommend to the court whether the child's treatment plan should include the prescribed antipsychotic medication. The term "Rogers" is derived from the name of an opinion establishing the process of judicial consent for antipsychotic medication among adults not able to consent themselves. This process is time-consuming for everyone involved, and feedback about its effectiveness is mixed. The Rogers working group is aimed at examining the efficacy of the Rogers process for giving informed consent for antipsychotic medication for children in DCF custody. An additional problem with the current Rogers protocol is that the list of medications for which judicial consent must be obtained is outdated.

The OCA strongly encourages continued support for these two working groups so that best practices are in place both for prescription of psychoactive medications and for obtaining informed consent on behalf of children in DCF custody.

Restraints and Seclusion

During 2009, the Commonwealth acted to reduce the use of restraints and seclusion in schools, programs, and residential facilities, including those under contract with the state. Aggregate data provided by DEEC suggests an 11% decrease in restraint episodes, from 65,150 episodes in Fiscal Year 2008 to 58,781 episodes in Fiscal Year 2009. This data likely was affected by a failure to report data by 20% of the programs and residential schools, as well as other factors; nevertheless, leaders in the movement to reduce restraint incidents are cautiously optimistic.

The Child Advocate attended an executive leadership forum for 225 residential treatment providers held in May 2009, which served both to galvanize the direction and commitment of five youth-serving state agencies – DMH, DCF, DYS, DEEC, and DESE – and as a notice to the residential providers and public school settings that the 'practice as usual' attitude toward the use of restraints and seclusion was no longer acceptable in Massachusetts. As a result, the state established the Interagency Restraint and Seclusion Prevention Initiative, co-chaired by DMH and DCF. DDS also joined the Initiative and conversations are underway with other state agencies interested in joining. The OCA is pleased to participate in the 45-member Steering Committee, which has broad representation from multiple constituencies, including youth, parents, advocates, provider leadership and state agency staff. The Initiative has established three subcommittees, focusing on training and support, policy and regulations, and data analysis and reporting practices. Over the year, the group issued a comprehensive charter to guide the work of the respective subcommittees, which can be found at: http://www.mass.gov/Eeohhs2/docs/dss/irsp_initiative_charter.pdf. The charter establishes a broad goal for the agencies to work "in partnership with providers, advocates, educators, schools, families and youth, to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing, in particular the use of restraint and seclusion." The charter also identifies the vision, structure, phases of activities, and explicit tasks for the first phase and year of implementation.

The Department of Mental Health has been a leader in restraint reduction in the Commonwealth for the past decade, and DMH has continued its dedicated initiative and doubled its training schedule to accommodate new interest demonstrated by the human service providers and public schools. DMH focused specifically on the inclusion of youth voices and on fostering youth empowerment in this movement. The Child Advocate participated in this six-month process, meeting with youth who had experienced restraints and seclusion in hospitals, residential programs, schools, and juvenile justice centers. This series led to the development of a youth position statement (see Appendix C), the first of its kind in the country and a model other states are beginning to employ. The statement captures direct quotes and offers suggestion for alternatives to restraints or seclusion and values for programs to embrace to prevent harmful procedures.

As OCA staff review institutional 51A and 51B reports concerning abuse and neglect in out-of-home settings, they continue to see injuries from restraints that are not employed as a last resort, but are used as contingent behavior management. Every restraint is a nonconsensual traumatic incident to the child and is potentially physically and emotionally harmful to the child, other children, and staff. Knowing this, the OCA is concerned about the continuing use of restraints and seclusion, but is encouraged by the cooperation and energy devoted to restraint and seclusion reduction by the child-serving agencies.

Use of Aversives at Judge Rotenberg Center

The Judge Rotenberg Educational Center (JRC) is a special needs school in Massachusetts for severely emotionally disturbed students. The population includes children as young as three years old through adults from Massachusetts and nearby states, with conduct, behavioral, emotional and/or psychiatric problems and developmentally delayed students with behaviors that fall on the autism spectrum. As part of its overall approach, JRC uses aversion therapy, the most controversial of which is the use of electric shock through the Graduated Electronic Device (GED). Children are fitted with backpacks with control units that can be activated by JRC staff at any time to administer a shock to the surface of the skin. In 2008, the Boston Globe reported that the use of electric shock at JRC has long been condemned by many as cruel and barbaric and continues to provoke considerable controversy. Wen, P. (2008-01-17).

The JRC website indicates that aversives are used only with parental approval and individualized authorization from a Massachusetts probate and family court judge after other positive and educational procedures have failed to produce desired outcomes. However, once authorization is given by the court for a resident to receive shock therapy, there appears to be considerable latitude afforded JRC staff as to when, why, and how frequently shock can be administered to a particular individual, and abuses have been cited.

Since 2008, The OCA has participated in a cross-secretariat administrative review of JRC programs and compliance with Massachusetts agency requirements. Three Massachusetts agencies are involved in regulating JRC's activities through licensure or certification. The Department of Developmental Services (DDS) oversees JRC's behavioral assessment, planning and compliance with DDS regulations. Additionally, the Massachusetts Department of Early Education and Care (DEEC), as the children's residential program licensing agency, and the Department of Elementary and Secondary Education (DESE), as the certifying entity for the special education services, also review JRC behavioral practices as they relate to their respective agencies' authorities. DDS has given JRC very restrictive (one year and two six-month) certifications for its Level III (aversive therapy) authority over the last two years because of continual findings of noncompliance in terms of their use of the GED device as well as other aversive techniques used for contingent behavior management. In spite of specific requirements regarding what behaviors may be targeted for aversive use and how individuals must make progress in terms of fading such use, there is ongoing inappropriate and inconsistent adherence by JRC to state rules and regulations.

In recent years, there have been a number of investigations of JRC's practices. In 2007 an investigation by New York authorities resulted in a report that was highly critical of both processes and oversight at JRC. In that same year, DEEC found JRC to have been abusive toward residents after two residents were administered shock based on a telephone call to JRC staff from a former resident posing as a staff member. In September 2009, 31 disability organizations filed a complaint letter with the U.S. Department of Justice, Civil Rights Division, requesting an investigation of JRC. In February 2010, the Division announced that they had initiated an official investigation of JRC to determine whether its treatments violate the Americans with Disabilities Act. In May 2010, Mental Disability Rights International (MDRI) filed a disturbing report with the United Nations Special Rapporteur on Torture alleging that JRC is engaging in torture of disabled children through electric shocks and restraints, http://www.mdri.org/PDFs/USReportandUrgentAppeal.pdf.

