

Office of the Child Advocate

Annual Report

Fiscal Year 2015



The Commonwealth of Massachusetts

Gail Garinger

The Child Advocate

The 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 children who are served by the Commonwealth's child welfare and juvenile justice systems.

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Our Partners in the Executive Agencies

CBHI	Children's Behavioral Health Initiative
DCF	Department of Children and Families
DDS	Department of Developmental Services
DEEC	Department of Early Education and Care
DESE	Department of Elementary and Secondary Education
DMH	Department of Mental Health
DPH	Department of Public Health
DYS	Department of Youth Services
EOHHS	Executive Office of Health and Human Services
ORI	Office for Refugees and Immigrants

Letter from The Child Advocate



August 2015

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

I am pleased to submit the Annual Report of the Office of the Child Advocate (OCA) for Fiscal Year 2015. This will be my last report as Child Advocate, as I have decided to move on to the next chapter of my career. This final report under my leadership offers me the occasion to look back, not just on the activities of the OCA over the past twelve months, but also on the last seven years. These are the years since the OCA was created during which my staff and I have sought to serve the Commonwealth by advocating for its most valuable and most vulnerable citizens — its children.

The OCA was created in December 2007 by executive order of Governor Deval Patrick based on a belief that an independent office would simultaneously demand accountability from and foster collaboration among the Commonwealth's child-serving agencies. The legislature shared this view and significantly expanded the role and responsibilities of the OCA through the Child Welfare Law enacted in July 2008. To hold agencies accountable, the OCA is authorized to investigate "critical incidents," the deaths or serious injuries of children receiving state services. This is the OCA's most visible responsibility, as it is triggered by the tragedies that capture headlines and prompt public officials and private citizens alike to call for an accounting when terrible and avoidable harm befalls a child.

At the OCA we have investigated the tragic deaths of children this year, as we have in past years. When state agencies or employees have fallen short in carrying out their obligations to protect children from harm, the OCA has not hesitated to bring such failings to the attention of both the public and those persons charged with managing or overseeing the agencies involved. But the OCA's responsibility continues after the headlines have faded and public attention has moved to other matters. This responsibility is to work with child-serving agencies not only to identify what went wrong, but also to figure out how such tragedies can be prevented, how to make sure that warning signs are not overlooked, how to best support children and

families, and how, in sum, to do better.

And we must do better, if we want our children to be safe and to thrive. This is a collective responsibility for all citizens. Even the best organized and managed child-serving agency will fail if its staff is overwhelmed. It is the responsibility of the governor and the legislature to ensure that sufficient resources are available. It is the responsibility of doctors, child care workers, teachers, ministers, and other professionals who are mandated to report child abuse and neglect when they see it. It is the responsibility of judges who face the daunting task of responding to families in crisis, to abused or neglected children, and to parents, foster parents, and guardians. My thirteen years as a Juvenile Court Judge made me acutely aware of the difficulty of that task.

And it is my responsibility as Child Advocate to call upon agencies, elected officials, mandated reporters, and judges to place the interests of children above the preferences and desires of adults. Our children are our most important citizens because we place in them our hopes for a better future.

That is the responsibility that has driven my efforts as Child Advocate over the past seven years. I have been blessed with a small but remarkably dedicated staff that has always demonstrated the possibility of the whole exceeding the sum of its parts. Every one of them deserves the gratitude of the Commonwealth and they all have mine. I would like to commend in particular Elizabeth Armstrong, who has been my deputy, my counselor, and my friend since I became Child Advocate. Her dedication to the work of protecting children has inspired me.

I am proud of the work we have accomplished both this year and in prior years. I am mindful that there is still much to be done. I thank you for the honor of serving as the Commonwealth's first Child Advocate.

Sincerely,

A handwritten signature in black ink, appearing to read "Gail Garinger". The script is fluid and cursive, with the first name "Gail" and last name "Garinger" clearly distinguishable.

Gail Garinger

OCA Mission and Values

Our mission is to improve the safety, health, and well-being of Massachusetts children by promoting positive change in public policy and practice. We further our mission by focusing on our core values: information, collaboration, and accountability.

Information: The Child Advocate and the OCA staff are always active, participating in meetings, forums, and events to learn more about services and initiatives for children and families in Massachusetts. We share this information with others through our policy work and our Helpline.

Collaboration: Collaboration is critical at every level. No single agency or system can provide all the resources needed to support and strengthen families. The OCA staff work to promote collaboration at every opportunity among initiatives, agencies, and systems.

Accountability: The OCA staff review critical incident reports and child abuse and neglect reports arising in out-of-home settings connected to state agencies. Through these reviews, we identify trends and look for opportunities for system improvements. We meet with agency commissioners and staff to learn from them and to share our perspective.

The role of the OCA is to connect the dots within and between the child welfare and juvenile justice systems. We work to promote system integration among agencies, courts, schools, and health service providers so that children and families can connect to resources in their communities.

OCA Activities and Data

This is the seventh annual report published since the OCA was created in 2008. Our 2008 and 2009 reports were based on the calendar year (CY); in 2010 we began reporting on our activities for the fiscal year (FY), though we continue to analyze data for the previous calendar year. This report focuses on OCA activities for FY 2015, from July 1, 2014, through June 30, 2015. The information on critical incidents, reports of abuse and neglect in out-of-home settings, and Helpline calls is based on CY 2015.

Helpline

The OCA responds to calls on the Helpline about services provided to children and youth in Massachusetts by state agencies. Anyone who needs help finding resources related to a child's health, safety, and well-being or with concerns about the treatment of a child receiving services from a state agency may contact the OCA. Family members, foster parents, advocates, attorneys, and others can call or write the OCA on behalf of a child to express concerns and ask for advice. The OCA maintains the confidentiality of all information shared with our office. In 2014 the majority of contacts were related to children involved with the Department of Children and Families (DCF). Many callers were parents and caregivers concerned about children achieving permanency. Our clinical specialist and program assistant help individuals resolve their problems directly with the agency involved and identify resources related to a child's safety and well-being. To improve access to information, the OCA recently added two new sections to our website, Resources and FAQs. Both sections provide a variety of information to help people identify services or resources for a child and assist with resolving a problem that involves a state child-serving agency. Helpline callers will receive information over the phone about the same resources and services described on our website.

The OCA maintains a confidential database of concerns from the Helpline and analyzes the information to improve our understanding of child welfare and juvenile justice systems. The Helpline informs our interagency and policy work and assists the OCA to identify priorities. See below for further information regarding the concerns we hear through the Helpline.