In May 2010, there were 213 residents at JRC, including 124 children from out of state, and 16 children from Massachusetts. Only two children placed by Massachusetts executive child-serving agencies remain at JRC, and they will be discharged in the near future. The remaining 14 Massachusetts children have been placed at JRC by school authorities.

The OCA shares the concern of many other organizations that are extremely critical of the use of aversives at JRC. The Child Advocate encourages local educational authorities and others to consider all options carefully before placing a child at JRC or in any placement that uses aversion therapy, and she supports legislation to ban aversion therapy in Massachusetts.

Disproportionate Minority Contact and Data Collection

The OCA remains concerned about the issue of Disproportionate Minority Contact (DMC), otherwise known as racial and ethnic disparities, in both the juvenile justice and child welfare systems. Within the juvenile justice system, the federal Juvenile Justice and Delinquency Prevention Act (JJDPA) requires all states to both identify and address the problem. For the identification component, Massachusetts must collect and report data on the number of youth that pass through key stages of the system from arrest to confinement, including their races and ethnicities. The JJDPA also requires Massachusetts to take steps to understand the causes for the disparities by conducting an assessment study. Unfortunately, Massachusetts has struggled with collecting this statistical data, and consequently accurate reporting has been a challenge. While Massachusetts was found in compliance with JJDPA requirements in 2009, there is concern that a failure to collect and report DMC information could jeopardize important federal funding in the future. This funding, as noted below, is being relied upon to pay for Alternative Lock-up Programs. Even more importantly, the lack of data has prevented Massachusetts from understanding the extent of the DMC problem and taking the appropriate steps to address it. There appear to be a number of reasons for the failure to collect and disseminate the necessary juvenile justice data, including poor data collection systems, inadequate resources within some departments, lack of overall coordination and, in some cases, lack of cooperation. MassCourts, the new technology system for the judiciary, is being integrated into the juvenile court, and the OCA hopes its design will capture relevant data and alleviate many data collection problems in the juvenile court and the Department of Probation.

Racial and ethnic disparities continue to exist within the child welfare system. Numerous studies have documented the overrepresentation of certain racial and ethnic groups in foster care and other out-of-home placements, but it is critical that data be collected at all key decision points in the child welfare system to identify disproportional representation and develop targeted strategies to address the problem. The OCA has been working with DCF and other EOHHS agencies and task forces around data collection and information sharing. The Child Advocate looks forward to further progress with these efforts and being able to report more fully on this subject at a later date.

Juvenile Justice

Juvenile Detention Alternatives Initiative

The OCA continues to participate in the Juvenile Detention Alternatives Initiative (JDAI), an Annie E. Casey Foundation project being spearheaded by DYS under the leadership of the Commissioner and the JDAI Statewide Steering Committee. JDAI focuses on safely reducing the numbers of youth charged with delinquency offenses who are held in secure detention prior to adjudication or while awaiting a violation of probation hearing, and on developing a multi-tiered system of detention alternatives and diversion programs that better serve the needs of court-involved youth.

JDAI was first piloted in Worcester and Suffolk Counties in 2007, and expanded to Essex and Middlesex Counties in 2009.

One of the core JDAI goals is to reduce the racial disparities that plague juvenile justice systems across the country. The JDAI State Steering Committee Disproportionate Minority Contact (DMC) Subcommittee has identified priorities and is actively developing its work plan. Much attention has focused on developing an evidence-based risk assessment instrument (RAI) that could aid juvenile probation officers and judges in deciding whether a youth should be detained. An essential component of JDAI is data collection and analysis. Preliminary data demonstrates significant reductions in detentions in those counties that have embraced JDAI.

Unnecessarily detaining youth who do not pose a significant risk to the community and who are likely to appear at subsequent court dates is costly to both the individual youth and the community. Research has demonstrated that youth who spend any time in secure detention experience short- and long-term negative outcomes, including increased likelihood of dropping out of school and increased recidivism. The OCA supports the DYS JDAI initiative and encourages all stakeholders, including juvenile probation, to participate.

Alternative Lock-up Programs

The Child Advocate has met with many individuals and agencies, including the Governor's Juvenile Justice Advisory Committee (JJAC), EOHHS, and the Executive Office of Public Safety and Security (EOPSS), to discuss continuing concerns about both the safety and sustainability of the Alternative Lock-Up Programs (ALPs) used to detain youth when juvenile court is not in session. The federal Juvenile Justice and Delinquency Prevention Act (JJDPA) prohibits the detention of recently arrested youth in police stations for more than six hours and requires that youth held longer be housed separately from adult arrestees. In order to comply with the JJDPA, the Commonwealth has been relying on federal funds to contract with providers who staff and maintain ALPs to house these youth throughout the Commonwealth.

The problem of safety has been partially addressed this past year by the new requirement put in place by EOPSS that all ALP providers be licensed by DEEC. In 2009, two of the four ALP providers were unlicensed. As of May 2010, one of the unlicensed providers has made adjustments to its programs in order to meet the requirements of DEEC and has received a license. The other unlicensed provider has stopped administering the program as of May 2010 and has been replaced with a licensed provider.

Not all safety issues have been adequately addressed, and the sustainability of the current system remains in serious doubt. There are currently only four ALP providers operating pursuant to contracts with EOPSS. In some regions of the Commonwealth no ALP exists and youth are being transported great distances. Although DYS has been helpful in supporting the existing ALPs and providing training for some of the staff, DYS has no direct oversight or role in designing and implementing ALPs across the Commonwealth. State reliance on federal funds to pay for ALPs consumes all the federal funding that is needed in order to stay in compliance with other core requirements of the JJDPA. Moreover, these federal funds have been dwindling, resulting in a strong likelihood that there simply will be insufficient funds to cover the cost of ALPs in the near future. As stated in the OCA 2008 Annual Report, DYS has the expertise and staff training capability best suited to operation of ALPs, and therefore it is in the best interests of our juvenile detained

population that DYS assume operation of ALPs. However, it is imperative that responsibility for ALPs not be transferred to DYS without a suitable, specific appropriation that would cover the cost of ALPs and help restore DYS' ability to provide services to its committed youth.

Education Meets Justice: Zero Tolerance Versus Dropout Prevention

The OCA continues to be concerned about the large numbers of children suspended or expelled from schools as a result of "zero tolerance policies." Zero tolerance policies, developed by schools in the wake of several highly publicized school shootings in the 1990s, punish all infractions of school rules equally, regardless of the student's intent or circumstances. These policies frequently are used to suspend or expel youth alleged to have engaged in delinquent behaviors, even when those behaviors are unrelated to school safety. In addition, some children are suspended or expelled for trivial incidents that fall far short of delinquent acts. Upon removal from school, students other than special education students are not entitled to receive educational services. Suspension has a negative impact on a student's level of school engagement and is a strong predictor for dropping out of school. In addition, the shift toward school zero tolerance polices has resulted in an increase in the number of referrals to the juvenile justice system, thereby contributing to the "school-to-prison pipeline." Poor children and children of color are particularly impacted by these policies. New legislation addressing harassment and bullying provides important protection for some students, yet holds the potential to leverage behavior problems into expulsions for others. A balanced approach is required, recognizing the need for order and safety in schools while employing an informed and thoughtful response to children and youth with behavioral health issues.

During the past year The Child Advocate engaged in a number of activities related to revisiting zero tolerance policies and procedures and enhancing the likelihood that children will succeed in school. The OCA participated in the work of the Massachusetts Graduation and Dropout Prevention and Recovery Commission that resulted in the release of its report in October 2009. We are encouraged by the development of innovative approaches to reducing exclusion stimulated by the trauma sensitive schools grant program. In addition, we have reviewed and met with advocates about pending legislation aimed at enhancing due process in school disciplinary proceedings. OCA staff also participated in the Behavioral Health and Public Schools Task Force, whose goal is to create linkages between schools and behavioral health in order to affect suspensions, expulsions, dropout and truancy. The Task Force published its interim report to the legislature in December of 2009, which can be found at: http://www.doe.mass.edu/research/reports/1209behavioralhealth.pdf.

Child's Counsel, Guardians *ad Litem*, and the Child's Voice

The OCA values the role that advocates play in representing children and youth in court. Through our complaint process staff consult with attorneys and guardians *ad litem* who contact the office about the rights of their clients. Staff have consulted with attorneys on issues such as permanency for children whose parents' rights have been terminated but do not have a permanent home and access to unified planning teams described in the Children's Mental Health Law of 2008, as well as issues concerning placement, psychoactive medication, and competency in delinquency cases. The Child Advocate met with representatives from the Children and Family Law (CAFL) Division of the Committee for Public Counsel Services (CPCS) to explore ways to train, monitor, and support attorneys for children.

The limitations on juvenile court appointments for guardians *ad litem* continue to concern the OCA, especially with regard to educational guardians. However, it is encouraging to learn that the CPCS Youth Advocacy Department (YAD) has applied for a grant to expand the EdLaw Project statewide in order to train all court-appointed attorneys to advocate for the educational rights of their child and youth clients. Many of the juvenile justice issues discussed in other portions of this report, such as Disproportionate Minority Contact (DMC), the overuse of detention, and zero tolerance policies in public schools, can be impacted by improving the juvenile defense function. CPCS, the state's public defender agency, addressed this issue by creating YAD in 2009 in order to train and support the juvenile defense bar in Massachusetts. YAD's purpose is to improve legal and life outcomes for youth by building the skills and capacity of their advocates.

In addition to her other outreach efforts, The Child Advocate is a frequent guest and lecturer at area law schools and child advocacy clinics. The OCA is committed to working with both the juvenile and the probate and family courts as well as CPCS to ensure that counsel for children advocate effectively for their clients.

Life Without Parole Sentences for Juvenile Offenders

In September 2009, the Children's Law Center of Massachusetts published a compelling report, *Until They Die a Natural Death: Youth Sentenced to Life Without Parole in Massachusetts*: http://www.clcm.org/UntilTheyDieaNaturalDeath9_09.pdf. The Office of the Child Advocate urges policymakers to read this report and act upon the recommendations outlined in it. Current Massachusetts law requires that juveniles charged with first or second-degree murder be tried in adult court and, if convicted of first-degree murder, be sentenced to life without the possibility of parole. There is never an opportunity for a judge or jury to consider the fact that these young people were adolescents at the time of their offenses, and there is no opportunity for a young person to attempt to demonstrate, through a parole or other review process, that he or she deserves to rejoin society. Massachusetts is one of only a handful of states that permit mandatory life without parole sentences to be imposed on children as young as 14 years old.

While young people must be held accountable and punished for their criminal activity, science and experience tell us that adolescents are different from adults. Current research regarding adolescent development has confirmed significant differences in both adolescent behavior and biological differences in the juvenile brain. Yet currently 59 individuals are sentenced to life in prison in Massachusetts for crimes committed when they were too young to vote or buy cigarettes. Over 40% of these young people were first-time offenders with no prior juvenile or adult record. One in five of the cases involved "felony murder" convictions, meaning that the young person did not necessarily directly cause or intend to cause the death of the victim. Sixty-one percent of the individuals serving these sentences are minorities.

In Graham v. Florida, the United States Supreme Court recently ruled that sentencing juvenile offenders to life in prison without the possibility of parole for a nonhomicide offense violates the Eighth Amendment's prohibition against cruel and unusual punishment. The Court was divided in its opinion, with a vigorous dissent, and its ruling applies neither to sentences for homicides, nor to past offenses. There is little reason to hope that the Graham decision will provide relief for the 59 inmates incarcerated in Massachusetts.

The recommendations from *Until They Die a Natural Death* are included in Appendix D. These recommendations are thoughtful, moderate, and promote the interests of justice, and the OCA endorses these recommendations. The Child Advocate will work with concerned stakeholders to generate recommendations regarding specific statutory reforms.

Competency of Juveniles in Delinquency Cases

Before holding a person criminally responsible, a court must first be satisfied that he is competent, meaning that he understands the charges against him and can assist in his own defense. Recent research, such as the MacArthur Juvenile Adjudicative Competence Study, has shown that issues of competence arise more frequently with juvenile offenders than with the adult population. The OCA is concerned that the rights of juveniles found to be incompetent in Massachusetts are not being protected and their service needs are not being met.

If a court finds a person incompetent, criminal charges are stayed until the person is "restored to competence." In the case of mental illness, this might be accomplished through treatment or medication. In the case of severe cognitive limitation, however, restoration to competence may require an intensive educational program, or may not be possible. If a juvenile charged with an offense has not been restored to competence and is held in pretrial detention, constitutional principles of due process require that he not be detained indefinitely. Persons who pose a danger to self or others may be civilly committed for the protection of the public. Accordingly, in the case of adults, Massachusetts law requires dismissal of criminal charges against a person found to be incompetent after a certain period of time. For juveniles, however, no maximum period of confinement is set. Thus juveniles found to be incompetent may be confined indefinitely. Moreover, during this confinement, no programs or services aimed at restoring competence are provided, other than mental health services that might relieve mood or thought disorders. The lack of a statutory remedy for indefinite confinement, the lack of services for restoration to competence, and the non-remediable nature of severe cognitive limitations all coalesce to create a large crack through which "our kids" may fall. Other states, faced with similar problems, have devised solutions that address the behavioral health needs of juveniles while protecting their constitutional rights. The OCA urges Massachusetts lawmakers to do the same.