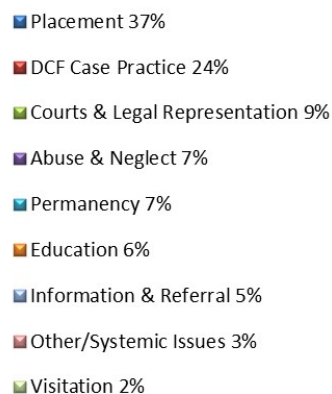
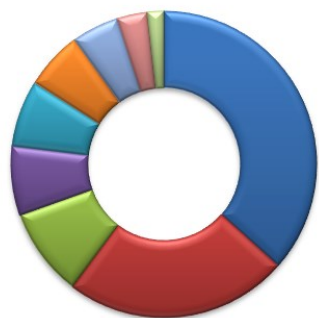
Reach our Helpline by phone, email, or mail

Phone: 617-979-8360 or toll-free 1-866-790-3690

Email: childadvocate@state.ma.us

Mail: Office of the Child Advocate, One Ashburton Place, 5th Floor, Boston, MA 02108

Helpline Concerns



Helpline Concerns

Placement

- Multiple placements
- Kinship placement rights
- Appropriateness of placement

Abuse & Neglect

- Filing a report (51A)
- DCF's response to a report (51A)
- Restraints in residential and group home facilities
- Maltreatment in school settings
- Mandated reporters failing to report

Information & Referral

- Where to direct questions and concerns
- Registering a complaint with DCF
- Eligibility criteria to receive state services
- Becoming a kinship placement

Courts & Legal Representation

- Probate & Family Court
- Rolling trials
- Contested custody issues
- Grandparent and kin custody and visitation rights
- Court rulings
- Infrequent contact between attorney and client
- Ineffective legal representation
- Role of attorney and Guardian ad Litem
- Obtaining an attorney or Guardian ad Litem

Education

- Advocacy for special education services
- Bullying
- Restraints and discipline policies in schools
- Individual Education Plan (IEP) questions and process

Visitation

- Grandparent visitation rights
- Appropriateness of visitation plan
- DCF caseworker not meeting home visiting requirements

Permanency

- Length of time in out-of-home placement
- Premature reunification
- DCF goal changes
- Delay of achieving permanency
- Adoption and guardianship
- Legal risk situation
- Transition plan for youth aging out of care

DCF Case Practice

- Decisions made by caseworker and agency staff
- Client/DCF communication and expectations
- Lack of agency responsiveness

Other/Systemic Issues

- Denial of services
- Coordinating multi-agency involvement
- Confidentiality and information sharing
- Cost shares for out-of-home placements
- Difficulty accessing services for children with complex needs
- Roger's Process
- Lack of professionalism
- Insurance limitations
- Overuse of psychoactive medication in foster care and treatment facilities

How We Help

Linda,* a maternal grandmother, contacted the OCA regarding her four-year-old grandson Joshua*. DCF placed Joshua with Linda when Joshua was two years old. Joshua was removed from his parents' care due to their long history of mental health issues and instability. DCF offered Joshua's birth parents services for their mental health and parenting issues, but they had not engaged with their DCF caseworker or the services offered in the last two years. A year ago, DCF changed Joshua's goal for a permanent home from reunification with his parents to adoption.

Linda wishes to adopt Joshua and up until now believed she would be able to do so once the court freed Joshua for adoption. However, a week ago DCF contacted Linda to inform her that Joshua's goal for a permanent home was changed back to reunification with his parents. The DCF caseworker told Linda that Joshua's parents have recently begun services to address their mental health issues and had demonstrated a period of stability. The DCF caseworker and supervisor have decided to begin supervised visits between Joshua and his parents. Linda told the ongoing DCF caseworker that she was concerned about this goal change, as her daughter had struggled with mental health issues and instability for a long time, and her periods of stability were short lived. Linda reports feeling fearful that Joshua be removed from her home and reunified with his parents.

OCA staff listened to Linda's concerns then helped her understand the role of the OCA. The Child Advocate cannot intervene in juvenile court cases, nor can OCA staff substitute their judgment for that of a judge or a DCF caseworker. We then identified with Linda the best people to contact regarding her concerns, such as Joshua's court-appointed attorney. The OCA cannot provide legal advice, and we suggested to Linda that she might want to consult an attorney regarding her legal rights. We talked Linda through the process of bringing her concerns up the chain of command within DCF and provided Linda with contact information for the DCF Ombudsman's office. The Ombudsman staff assist people involved with DCF, have access to DCF case records, and talk directly with DCF staff. The DCF Ombudsman's Office can be reached at (617) 748-2444. We invited Linda to keep in touch with the OCA and let us know how things were unfolding for her family and for Joshua.



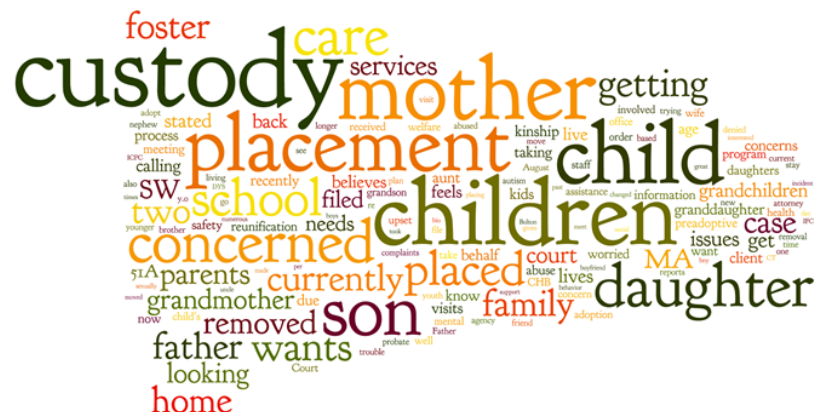
**The names in this vignette have been changed.*

As our Program Assistant heads off to graduate school, we asked her to share her thoughts about her experience on the Helpline.

- There are two sides to every story.
- Everyone deserves to be listened to.
- No one wants their children to be removed.
- Social workers are human - there are great social workers and not-so-great social workers, similar to any workforce.
- Allowing a person to speak while suspending your judgment and keeping an open mind will provide you with a much clearer picture of what a person is looking for.

I remember listening to foster parents concerned about their foster children going home to their biological parents. Foster parents have it tough -- they bring children into their homes and love and care for them. On the other hand, parenting is a fundamental right and the juvenile court looks at the biological parent's current fitness when assessing whether to return a child to their custody. This can create havoc with the child's behavior and can be very difficult for a foster parent to watch. Many continue to offer support to the child and raise their concerns to DCF, however when a judge orders reunification, a social worker, an attorney, or an advocate can only do so much.

Many of the calls I receive begin with a caller who is frustrated and angry, however once the caller is given time to express themselves the tone of the call quickly changes. Everyone deserves to be heard and to have their concerns validated. It makes me feel really good when I can hear the tone of a caller's voice change from completely frustrated to calm and hopeful. This can happen after providing the caller with new information or just listening to them. Many callers will end their call by saying, "You are the first person who has taken the time to listen to me."



Website

The OCA website provides consumers and professionals with access to timely information and updates on the OCA's activities. The website, shown on right, includes pages dedicated to the OCA's Helpline, FAQs, and resources for child welfare, juvenile justice, behavioral health, education, and legal issues. Readers can also find annual reports, investigation reports, reports on the FY 2015 DCF management project, and reports on DCF's Fair Hearing system under the Reports and Investigations tab.

Link: <http://www.mass.gov/childadvocate/>

In addition to the website, the OCA created a Twitter account, an online social networking site, shown below. This was part of the OCA's continuing effort to communicate new updates and information in a timely manner and to include youth and young adults in our audience. Examples of "Tweets," or short messages, include tips for summertime safety, infographics on safe sleep for infants, links to new research reports, and various events held for youth involved with DCF, DYS, DMH, and other organizations.