Recommendations

Online Mandated Reporter Training

The OCA continues to advocate for standardized online mandated reporter training (OMRT). The OCA envisions a system in which an EOHHS-approved curriculum is developed in conjunction with other stakeholders, and mandated reporters are able to learn the basic principles involved with reporting suspected abuse and neglect through a free or low-cost OMRT.

Expert Consultation in the Investigation of Child Abuse

It is critical that a coordinated system be in place across the state so that DCF staff can readily obtain expert medical consultation during initial screening of 51A reports, and during initial assessments or investigations.

Psychoactive Medication and the "Rogers" Process

The OCA strongly encourages continued support for working groups aimed at establishing best practices for prescription of psychoactive medications and for obtaining informed consent on behalf of children in DCF custody.

Restraints and Seclusion

The OCA wholeheartedly endorses the work of the Interagency Restraint and Seclusion Prevention Initiative, co-chaired by DMH and DCF, and the ongoing efforts of EOHHS agencies and human service providers to reduce the use of restraints and seclusion in child-serving programs. We encourage further expansion of this initiative, particularly with respect to school-based personnel.

Use of Aversives at Judge Rotenberg Center

The OCA shares the concern of many other organizations that are extremely critical of the use of aversives at JRC. We encourage local educational authorities and others to consider all options carefully before placing a child at JRC or in any placement that uses aversion therapy, and we support legislation to ban aversion therapy in Massachusetts.

Juvenile Detention Alternatives Initiative

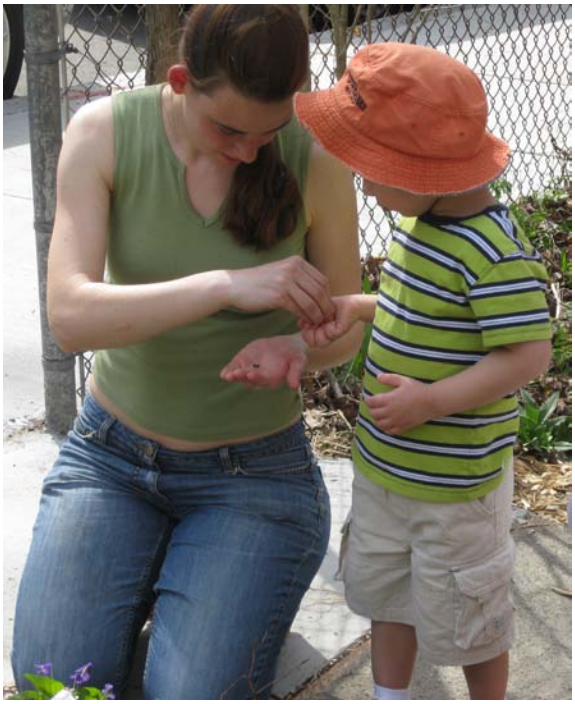
Additional programs must be developed as alternatives to secure detention. The OCA recommends that all interested stakeholders, including juvenile probation, work with DYS and the juvenile court to develop alternatives other than DYS detention for youth who can safely be kept in the community while awaiting adjudicatory hearings or violation of probation hearings.

Alternative Lock-up Programs (ALPs)

The current system for detaining youths prior to arraignment, or after arraignment but prior to adjudication, is not well-designed and is not sustainable. Given its expertise, DYS is the appropriate entity to assume leadership for designing and operating the ALPs system. It is imperative, however, that the responsibility for ALPs not be transferred to DYS without a suitable, specific appropriation that would cover the cost of ALPs and help restore DYS' ability to provide services to its committed youth.

Competency of Juveniles in Delinquency Cases

Advocates for juveniles agree that the lack of a statutory remedy for indefinite confinement, the lack of services for restoration to competence, and the nonremediable nature of severe cognitive limitations come together to create a large crack through which "our kids" may fall. We urge Massachusetts lawmakers to consider legislative solutions that ensure the constitutional rights of juveniles are respected, and their service needs are met.



Appendix A: M.G.L. Chapter 18C

Office of the Child Advocate

Section 1. As used in this chapter, the following words shall have the following meanings, unless the context clearly requires otherwise:—

"Advisory board", the child advocate advisory board established by section 4.

"Child advocate", the child advocate appointed under section 3.

"Critical incident", (a) a fatality, near fatality, or serious bodily injury of a child who is in the custody of or receiving services from the executive office of health and human services or 1 of its constituent agencies; or (b) circumstances which result in a reasonable belief that the executive office of health and human services or 1 of its constituent agencies failed in its duty to protect a child and, as a result, the child was at imminent risk of, or suffered, serious bodily injury.

"Department", the department of children and families.

"Executive agency", a state agency within the office of the governor that includes the executive office of education, the executive office of public safety and security, executive office of health and human services, the Massachusetts interagency council on homelessness and housing established by Executive Order No. 492 and the executive office of housing and economic development.

"Office", the office of the child advocate.

"Serious bodily injury", bodily injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty.

Section 2. There shall be an office of the child advocate which shall be independent of any supervision or control by any executive agency. The office shall:

(a) ensure that children involved with an executive agency, in particular, children served by the child welfare or juvenile justice systems, receive timely, safe and effective services;

(b) ensure that children placed in the care of the commonwealth or treated under the supervision of an executive agency in any public or private facility shall receive humane and dignified treatment at all times, with full respect for the child's personal dignity, right to privacy, and right to a free and appropriate education in accordance with state and federal law;

(c) examine, on a system-wide basis, the care and services that executive agencies provide children; and

(d) advise the public and those at the highest levels of state government about how the commonwealth may improve its services to and for children and their families.

Section 3. The office shall be under the direction of the child advocate, who shall devote full time to the duties of this office. The child advocate shall serve at the pleasure of the governor and report directly to the governor. The child advocate may, subject to appropriation, appoint such other personnel as he deems necessary for the efficient management of the office. The governor shall appoint the child advocate to a term coterminous with that of the governor, except that the child advocate shall continue to serve following the end of a governor's term until a successor is appointed.