Twitter: <https://twitter.com/MACHildAdvocate>

Reports of Abuse and Neglect in Out-of-Home Settings

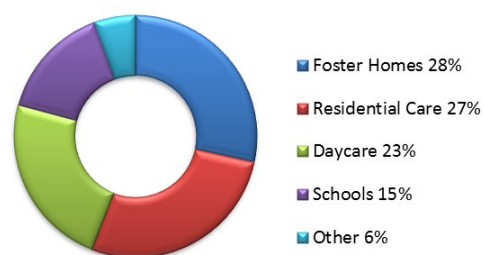
The OCA receives reports that have been investigated and supported by DCF regarding abuse and neglect (51A reports) of children and youth in out-of-home settings. These settings include foster homes, residential treatment programs, licensed and unlicensed preschool and day care, elementary and secondary schools, and transportation services. OCA staff analyze and discuss each report and obtain more information in selected cases. We provide feedback to the agencies about concerning issues and trends. On the basis of our reviews, OCA staff connected with:

- DCF concerning trends within foster homes and decisions regarding specific foster homes; also concerning staffing and programmatic issues in residential treatment programs utilized by DCF for placement of children and youth in state custody.
- DCF and DEEC regarding issues that arise with families who provide both foster care and family day care.
- DEEC to review relevant licensing reports of licensed preschool and child care programs and concerning issues related to providers of transportation to licensed child care programs.
- DESE regarding safety in swimming pools located in schools.
- DPH concerning staffing and programmatic issues in residential substance abuse treatment programs for youth.
- DYS concerning staffing and programmatic issues and restraint reduction in detention and treatment programs.
- Provider agencies to learn about improvements in their services to children. OCA staff visited a provider agency residential treatment program to learn more about their staffing and programmatic improvements.

Our reviews of these 51A reports inform our participation in the [Interagency Restraint and Seclusion Prevention Initiative](#)¹ as well as our partnership with the [Committee for Public Counsel Services](#)² to examine the performance of counsel for children in state custody.

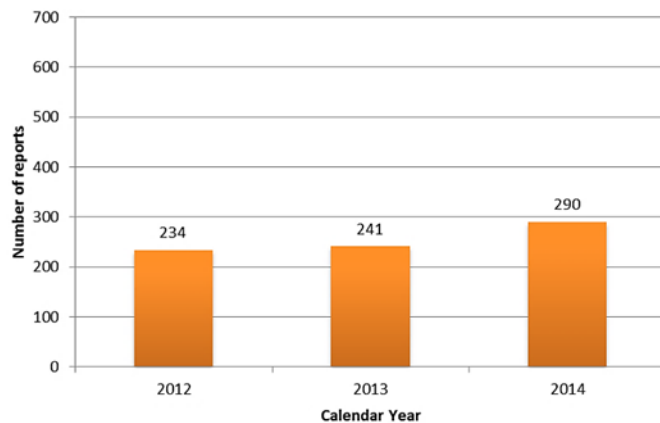
Depending on the circumstances, one 51A report may involve multiple allegations of abuse or neglect, multiple alleged perpetrators, or multiple children named as victims. Therefore, there can be multiple supported allegations in a single DCF investigation of abuse or neglect.

Settings of 2014 Reports

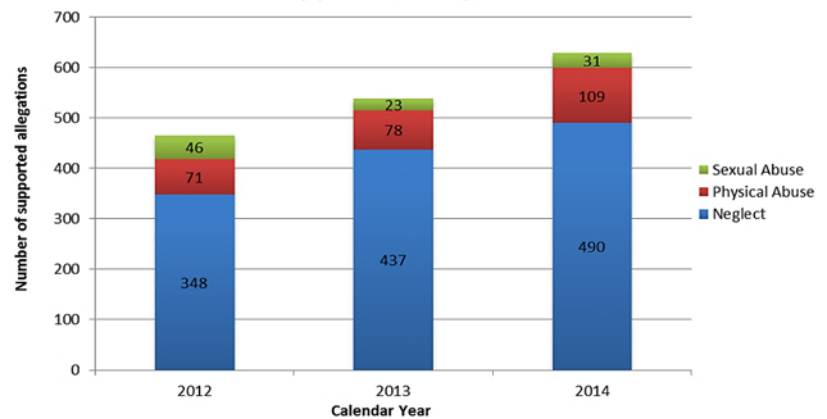


In CY 2014 the OCA reviewed 290 reports of abuse or neglect supporting 633 individual allegations of maltreatment. In CY 2013 the OCA reviewed 241 reports of abuse or neglect supporting 538 individual allegations of maltreatment. Not depicted in the bar graphs are the supported allegations of emotional abuse and death. There was one supported allegation of death and one supported allegation of emotional abuse in 2012; none in 2013; and one supported allegation of death and two supported allegations of emotional abuse in 2014.

Reports of Abuse and Neglect



Supported Allegations



The 290 reports reviewed by the OCA contained supported allegations concerning 184 children and youth who were in DCF custody when the report was filed. The majority of these reports are related to foster homes and residential care settings. By definition, foster homes necessarily involve children in DCF custody, and reports from foster homes account for 117 children and youth. Many children in residential placement are also in DCF custody, accounting for another 53 children and youth. The remaining 14 children and youth were the subject of reports in school, child care, hospital, or other out-of-home settings.

Review of these reports has impressed upon The Child Advocate and the OCA staff the importance of screening, training, and supervising our child-serving workforce and adopting a trauma-informed approach to care.

In the fall of 2011, Massachusetts was awarded a five-year federal grant resulting in the [Massachusetts Child Trauma Project](#)³ (MCTP). MCTP is a collaborative statewide initiative to enhance the capacity of the child welfare system and child mental health providers to identify, respond, and intervene early and effectively with children and youth traumatized by chronic loss, abuse, neglect, and/or violence. In June 2014 the Children and Youth Services Review

published an [update](#)⁴ on Massachusetts efforts to implement this project. As of July 2015, 2,000 child welfare workers and 270 foster, adoptive, and kinship parents and providers (“resource parents” in the graphic below) have been trained in trauma-informed practices utilizing curricula from the National Child Traumatic Stress network. Over 500 mental health professionals have been trained in evidence-based treatments for trauma.

Massachusetts Child Trauma Project

What is Traumatic Stress?

Child traumatic stress refers to the physical and emotional responses of a child who has experienced or witnessed a traumatic event. Such events overwhelm a child’s capacity to cope and elicit physical and psychological symptoms. -- [National Child Traumatic Stress Network](#)⁵

Treatment Works

Treatment from a mental health professional with training and experience working with traumatized children can reduce traumatic stress and minimize physical, emotional, and social problems. MCTP is working with eligible mental health providers to train and provide ongoing consultation in the following evidence-based treatments (EBTs):



Graphic provided by the Massachusetts Child Trauma Project

Evidence-based Trauma Treatments

ARC: Attachment, Self-Regulation, and Competency is a comprehensive, systemic intervention framework for children, adolescents aged 3-22 and families impacted by complex traumatic experiences including chronic maltreatment, neglect, and disrupted caregiving. ARC is designed to be flexibly applied across settings from home and community based programming to school-based, outpatient and residential treatment.

TF-CBT: Trauma Focused-Cognitive Behavioral Therapy is a brief components-based treatment for children aged 3 to 18 affected by traumatic life experiences and their parents or primary caregivers. TF-CBT helps children develop skills for processing the trauma; managing distressing thoughts, feelings, and behavior; enhancing safety; and improving communication with parents; and helps parents increase parenting skills.

CPP: Child Parent Psychotherapy is a model of treatment used with children ages 0-6 and their primary caregivers to overcome the effects of past traumatic experiences. Child and caregiver(s) heal from trauma through the strengthening of their relationship.

Source: <http://www.machildtraumaproject.org/index.php/product>

Currently, 739 children and youth are enrolled in therapy with a provider trained in an EBT through MCTP. Of these children and youth, 41% are in state custody, 40% are on psychotropic medications, and on average these children have experienced five different types of trauma. MCTP examined posttraumatic stress symptoms and problem behaviors of 236 children and youth from the time they enrolled in EBT to their first follow-up assessment at six months or an earlier discharge. They found a decrease in children’s posttraumatic stress symptoms with reductions in total problem behaviors across all age groups.