The governor shall appoint the child advocate from among 3 nominees submitted by a nominating committee to recommend a child advocate. The nominating committee shall consist of: the secretary of health and human services; the commissioner of children and families; the commissioner of youth services; commissioner of mental health; the executive director of the child abuse prevention board; a pediatrician experienced in treating child abuse designated by the Massachusetts chapter of the American Academy of Pediatrics; a child psychiatrist designated by the Massachusetts Psychiatric Society; a child psychologist designated by the Massachusetts Psychological Association; a repre-

sentative from the Massachusetts Association of Mental Health; a representative of an organization which advocates on behalf of children at risk of abuse designated by the Children's League of Massachusetts; a lawyer experienced in care and protection cases designated by the Massachusetts Bar Association; a social worker designated by the Massachusetts Chapter of the National Association of Social Workers; a person with experience in the juvenile justice system designated by the chief justice of the juvenile court department; and a representative of organized labor to be designated by the president of the collective bargaining unit that represents the social workers of the department. A vacancy occurring in the position of child advocate shall be filled in the same manner, except that if the child advocate ceases to serve for any reason, the governor shall appoint an acting child advocate who shall serve until the appointment of a successor.

Section 4. There shall be a 25-member child advocate advisory board. The advisory board shall consist of the child advocate, who shall serve as chair, the secretary of health and human services, the secretary of public safety and security, the secretary of education, the executive director of the criminal history systems board, the undersecretary of criminal justice from the executive office of public safety and security, the commissioner of early education and care, the commissioner of elementary and secondary education, the commissioner of mental health, the commissioner of mental retardation, the commissioner of public health, the commissioner of children and families, the commissioner of transitional assistance, the commissioner of youth services, the deputy commissioner of the child support enforcement division within the department of revenue, the president of the Massachusetts District Attorneys Association, the commissioner of probation, the chief counsel of the committee for public counsel services, the chief justice of the superior court department, the chief justice of the juvenile court department, the chief justice of the probate and family court department, the executive director of the child abuse prevention board, and 3 persons appointed by the governor.

Section 5. (a) An executive agency shall inform the child advocate when a critical incident has occurred. The child advocate may conduct an investigation of the critical incident or may review an executive agency's investigation of a critical incident. When the child advocate conducts his own investigation, he shall determine: (1) the factual circumstances surrounding the critical incident; (2) whether an agency's activities or services provided to a child and his family were adequate and appropriate and in accordance with agency polices and state and federal law; and (3) whether the agency's policies, regulations, training or delivery of services or state law can be improved.

(b) Before investigating any critical incident, the child advocate shall determine whether an executive or law enforcement agency is already conducting an investigation. If a law enforcement agency is conducting an investigation, the child advocate shall, when appropriate, defer to that agency or may conduct his own investigation. The child advocate shall coordinate efforts to minimize the impact on the child, family or employees of the agency involved, unless he determines such coordination would impede his investigation. If an executive agency is conducting an investigation, the child advocate may defer to that investigation or may conduct his own investigation. The child advocate may coordinate efforts to minimize the impact on the child, family or employees of the agency involved. In every instance, the child advocate shall notify the head of the relevant agency of his involvement before beginning any investigation.

(c) The child advocate shall receive complaints relative to the provision of services to children by an executive agency and shall review and monitor the complaints that reasonably cause him to believe that a child may be in need of assistance and to ensure that the complaint is resolved. If the complaint is not resolved by the relevant executive agency within a reasonable period of time in light of the circumstances, if the resolution is determined to be unsatisfactory to the child advocate, or if the complaint reasonably causes the child advocate to believe that a child may be in need of

immediate assistance, he may conduct an investigation of the complaint.
(d) The child advocate shall receive complaints from children in the care of the commonwealth and assist such children in resolving problems and concerns associated with their placement, plans for life-long adult connections and independent living, and decisions regarding custody of persons aged between 18 and 22, including ensuring that relevant executive agencies have been alerted to the complaint and facilitating intra-agency cooperation, if appropriate. For the purposes of this section, the office shall develop procedures to ensure appropriate responses to the concerns of youth in foster care 24 hours a day, 7 days a week.
(e) The child advocate shall periodically review, report and make recommendations, as appropriate, with respect to system-wide improvements that may increase the effectiveness of the care and services provided to children and their families and suggested legislative and regulatory changes including, but not limited to, a review of the programs and procedures established by the department to provide and administer a comprehensive child welfare program under section 2 of chapter 18B.
(f) At the request of the governor, the child advocate shall perform oversight functions to ensure that agencies serving children are fulfilling their obligations in the most effective and efficient manner.
(g) The child advocate shall undertake activities designed to educate the public regarding the services of the office and of the mission of the executive agencies in providing services to children and families.
(h) The child advocate shall be authorized to apply for, and accept on behalf of the commonwealth, federal, local or private grants, bequests, gifts or contributions for the purpose of carrying out the functions of the office.
Section 6. The child advocate or his designee shall have access at any and all reasonable times to any facility, residence, program, or portion thereof, that is operated, licensed or funded by an executive agency, and to all relevant records, reports, materials and employees in order to better understand the needs of children in the custody of the commonwealth or who are receiving services from an executive agency. The child advocate shall be bound by any limitations on the use or release of information imposed by law upon the party furnishing such information, except as provided in subsection (e) of section 12.
Section 7. The child advocate may request the attendance and testimony of witnesses and the production of documents, papers, books, records, reports, reviews, recommendations, correspondence, data and other evidence that the child advocate reasonably believes is relevant. If a request is denied, the child advocate shall have the power to issue a subpoena for witnesses and the production of documents and any other data and evidence that the child advocate reasonably believes is relevant.
If any person to whom a subpoena is issued fails to appear or, having appeared, refuses to give testimony or fails to produce the evidence required, the child advocate may apply to the Suffolk county superior court to issue an order to compel the testimony and production of documents of any such witnesses. A failure to obey the order may be punished as contempt.
The district attorney may seek injunctive relief in Suffolk county superior court to defer a subpoena issued by the child advocate.
Section 8. No discriminatory or retaliatory action shall be taken against any person who communicates with or provides information to the office. Any person who knowingly or willfully discriminates or retaliates against such a person shall be liable to such person for treble damages, costs and attorney's fees.
Section 9. The child advocate shall develop internal procedures appropriate for the effective performance of his duties.

The child advocate may, subject to chapter 30A, adopt, amend or repeal such rules and regulations as are deemed necessary to carry out the functions of the office.

Section 10. The child advocate shall report annually to the governor, the president of the senate, the speaker of the house, the senate and the house committees on ways and means, and the chairs of the joint committee on children, families and persons with disabilities on the activities of the office, including an analysis of activities undertaken to implement subsection (d) of section 5, recommendations for changes in agency procedures which would enable the commonwealth to better provide services to and for children and their families and priorities for implementation of those changes to services. The report shall be made public.

Section 11. (a) The child advocate, in consultation with the advisory board and the interagency child welfare task force established by section 215 of chapter 6, shall formulate a comprehensive plan, with periodic benchmarks and cost estimates, to recommend a coordinated, system-wide response to child abuse and neglect, including related mental health, substance abuse and domestic violence issues. The comprehensive plan shall look forward 5 years or more, shall be updated annually to plan for the ensuing 5-year period, shall assess previous efforts and, if appropriate, shall include legislative and regulatory recommendations, such as changes to the issues itemized in the comprehensive plan.

(b) The child advocate may seek advice broadly from individuals with expertise in child welfare in formulating the plan and consult with, social workers of the department, pediatricians, child psychiatrists, early childhood education and adolescent behavior specialists, parents of children who have received services from the commonwealth, and persons who, as children, were clients of the department.

(c) The comprehensive plan shall be filed annually with the governor, the clerks of the senate and the house, the senate and house committees on ways and means, and the joint committee on children, families and persons with disabilities.

(d) The comprehensive plan shall examine the status of and address the following issues:—

(1) racial disproportionality and disparity of the department's client population, including the effectiveness of reforms designed to address overrepresentation of children of color within that population;

(2) the needs of families whose children are truant, runaways, or whose conduct interferes with their parent's ability to adequately care for and protect them. The plan shall propose a system of community-based programs to assist these children and families by providing services on a continuum of increasing intensity with the goal of keeping children out of the juvenile justice and child protection systems. The plan shall examine: (i) the existing complex system of services available from multiple public and private agencies; (ii) the differences in service delivery throughout the state; (iii) the need for immediate response to stabilize a family in crisis and to connect the family to services in their own community; and (iv) the collection and analysis of information needed to evaluate and identify gaps in service to such children and families throughout the commonwealth;

(3) mandated reporting, including: (i) the quality and quantity of training provided to mandated reporters; (ii) standards for training based on best practices for recognizing and reporting suspected child abuse and neglect; and (iii) the use of the following as forums for training mandated reporters: online programs, training offered by state agencies, and existing programs of professional training such as those required for initial licensure or certification and relicensure or recertification, continuing education programs or in-service training;

(4) screening of child abuse and neglect reports, including: (i) centralizing the reporting and screening processes; (ii) a single, 24-hour, toll-free telephone number for all oral reports, a single fax number or mailing address for all written reports and internet-based filing of reports; (iii) multiple

reports filed about a particular child or family; (iv) a determination of when and under what conditions reports may have been inappropriately screened out and the impact of those decisions; and (v) direct, electronic access to the National Crime Information Center for criminal history records and warrants;

(5) child protection teams, which are multidisciplinary teams that provide specialized medical examinations of children who present signs of abuse or neglect and that include pediatricians or pediatric nurses and psychologists or social workers who have been trained to recognize child abuse and neglect, including statewide expansion to regional hospitals, all hospitals with emergency rooms and all pediatric care hospitals;

(6) the shortage of experts in the commonwealth who specialize in the prevention, diagnosis and treatment of abused or neglected children, with recommendations to train pediatricians and pediatric nurse practitioners to become clinical experts who are knowledgeable and competent in all areas of child abuse and neglect, including: the identification, assessment, and treatment of physical abuse, sexual abuse, neglect, emotional abuse and neglect and factitious illness by proxy; multidisciplinary training with law enforcement, state and local agencies and child advocacy centers; collection of forensic evidence; court testimony; research; and child advocacy;

(7) family engagement model or other nationally recognized models to strengthen child welfare practice, including: (i) the evaluation of the model and its use of differential response and risk assessment tools to determine how effectively findings of abuse or neglect are made; (ii) the cost to implement the model state-wide; (iii) the combination of departmental functions such that an individual social worker investigates, assesses and provides ongoing case management, particularly as that combination impacts incidents requiring specialized investigatory skills; (iv) delays in the fair hearing process; and (v) time limits allowed for screenings, investigations and assessments;

(8) social worker caseloads and teaming, including: (i) the effects of teaming on caseloads and of caseloads on teaming; (ii) the cost of state-wide adoption of various standard caseload ratios; (iii) a potential multi-year plan to reduce caseloads; and (iv) duties handled by social workers that may be more affordably and efficiently handled by other staff;

(9) law enforcement involvement, including: (i) how effectively the department and law enforcement collaborate and whether there is room for improvement or coordination of resources; (ii) protocols for mandatory reporting of certain abuse or neglect to local law enforcement and district attorneys and (iii) potential alignment with efforts to prevent or prosecute domestic violence and with the procedures used in the investigation of sexual abuse, such as the sexual abuse intervention network and the sexual assault nurse examiners program;

(10) schools of social work, including: (i) how effectively social work and related degree programs teach child welfare practice; (ii) greater cooperation between the department and higher education to study child welfare issues; (iii) the capacity of public and private schools to meet increased demand for social work and related degrees, including concentrations in child welfare; and (iv) a timeline for inclusion of child welfare concentrations in bachelor's and master's degree programs at public institutions of higher education;

(11) social worker qualifications, including the infrastructure needed to support a more qualified workforce, such as full implementation of proposed programs at the child welfare institute and the transferability of certificate coursework to degree-granting programs;

(12) confidentiality, including research of legal and ethical considerations to be addressed if information relative to cases of child abuse and neglect is shared between the office and other executive agencies;

(13) health service needs of the department's client population and health consultation needs of the department, including: (i) the need for physical and behavioral health services and consultation,