Critical Incident Reports

When a child receiving services from an agency organized under EOHHS dies or is seriously injured, the agency reports the death or injury to the OCA. These are called critical incident reports. The child may have been receiving family-based support services in the community or out-of-home services such as foster, group, or residential care. The agencies report on the different populations they serve:

- DCF reports critical incidents involving children in DCF care or custody as well as children whose families have had DCF involvement within the last six months.
- DDS reports critical incidents involving children and youth receiving services in the community.
- DMH reports critical incidents involving children who are receiving services in the community and in acute care, residential programs, and hospital settings.
- DPH reports critical incidents involving children receiving DPH-funded services in the community and in residential treatment programs licensed and funded by DPH.
- DYS reports critical incidents involving youth committed by the juvenile court to DYS who are receiving services in the community and in group or foster care, residential treatment programs, and secure treatment centers.

In each of these settings, the death or serious injury of a child is a sentinel event that prompts the OCA to review the circumstances and the reporting agency's involvement.

OCA staff carefully review each critical incident report and follow up with the agency to learn more information as needed. When a matter warrants closer investigation, OCA staff request investigation reports from the agency, speak with agency staff, and review case records to learn of a family's history and involvement with the agency. The OCA works with the agency to review and learn from the reported situation and promote accountability. We continue to work with the agencies to improve the reporting process and move toward the goal of timely notification of all critical incidents followed by appropriate review by the agency and the OCA.

The OCA received 136 critical incident reports concerning 128 incidents that occurred in calendar year 2014. In some instances, we received two reports concerning the same critical incident. The number and type of reports filed varies from year to year, as depicted in the graph below. The increase in reports from CY 2013 is explained by an increase in reports due to deaths from medical conditions and natural causes, and an increase in reports related to children who are NOT receiving services from EOHHS ("Additional Reports" in the graph below).

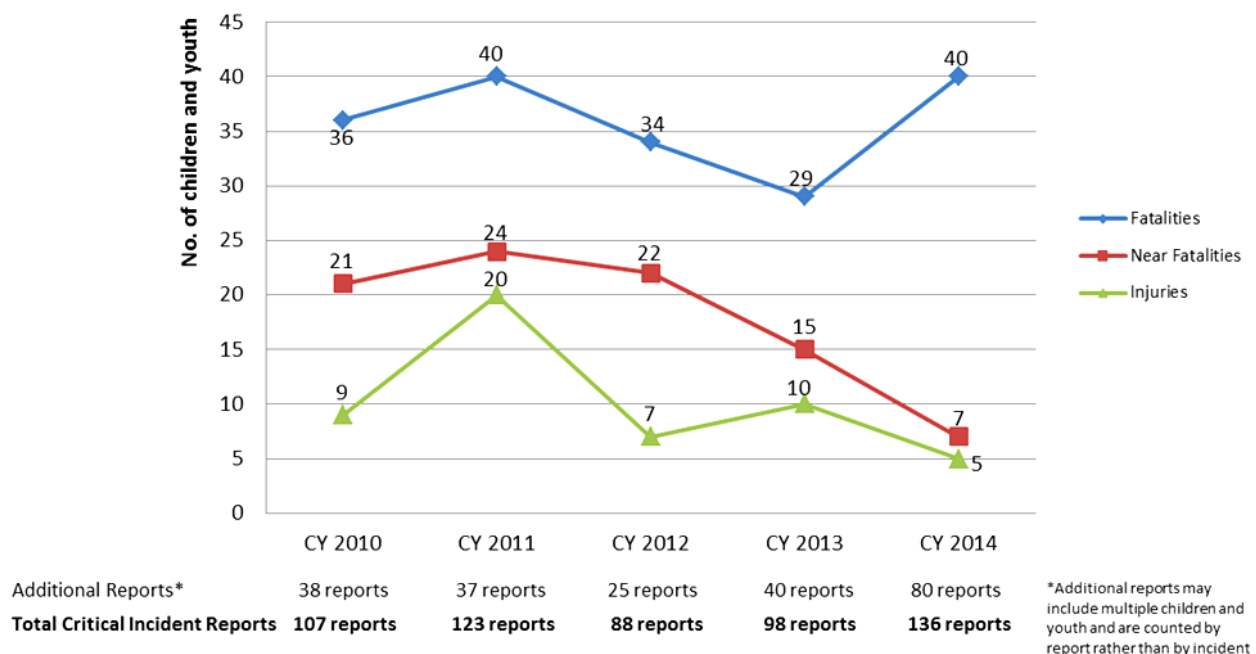
The following agencies filed the corresponding number of reports for critical incidents in 2014:

Department of Children and Families:	96 (10 reports regarding 10 children in DCF custody)
Department of Developmental Services:	5
Department of Mental Health:	4
Department of Public Health:	10 (1 report regarding 2 youth in DCF custody)
Department of Youth Services:	<u>21</u> (14 reports regarding 15 youth committed to DYS)
	136

As discussed above, critical incident reports concern children receiving services from state agencies as well as children in state custody or care. State custody means that a judge has given legal custody of a child to DCF, along with the right to determine the placement of the child. DCF is the only agency that can be awarded legal custody of children through a Care and Protection proceeding, through a petition for a Child Requiring Assistance, or by the order of a probate and family court judge. Children in DCF custody may be placed with their parents, in licensed foster homes (including kin or extended family), in group homes, or in residential treatment programs. DCF care is different from DCF custody in that a child in care receives services under a voluntary placement agreement between the child's parent or guardian and DCF.

When a youth is committed by a judge to DYS, the parent or guardian remains the youth's legal custodian even though DYS determines services and placement for the youth. DMH, DPH, and DDS provide services on a voluntary basis to child clients and custody remains with the parent or guardian, even when the child is placed in a hospital or acute treatment setting.

Critical Incidents (CY 2010 - 2014)



OCA Reporting, Confidentiality, and CAPTA

The OCA is responsible for reporting annually to the governor, legislative leaders, and the public on the activities of our office. In addition, Massachusetts has a duty under the federal Child Abuse Prevention and Treatment Act (CAPTA) to disclose to the public information about child abuse or neglect resulting in a child fatality or near fatality. By providing the information below, the OCA staff seek to balance the confidentiality of the information received with the duty of annual reporting and the duty to disclose the deaths and near deaths of children from abuse and neglect.

Fatalities

Reviewing the deaths of children is difficult but important work. Through our involvement with the statewide Child Fatality Review Program, OCA staff are well-grounded in principles of child death review and knowledgeable about Massachusetts child mortality data.

Forty-four critical incident reports documented 40 deaths of children and youth involved with EOHHS agencies that occurred in 2014. In four instances, the OCA received more than one report from an agency or agencies concerning the same death. After reviewing each critical incident report, the OCA staff met to discuss the fatality and the agency response. If the agency conducted an investigation, OCA staff reviewed the resulting report. When both the OCA and law enforcement conducted an investigation into a child's death, OCA staff coordinated their work with the District Attorney's Office. Whenever possible, OCA staff attended local child fatality review team meetings to learn more about the involvement of agencies, courts, schools, and health care providers in the lives of the children who died. The Child Advocate and OCA staff met quarterly with DCF management to discuss our observations concerning fatalities and injuries to children.

Injury-related deaths occurred in six children and youth aged nine to 17 years. One child was in DCF custody. The causes of injury-related deaths were suicides, motor vehicle crashes, and a homicide. These were also leading injury-related causes of death for children across Massachusetts during 2011 through 2012, the period for which the most recent statewide data is available.

- A 17-year-old male died from injuries sustained as a passenger in a motor vehicle crash.
- A 17-year-old female pedestrian died after being struck by a motor vehicle.
- A 15-year-old male died from suicide by hanging.
- A 15-year-old female died from suicide by hanging.
- A 12-year-old male died from suicide by hanging.
- A 9-year-old male died from homicide by a gunshot wound.

Pools in Schools: Between August 2012 and April 2013, three Massachusetts youths drowned in swimming pools located in public schools. The OCA worked with the Child Fatality Review Program, DPH, and DESE to advocate for safety guidelines for swimming pools located in schools. A joint advisory addressing these concerns was distributed to school superintendents and charter school leaders and can be found on the DESE website at: <http://www.doe.mass.edu/cnp/resources/SwimmingPools.pdf>.

Deaths due to natural causes or medical conditions occurred in 16 infants, children, and youth. Two children were in DCF custody at the time of their deaths.

- Five infants aged one month or younger died from complications of premature birth, congenital anomalies, or complications of pregnancy and delivery. These are common causes of infant death across Massachusetts and the United States. Two of these infants were male and three were female.
- A newborn male died from a respiratory virus.
- An eight-month-old male died from complications of prematurity.
- An 18-month-old male died from cancer.
- A two-year-old female with a complex medical history died.
- A two-year-old male died from complications of pneumonia.
- A 10-year-old male died from complications following cardiac surgery.
- A 10-year-old male with a complex medical history died.
- An 11-year-old male with a complex medical history died.
- A 15-year-old female died from cancer.
- A 15-year-old female with a complex medical history died from complications of a seizure disorder.
- A 15-year-old male died from complications of asthma.

Sudden and unexpected infant and toddler death (SUID) is a category that includes Sudden Infant Death Syndrome (SIDS), accidental suffocation in bed, and undetermined causes of death in the infant and toddler population. SUID is the most common type of death for infants between the ages of one month and one year in Massachusetts. A death cannot be definitively categorized as SUID until a medical examiner has determined the cause and manner of death. In 2014, the OCA received 12 critical incident reports concerning deaths of 11 young children receiving services from EOHHS agencies in circumstances that appear to be SUID. Of these 11 deaths, the Office of the Chief Medical Examiner has established the cause and manner of death for eight infants and toddlers. These eight SUID deaths are described below. The remaining three deaths, for which cause and manner of death have not been established, will be described in the next section. Six of the eight SUID deaths occurred in the setting of

bed-sharing. Additional risk factors, such as parental substance use, were present in most of the deaths. All these infants lived with their families in the community; one was in DCF custody but was living in the home of a relative.

- A four-day-old female died while sleeping in a bed with an adult and siblings.
- A two-week-old female died while sleeping in a bed with adults.
- A two-month-old male died while sleeping in a bed with an adult.
- A three-month-old female died while sleeping in a bed with an adult and a sibling.
- A three-month-old female died while sleeping in a bed with an adult.
- A four-month-old male died while sleeping in a bassinet in a side-lying position.
- A six-month-old male died while sleeping in a bed with two adults and a sibling.
- A 23-month-old male died while sleeping.

The OCA continues to work with the Child Fatality Review Program, DCF, and DPH to examine the deaths of infants who die suddenly and unexpectedly. OCA staff participated in the DPH Safe Sleep Task Force and the EOHHS Safe Sleep Working Group during FY 2015. See page 21 for a further discussion of issues related to sudden and unexpected infant deaths.

The medical examiner has not finalized the cause and manner of death of 10 infants and children who were the subject of 13 critical incident reports. None of these children were in DCF custody at the time of death.

- A two-month-old female died while sleeping in a bed with adults.
- A two-month-old female died while sleeping in a bassinet.
- A three-month-old male died while sleeping in a side-lying position in a bassinet.
- A one-year-old female died after a viral illness.
- A two-year-old female died while unattended in a car seat.
- A six-year-old female with a history of asthma died following an incident of respiratory failure.
- A 10-year-old female with a complex medical history died.
- A 13-year-old male with a complex medical history died in his sleep.
- A 16-year-old female died while hospitalized with pneumonia.

In the Critical Incident Report section of the [FY 2014 Annual Report](#), we listed four deaths reported in 2012 and 10 deaths in [2013](#) for which the medical examiner had not determined the cause of death. Two of these children were in DCF custody at the time of death. Of these 14 deaths, the medical examiner has since finalized the cause and manner of death for nine children. After post-mortem examination and testing and scene investigation, if the medical examiner is unable to establish the cause or manner of death, it is described as “undetermined.”

Four of the deaths were determined to be a SUID:

- A three-week-old female died while sleeping in a crib and the cause and manner of her death have been ruled undetermined.
- A four-week-old male died while sleeping in an adult bed with a parent. The cause was sudden death of an infant while co-sleeping with an adult and the manner was undetermined.
- A five-week-old female died while sleeping on a sofa with a parent. The cause and manner of her death have been ruled undetermined.
- A six-month-old male died while sleeping in an unsafe environment. The cause of death was positional asphyxia and the manner of death was accident.

One of these deaths was a homicide:

- A five-month-old male died from blunt force trauma to his head and torso.

Three children died from natural causes:

- A seven-month-old male died from an infection.
- A 14-month-old female died after a brief viral illness.
- A five-year-old male died from an infection.

One child died in a manner that was undetermined:

- A 21-month-old female died from complications of a seizure disorder of uncertain etiology and the manner of death was undetermined.

The cause and manner of death is still pending for these children:

- An 11-week-old female died while sleeping in a bed with an adult.
- A five-month-old male died while sleeping in an unsafe environment.
- A nine-month-old male died after his caretaker fell on him.
- A two-year-old female died suddenly and unexpectedly.
- An 11-year-old male died following abdominal trauma.

Near Fatalities

The OCA received eight critical incident reports concerning seven incidents of near fatalities of children and youth involved with EOHHS agencies that occurred in 2014. The OCA defines a near fatality as an event that places a child in critical or serious condition. Because of the imminent risk of death involved, we include all wounds from dangerous weapons and suicide attempts in this definition. The OCA is working with involved agencies to understand each agency's response to near fatalities and to coordinate our work with that of the agency. For children receiving services from DCF, OCA staff review case practice and ensure that a clinical review is done at the area office or regional level. For youth receiving services from DYS, OCA staff request additional information in selected cases to review case management. Four of the incidents related to youths committed to DYS and receiving services in the community; two incidents involved youths in DCF custody. The most common causes of the near fatalities reported to the OCA were gunshot and knife wounds in adolescents, which accounted for five reports.

- A five-month-old male suffered abuse at the hands of his caretakers resulting in life-threatening injuries.
- A 17-year-old male pedestrian was struck by a motor vehicle resulting in life-threatening injuries.
- Three males ages 16 through 17 years sustained gunshot wounds; two were living in the community and one was on the run from a residential treatment facility.
- Two males ages 16 through 17 years sustained stab wounds; one was living in the community and one was on the run from a residential treatment facility.

Injuries

The OCA received four critical incident reports concerning serious but nonlethal injuries to five children and youth involved with EOHHS agencies that occurred in 2014. One report involved a child in DCF custody. OCA staff followed up with agencies and reviewed relevant investigation reports.

- A four-month-old female suffered bruising and fractures of her ribs, legs, and arms.
- An 11-month-old female suffered bruising and spinal fractures.
- A two-year-old boy and a three-year-old boy suffered serious burns.
- A 17-year-old male was sexually abused by staff while residing at a state-funded and licensed program.