including those related to mental health and substance abuse treatment; (ii) coordination and consultation among executive agencies; (iii) proposed best-practice models for more effective client behavioral health services; and (iv) oversight and peer review of the safety and effectiveness of the use of psychotropic drugs by children involved with executive agencies;
(14) critiques of the department, including: (i) potential alignment of a internal or external audit unit with the department's continuous quality improvement and quality service review initiatives; and (ii) dissemination of the findings of these critiques to policy makers within and outside of the department;
(15) criminal offender record information reviews, including: (i) the use of these reviews in out-of-home, kinship and foster placements and (ii) areas for improved efficiency and equality;
(16) permanency planning for those who, due to their age, are transitioning out of the child welfare system to assist with health care, housing, higher education, long-term interpersonal connections and other needs for independent living;
(17) examine the frequency of transitions in the treatment plans and living placements of foster children;
(18) provide an analysis of the administrative and cost requirements and recommendations to create a personal needs and individual development account for each child in foster care over the age of 14;
(19) review the process of adopting children in foster care and recommend streamlined procedures to reduce the time required to complete the adoption process;
(20) the impact on child welfare efforts of the early and periodic screening, diagnostic and treatment services provision and reasonable promptness provision of the federal Medicaid law, 42 U.S.C. 1396a(a)(10)(A),-(a)(43), 1396d(r)(5),-(a)(4)(B), and 1396a(a)(8)(2005), respectively;
(21) oversight provided by MassHealth and its contractors of medical and behavioral health expenditures made on behalf of the department's client population;
(22) federal funding available for child welfare purposes and factors affecting that funding, including: (i) the Title IV-E saturation rate for foster children, (ii) the determination of AFDC status for the non-TANF population, and (iii) expedited judicial determinations made within the required time frames;
(23) an estimate of the expenditure necessary to implement an annual adjustment to the daily rate for maintenance payments to foster care, adoptive and guardianship families, to provide care so as to meet the rate recommended periodically by the United States Department of Agriculture; and
(24) the effectiveness of the state's child abuse laws as they relate to defining, prohibiting, preventing and reporting cases of emotional abuse of children, including recommendations to increase public and professional education and awareness of the symptoms and impact of emotional abuse.
Section 12. The following provisions apply to information and records obtained, reviewed or maintained by the child advocate:
(a) Notwithstanding chapter 66A, section 70 of chapter 111, section 11 of chapter 111B, section 18 of chapter 111E, sections 51E and 51F of chapter 119, chapter 112, chapter 123, or sections 20B, 20J, or 20K of chapter 233 to the contrary, the disclosure of information to the office of the child advocate pursuant to this chapter shall not be prohibited. Any information considered to be confidential under the aforementioned sections shall be submitted for the child advocate's review upon the determination of the child advocate that the review of said information is necessary. The child advocate shall ensure that no information submitted for his review is disseminated to parties outside the office. Under no circumstances shall the child advocate or any employee of the office violate the confidentiality provisions set forth in the aforementioned statutes, except as authorized under subsection (e).

(b) Any and all information and records acquired by the child advocate in the exercise of the office's purpose and duties under this chapter shall be confidential and exempt from disclosure under chapter 66 and clause Twenty-sixth of section 7 of chapter 4.
(c) Information, documents and records of the child advocate and his office shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding; provided, however, that information, documents and records otherwise available from any other source shall not be immune from subpoena, discovery or introduction into evidence through these sources solely because they were presented during the child advocate's investigation or maintained by the office of the child advocate.
(d) Statistical compilations of data which do not contain any information that would permit the identification of any person may be disclosed to the public.
(e) The restrictions of this section shall not preclude the child advocate from sharing with the governor, the attorney general, a district attorney, a secretary, an agency commissioner or other agency personnel, or the chairs of the joint committee on children, families and persons with disabilities, the report of, or the results of, a critical incident investigation involving that agency. Any executive or legislative branch employees who receive or read such a document shall be bound by the confidentiality requirements of this section.
Section 13. No person employed by or contracted by or volunteering for the office shall be subject to suit directly, derivatively or by way of contribution or indemnification for any civil damages under the laws of the commonwealth resulting from any act or omission performed during or in connection with the discharge of his duties within the scope of his employment or appointment, unless such act or failure to act was committed with gross negligence, maliciously, or in bad faith.

Appendix B: Complete List of Child Advocate Advisory Board Members

***Ex-officio* members:**

Gail Garinger, Chair
The Child Advocate
Office of the Child Advocate

Dr. JudyAnn Bigby
Secretary
Executive Office of Health and Human Services

Kevin M. Burke
Secretary
Executive Office of Public Safety and Security

Paul Reville
Secretary
Executive Office of Education

Curtis M. Wood
Executive Director
Criminal History Systems Board

Mary Elizabeth Heffernan
Undersecretary of Criminal Justice
Executive Office of Public Safety and Security

Sherri Killins
Commissioner
Department of Early Education and Care

Mitchell D. Chester
Commissioner
Department of Elementary and Secondary Education

Barbara Leadholm
Commissioner
Department of Mental Health

Elin M. Howe
Commissioner
Department of Developmental Services

John Auerbach
Commissioner
Department of Public Health

Angelo McClain
Commissioner
Department of Children and Families

Julia Kehoe
Commissioner
Department of Transitional Assistance

Jane Tewksbury
Commissioner
Department of Youth Services

Laurie McGrath
Deputy Commissioner
Child Support Enforcement Division
Department of Revenue