Additional Reports

The OCA received an additional 80 reports concerning 77 incidents that occurred in 2014. Four reports involved five children in DCF custody. Eleven reports involved 11 youths committed to DYS. Eleven reports documented violent behavior in community settings allegedly caused by youths involved with EOHHS agencies. Thirty-five reports described injuries or deaths of children and youth NOT involved with EOHHS agencies. Five reports described injuries or deaths of five youths over age 18 receiving services on a voluntary basis from EOHHS agencies. Other reports documented the following circumstances:

- Children and youths involved with EOHHS agencies who witnessed violence in their homes.
- Youths involved with EOHHS agencies who had run away from their homes or placements.
- Incidents in state-funded schools and programs, including sexual activity, assaults, threats, and ingestion of substances.
- Media alerts regarding children and families.

Child Fatality Review Program

The death of a child is a community responsibility. It is a sentinel event that should urge communities to identify other children at risk for illness and injury. Reviewing the deaths of children requires comprehensive case information and multidisciplinary participation from the community. Each review should lead to an understanding of risk factors and result in recommendations and actions to prevent deaths and to keep children healthy, safe and protected.⁶

The statewide Child Fatality Review Program was created in 2000 with the goal of decreasing the incidence of preventable childhood deaths and injuries. The state team is co-chaired by the Chief Medical Examiner and the DPH Director of the Bureau of Community Health and Prevention. Eleven local teams meet under the leadership of the District Attorneys' Offices to conduct multidisciplinary reviews of individual deaths. The local teams take local action and formulate recommendations for the state team to consider, including changes to statewide policy, practice, or regulation. The Child Advocate is an *ex officio* member and OCA staff take an active role on the state team.

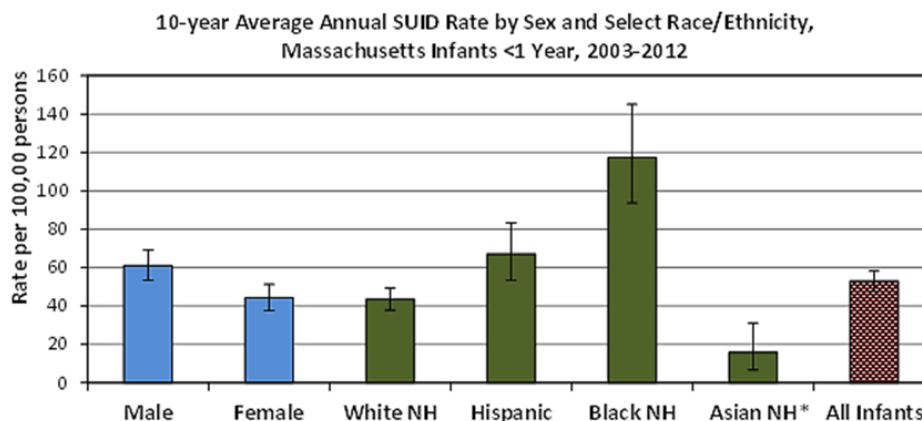
Certain child fatalities reviewed by the OCA as critical incidents are also reviewed by local child fatality review teams. OCA staff members attend as many local team meetings as possible and attempt to attend whenever the death being reviewed was the subject of a critical incident report. During the last year OCA staff attended local team meetings in Bristol, Essex, Hampden, Middlesex, and Norfolk counties. Attending local team meetings helps OCA staff to learn about the circumstances in which all Massachusetts children are at risk for fatal injuries and other preventable deaths. It is important to understand the deaths of agency-involved children within this context. A sense of perspective is vital to child fatality review, because while difficult things sometimes happen to children involved with agencies, difficult things happen to other children, as well. At the OCA we continually examine whether agency-involved children are at increased risk of injury or illness and whether interventions aimed at prevention can be tailored to decrease this risk.

Since its inception a decade ago, the Child Fatality Review Program has relied on resources allocated by its contributing members. As discussed in prior OCA annual reports, dedicated resources are necessary for this important program to fulfill its mandate and achieve its potential for preventing child fatalities and injuries. The most recent report of the Massachusetts Child Fatality Review Program, *A Multi-Disciplinary Approach to the Prevention of Child Deaths*, presents data and program information for the years 2009-2012. It can be viewed at <http://www.mass.gov/eopss/docs/eops/publications/cfrr-2009-2012-annual-report.pdf>.

Recommendation: The Child Fatality Review Program is a critical component of the state's efforts to prevent child deaths and injuries and should receive adequate resources to enable the work of both the state and local teams.

Sudden Unexpected Infant Deaths

Newborns are vulnerable to complications arising from pregnancy, fetal development, and the birth process, particularly during the first month of life. For infants ages one month to one year, Sudden Unexpected Infant Death (SUID) is the most common type of death. Between 30 and 50 infants die suddenly and unexpectedly in Massachusetts each year – the equivalent of the loss of two classrooms of kindergarten students. As demonstrated in the graph below, SUID impacts Hispanic and black infants at higher rates than white infants in the Commonwealth.



Source: Registry of Vital Records and Statistics, MDPH, 2003-2012. The 2012 death file was prepared in September 2014; counts and rates presented using this file may differ from earlier files. NH is non-Hispanic.

*Rate is based on a count less than 20 and is considered unstable.

Understanding why infants die unexpectedly requires careful scene investigation and data collection by law enforcement agencies, medical examiners, and public health officials. In Massachusetts, the Center for Sudden Infant Death at Boston Medical Center and the Child Fatality Review Program are important resources for this work.

The relationship between SUID and unsafe sleep environments is well established. Multidisciplinary reviews conducted by local child fatality review teams have found that many of these deaths are associated with unsafe infant sleep positions and sleep environments, such as bed-sharing, couches, and prone or side-lying positions. The understanding of SUID has evolved nationally, leading the American Academy of Pediatrics (AAP) to expand its recommendations concerning safe sleep practices for infants in 2011. In 2012 DPH issued “Policy Recommendations for Safe Infant Sleep Practices,” based on the AAP recommendations. These policy recommendations were endorsed by the State Child Fatality Review Team and the OCA.

Massachusetts child-serving agencies have embraced the need to deliver a consistent message about safe sleep. DPH has identified safe sleep as a priority area in its Injury Prevention Strategic Plan and convenes the Safe Sleep Task Force. DPH personnel conduct trainings on safe sleep throughout the child-serving agencies and have partnered with the Women, Infants, and

Children program (WIC) to promote safe sleep. DEEC staff train licensed child care providers on safe sleep practices. DCF caseworkers teach families with infants about safe sleep practices and distribute Welcome Baby bags containing safe sleep materials for parents with infants. In December 2015 DCF hosted a conference on infant safe sleep for workers from Early Intervention, EEC licensors, and DCF investigators and managers.

Recommendation: Our goal is for every parent of every newborn to hear the safe sleep message during pregnancy, at birth, and at doctor visits. The Child Advocate encourages all state organizations to offer clear and consistent information to the public about safe sleep practices for infants.

The infant mortality rate measures how many infants under one year of age die per 1,000 live births and is considered to be an indicator of well-being in a society. The child mortality rate measures deaths of children ages 0 - 17 per 100,000. Massachusetts' infant mortality and child mortality rates are among the lowest in the nation.

Massachusetts Infant Mortality Rate (average annual rate 2011-12): 4.2 per 1,000 live births

National Infant Mortality Rate (average annual rate 2011-12): 6.0 per 1,000 live births

Massachusetts Child Mortality Rate (average annual rate 2011-12): 33.8 per 100,000 persons

National Child Mortality Rate: (average annual rate for 2011-12): 51.2 per 100,000 persons

Sources: Registry of Vital Records and Statistics, Massachusetts Department of Public Health; Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2013 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Mar 16, 2015 2:46:26 PM.



Safe Sleep Legislative Breakfast, October 2, 2014.

Safe Sleep Tips for Parents

1. Always put babies **on their backs** to sleep for naps and at night.
2. **Keep babies near, but in their own cribs**. New parents often want to be close to their babies at night, but sharing a bed puts your baby at risk for suffocation from someone rolling over on them, or from pillows and blankets. Taking medications, sleeping aids, or drinking alcohol can affect your sleep and put your baby at even higher risk.
3. **Don't let your baby sleep or nap in the same bed with anyone else** – even a twin, sisters, brothers, or babysitters. Another person, no matter how small, could roll over and smother the baby. This includes pets.
4. **Put your baby in her own crib but keep the crib close enough to know when your baby needs you**. If you are breastfeeding, sleeping near your baby's crib makes it easy for you to feed your baby when she's hungry and helps you build a good milk supply. Breastfeeding has been shown to reduce the risk of sudden infant death and has many health benefits for babies, but even breastfeeding moms should keep their babies in their own cribs.
5. **Use a firm mattress and a tight-fitting sheet in your baby's crib**. Fluffy pillows, quilts, and toys are not safe for sleep. Blankets, pillows, or bumper pads in the crib could make it hard for your baby to breathe. Young babies can't move around enough to hurt themselves, and the slats on their cribs should be close enough together to prevent their heads from getting stuck.
6. **Keep babies cool**. Don't overheat the room or overdress the baby. You can dress your baby in warm pajamas or a sleep sack and put your baby to sleep without a blanket.
7. **Never smoke around babies**. Keep the sleeping area and the home smoke-free. Second and third-hand smoking are also risk factors for babies.
8. Give your baby **plenty of tummy time** when he is awake and an adult is watching. This will help your baby's neck and shoulder muscles get stronger.
9. If you have an older crib or a used crib, **make sure the crib meets current safety standards**. To find out if the crib is approved for infants, call the Consumer Product Safety Commission toll-free at 1-800-638-2772 or visit their Check Your Crib for Safety video.

Source: Massachusetts DPH Injury Prevention and Control Program

Safe Sleep Examples



Source: The Safe to Sleep® Campaign, National Institute of Child Health and Human Development.



Image source: The Infant Safe Sleep Partnership (Colorado)

Note: This infographic was developed based on the American Academy of Pediatrics' recommendations for safe sleep.

The Opioid Epidemic and Substance Exposed Newborns

Substance use among pregnant women presents a significant public health challenge in the United States. Prenatal exposure to both legal and illegal substances can affect a newborn's health and development, increases the newborn's risk for abuse and neglect, and is a risk factor associated with Sudden Unexpected Infant Death (SUID). In a recent study of infants admitted to neonatal intensive care units (NICUs) throughout the U.S. from 2004 through 2013, the rate of admissions to NICUs for neonatal abstinence syndrome increased from 7 to 27 cases per 1000 admissions and the median length of stay increased from 13 to 19 days.⁷ These data show that substance use among pregnant women is on the rise, affecting the health and future of infants and requiring increased resources and responses from hospitals and child protection agencies. Collaboration among state agencies and birthing hospitals to assure proper intervention and response to these vulnerable infants and families is critical.

In Massachusetts health care providers are required to file a report of abuse or neglect with DCF when a baby is born physically dependent on an addictive substance. In August 2013 DCF implemented new screening and response guidelines related to substance exposed newborns (SEN). DCF also added capacity in their data management system to identify SENs to follow their safety and well-being. Between March 2014 and March 2015, DCF received 2,376 reports on SEN; 95% were screened in for a protective response with an overall support or concern rate of 77%. If a case had been open with DCF prior to the SEN-related 51A intake, it remained open. DCF opened 1,272 new cases following the response finding and closed 579 cases at the end of the response. DCF took custody of the newborn in 490 cases.

The Department of Children and Families (DCF) received 2,376 reports of a substance exposed newborn (SEN) between March, 2014 and March, 2015

A SEN designation is given when 1 or more of the following occurs:

- A positive toxic screen on the newborn;
- A positive toxic screen on the mother during her pregnancy or at delivery;
- A newborn has been diagnosed with Neonatal Abstinence Syndrome (NAS);
- Evidence of withdrawal symptoms from alcohol or drugs on the mother or the baby;
- A newborn shows signs of Fetal Alcohol Syndrome (FAS);
- A newborn tests positive for methadone, buprenorphine (Subutex), or buprenorphine with naloxone (Suboxone); or
- A self report by the mother or a verifiable report from a treatment provider that during pregnancy the mother used illicit drugs.

SEN reports to DCF

Mar, 2014	133
Apr, 2014	142
May, 2014	157
Jun, 2014	159
Jul, 2014	168
Aug, 2014	206
Sep, 2014	244
Oct, 2014	219
Nov, 2014	160
Dec, 2014	200
Jan, 2015	177
Feb, 2015	203
Mar, 2015	208
Total	2,376

Finding 3: Pregnant women and mothers with a substance use disorder need specialized care

Source: <http://www.mass.gov/eohhs/images/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf>

The Massachusetts Neonatal Abstinence Syndrome (NAS) improvement project was launched in 2013 with the goal of improving the care of infants impacted by NAS as well as their families. Over 40 hospitals in the state have joined together to share practices, compare data, and develop local improvement projects focused on the care of these infants. The project is conducted in partnership with the Vermont-Oxford Network (VON) and with the support of DPH.

In February 2015, Governor Charlie Baker convened an Opioid Task Force to identify strategies for prevention, intervention, treatment, and recovery from addiction. The task force published recommendations which included a finding that pregnant women and mothers with a substance use disorder need specialized care.

Recommendations Related to Neonatal Abstinence Syndrome, Prenatal Care & Neonatal Care

- Outreach to prenatal and postpartum providers to increase training about: screening, intervention, and care for women with a substance use disorder
- Promote early identification and proper treatment, raise awareness of NAS within the public health and medical communities
- Review the costs and benefits of mandating testing for in utero exposure to alcohol and drugs at every birth
- Ensure adequate capacity for pregnant women in the treatment system
- Develop and institute a training program focused on NAS and addiction for Department of Children and Families staff
- Work with health care providers to ensure all infants with NAS are referred to early intervention by the time of hospital discharge
- Partner with early intervention (EI) leadership and developmental experts to study the value of increasing automatic EI eligibility for infants with NAS from one year to two years

Finding 3: Pregnant women and mothers with a substance use disorder need specialized care

Source: <http://www.mass.gov/eohhs/images/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf>

The OCA supports these efforts by Massachusetts child-serving agencies and health care providers to increase responsiveness to the needs of substance exposed newborns and their caregivers.

Psychotropic Medication for DCF Children

Since 2009 the OCA has been urging DCF to review its process for authorizing and overseeing antipsychotic medication for children in DCF custody so that all psychotropic medications are subject to review as part of a child's overall behavioral health treatment plan. In 2012 the OCA recommended to the Secretary of EOHHS a tiered system of oversight, and the Psychopharmacology Steering Committee, co-chaired by the DCF Commissioner and The Child Advocate, was formed to develop a plan for implementing these recommendations.