David F. Capeless
President
Massachusetts District Attorneys Association

John J. O'Brien
Commissioner
Department of Probation

William J. Leahy
Chief Counsel
Committee for Public Counsel Services

Hon. Barbara J. Rouse
Chief Justice
Superior Court

Hon. Michael F. Edgerton
Chief Justice
Juvenile Court

Hon. Paula M. Carey
Chief Justice
Probate and Family Court

Suzin Bartley
Executive Director
Children's Trust Fund

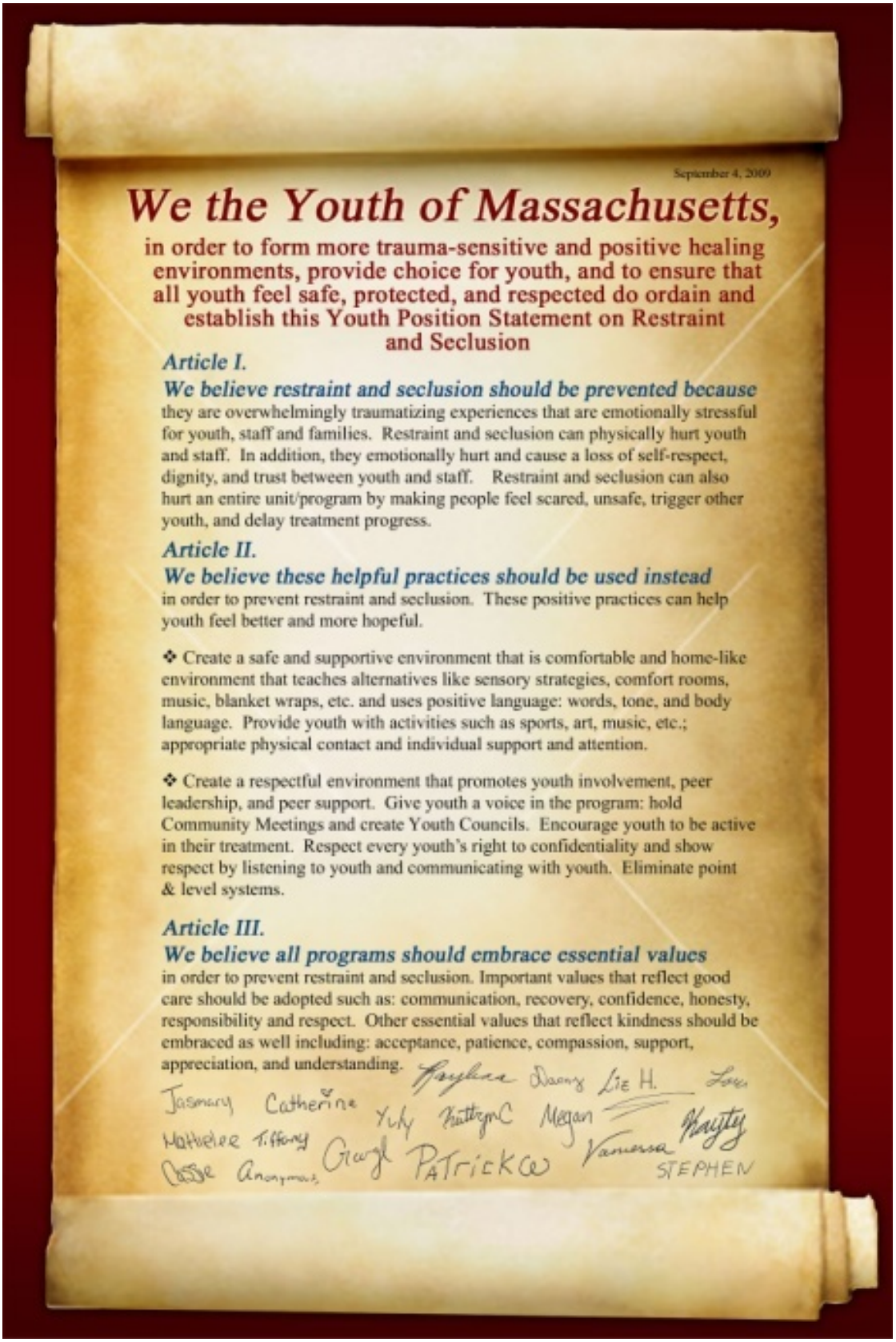
Gubernatorial appointees, selected to represent non-governmental interests:

Barbara Kaban
Deputy Director/Director of Research & Policy
Children's Law Center of Massachusetts

Anthony Barrows
Project Manager
Judge Baker Children's Center

Valdace Levarity
Teacher
Quincy Public Schools

Appendix C: DMH Youth Position Statement on Restraints and Seclusions



September 4, 2009

We the Youth of Massachusetts,

in order to form more trauma-sensitive and positive healing environments, provide choice for youth, and to ensure that all youth feel safe, protected, and respected do ordain and establish this Youth Position Statement on Restraint and Seclusion

Article I.

We believe restraint and seclusion should be prevented because

they are overwhelmingly traumatizing experiences that are emotionally stressful for youth, staff and families. Restraint and seclusion can physically hurt youth and staff. In addition, they emotionally hurt and cause a loss of self-respect, dignity, and trust between youth and staff. Restraint and seclusion can also hurt an entire unit/program by making people feel scared, unsafe, trigger other youth, and delay treatment progress.

Article II.

We believe these helpful practices should be used instead

in order to prevent restraint and seclusion. These positive practices can help youth feel better and more hopeful.

❖ Create a safe and supportive environment that is comfortable and home-like environment that teaches alternatives like sensory strategies, comfort rooms, music, blanket wraps, etc. and uses positive language: words, tone, and body language. Provide youth with activities such as sports, art, music, etc.; appropriate physical contact and individual support and attention.

❖ Create a respectful environment that promotes youth involvement, peer leadership, and peer support. Give youth a voice in the program: hold Community Meetings and create Youth Councils. Encourage youth to be active in their treatment. Respect every youth's right to confidentiality and show respect by listening to youth and communicating with youth. Eliminate point & level systems.

Article III.

We believe all programs should embrace essential values

in order to prevent restraint and seclusion. Important values that reflect good care should be adopted such as: communication, recovery, confidence, honesty, responsibility and respect. Other essential values that reflect kindness should be embraced as well including: acceptance, patience, compassion, support, appreciation, and understanding.

Jasmary Catherine Yuly Kaitlyn C Megan Kayley
Katherine Tiffany Patrick Vanessa
Jesse Anonymous STEPHEN

Appendix D: Recommendations from *Until They Die a Natural Death: Youth Sentenced to Life Without Parole in Massachusetts*

Since the enactment of the current law imposing mandatory life without parole sentences on children in Massachusetts, several important developments compel a re-examination of that practice. Juvenile homicide rates have declined markedly, belying alarmist predictions in the 1990s that such rates would continue to climb. The United States Supreme Court struck down the use of the death penalty for all youth under age 18. Advances in neuroscience have found striking anatomical differences between adolescent and adult brains that confirm children's greater capacity to change. Sentences for youth must reflect the harm they have caused while also reflecting the acknowledged differences between children and adults. To protect public safety, it is not necessary to decide that a child is irredeemable based on acts that occurred when he or she was as young as 14 years old. It is not necessary to spend millions of taxpayer dollars on 50-60 years of lifetime incarceration. After a lengthy sentence, youth should be given a chance to appear before the Parole Board and prove that they have been rehabilitated.

To that end, we are making the following recommendations:

To Massachusetts legislators:

• Enact legislation establishing a meaningful opportunity for periodic review of life sentences for juveniles. Sentences for juveniles convicted of first degree murder should mirror the life sentences imposed on adults for second degree murder, such that they become eligible for parole after 15 years and at periodic intervals thereafter.
• Provide for retroactive application of the new legislation.
• Ensure that current victim notification and victim services provisions governing parole eligibility of adults are strictly applied to review of life sentences for juveniles.
• Eliminate mandatory sentencing for all juveniles in adult court so that they receive individualized sentencing, consistent with juvenile court practices.
• Retain all convicted juveniles in DYS custody until their 21st birthdays so that they have access to rehabilitation, education and job training programs. When youth are transferred from DYS to DOC, credit their successful participation in such programs when determining their appropriate classification.

To the Governor of Massachusetts:

• Support the enactment of legislation establishing a meaningful opportunity for periodic review of life sentences for juveniles.
• Amend the Executive Clemency Guidelines to establish criteria for the commutation of juvenile life sentences in light of a petitioner's age at offense, level of participation in the crime and capacity for rehabilitation.

To the Supreme Judicial Court of Massachusetts:

• When reviewing a juvenile's life sentence on direct appeal under MGL Ch. 278 § 33E, consider the juvenile's age and related factors.

To Massachusetts practitioners:

• Establish a specialized area of practice for defending youth who face life without parole sentences.