In 2013 DCF established an internal monitoring system to review the treatment plans for children who fell into categories that caused the most concern. The Psychopharmacology Steering Committee then began exploring additional strategies, such as requiring prior authorization of medications that fall into "red flag" categories, as well as ongoing review and monitoring procedures for children in DCF custody. In 2014 the MassHealth Pharmacy Program developed the Pediatric Behavioral Health Medication Initiative (PBHMI) in collaboration with DCF and DMH to monitor the psychotropic medications of all children insured by MassHealth. In November 2014 PBHMI began evaluating children and adolescents less than 18 years of age enrolled in the Primary Care Clinician plan. PBHMI uses evidence-based medicine and clinical practice guidelines to evaluate prior authorizations for behavioral health medications and polypharmacy regimens. The Managed Care Entities are working towards implementation in the later part of 2015 and 2016.

Since its implementation, PBHMI has worked closely with DMH and expert prescribers to clarify and refine PBHMI authorization guidelines. PBHMI offers resources for prescribers, including a designated webpage with clinical information on the MassHealth Drug List, a Clinical Call Center for prescribers and pharmacies regarding specific claims, and a Clinical Call Line for prescribers who wish to discuss more general PBHMI goals or criteria or schedule a telephone appointment with a clinical pharmacist. DCF has developed tip sheets about PBHMI for social workers, parents, guardians, and foster parents. In addition, DCF nurses and mental health specialists are available to assist social workers responsible for consenting to the initiation of psychotropic (other than antipsychotic) medications for children on their caseloads.

Early data suggests that PBHMI can play an important role in the oversight of psychotropic medications for children in Massachusetts. PBHMI does not, however, focus specific attention on children in DCF custody. When a child is removed from her family and taken into DCF custody, the Commonwealth becomes responsible for that child's health and well-being. This responsibility requires more than prior authorization for psychotropic medications – it requires that medication be part of an individualized behavioral health treatment plan that includes ongoing review and evaluation. A more comprehensive and integrated process for

authorizing and overseeing psychotropic medication for children in DCF custody is needed. DCF should examine and revise its regulation requiring judicial authorization of antipsychotic medications, known as the Rogers Process, for children in DCF custody as well as its process for obtaining informed consent for all psychotropic medications for children in DCF custody.

Recommendation: The Child Advocate urges DCF to develop a process for authorizing and overseeing psychotropic medication for children in DCF custody that places medication in the context of individualized behavioral health treatment plans and incorporates evidence-based practices.



Justice for Youth

Juvenile Court Jurisdiction for Homicides

The Child Advocate has worked persistently over the last seven years to advance justice for youth throughout the juvenile justice system. This work is premised on an understanding that children and youth are different from adults. Their brains are still developing in ways that affect their judgment, and while youth must be held accountable for their actions, their lack of maturity and potential for rehabilitation should be considered at every step in the juvenile justice system, including sentencing.

During the last three years, federal and Massachusetts courts and legislatures have recognized that youth should be treated differently. In June 2012, the United States Supreme Court in *Miller v. Alabama* prohibited mandatory sentences of life without the possibility of parole for youth convicted of committing first degree murder while under the age of 18. Legislation was passed in Massachusetts in September 2013 that raised the age of juvenile court jurisdiction from 17 to 18 for delinquency matters. In December 2013, the Massachusetts Supreme Judicial Court in *Commonwealth v. Diatchenko* prohibited a sentence of life without the possibility of parole for youth under any circumstances and provided that, absent action by the Legislature, the time to a parole hearing would be 15 years.

The Legislature responded in July 2014 by passing a law setting sentences for youth who are between 14 and 18 years of age when they commit a first degree murder to life in prison with a parole hearing after 20-30 years. The time before the first parole hearing will be set by the court according to statutory time frames.

The Child Advocate continues to address fair sentencing issues at both the federal and state level by speaking and writing about post-*Miller* and post-*Diatchenko* issues and by joining in selected *amicus curiae* briefs before the United States Supreme Court and the Massachusetts Supreme Judicial Court. Although the Legislature expanded juvenile court jurisdiction to age 18 for all non-homicide offenses, it left jurisdiction for 14- to 18-year-old youths charged with homicide in the superior court. But as the United States Supreme Court recognized in *Miller*, the developmental characteristics of adolescents must inform the handling of homicides as well. The juvenile court is particularly suited for taking these characteristics into account. The Child Advocate urges the Legislature to restore jurisdiction to the juvenile court for youths under age 18 charged with homicide.

Recommendation:

The Child Advocate strongly supports legislation that would restore jurisdiction to the juvenile court for youths under age 18 charged with homicide.

Due Process for Youth Found Incompetent to Stand Trial

As policymakers recognize the cognitive and developmental limitations of adolescents, we have a corresponding duty in the Commonwealth to address the particular problems faced by youth found incompetent to stand trial (please refer to OCA Annual Report 2009). Unlike many states, Massachusetts has no statutory scheme that limits the period of confinement for these youths or that provides the programs or services they need to achieve or be restored to competency. Other states have devised solutions that address the educational and behavioral health needs of juveniles while protecting their constitutional rights. Massachusetts must do the same.

Recommendation:

The Child Advocate urges policymakers to ensure the constitutional rights of juveniles who have been found incompetent to stand trial are guaranteed, and their needs for assessment, education, and treatment are met.

Expungement of Juvenile Court Records

In 2011 the OCA became increasingly concerned that records documenting a young person's involvement with the juvenile court could create life-long barriers to educational and employment opportunities. In Massachusetts a juvenile court record can be sealed under some limited circumstances, but not wholly erased or expunged. In 2011 the OCA partnered with students from the Northeastern University School of Law's Social Justice Program to examine this issue. The students' final report and recommendations can be found on the OCA website: <http://www.mass.gov/childadvocate/>. The OCA indicated a desire to partner with others to follow up on the Northeastern research findings.

In August 2013, [Teens Leading the Way](#) (TLTW) approached the OCA to learn more about record expungement and the Northeastern research. TLTW is a statewide youth-led coalition which seeks to empower young people to create lasting change through policy-making. TLTW spent the next year laying the groundwork, then launched a campaign in August 2014 to create expungement opportunities for youth with delinquency records.

A number of bills dealing with expungement have been filed in the current legislative session. The bills differ in the following ways:

- whether the youth must file a petition with the court to begin the process
- whether expungement is automatic for certain conditions
- what types of offenses would be subject to expungement
- waiting periods before seeking expungement
- other factors

Expungement is not a simple issue. The appropriate balance must be struck between maximizing opportunities for youth and public safety; in addition, implementation will lead to practical difficulties. An additional concern is whether records stored electronically ever truly go away once they have been created. Further discussion is needed to reconcile the issues raised in the bills that have been filed.

The Child Advocate supports legislation that would allow the automatic expungement of juvenile court records for first-offense nonviolent misdemeanors upon final disposition and a specified waiting period provided there has been no subsequent delinquency or criminal offense charged during that period. For second-offense misdemeanors and other offenses, The Child Advocates supports legislation that would allow a young person to petition the juvenile court to expunge his record after a specified period of years following disposition of the matter. Statutory criteria would guide the judge in exercising discretion as to whether to order expungement.

Recommendation:

The Child Advocate supports legislation that would allow the automatic expungement of juvenile court records for first-offense nonviolent misdemeanors and allow youth to petition a court for expungement for other offenses.



Teens Leading the Way kicks off campaign to expunge juvenile court records, August 13, 2014.

Overview of ORI and the Unaccompanied Refugee Minor Program

The OCA's focus is on children who are served by the Commonwealth's child welfare and juvenile justice systems. In FY 2015 we conducted informational research on how the Office for Refugees and Immigrants (ORI) serves children in the Commonwealth. The agency provided the following information about their services:

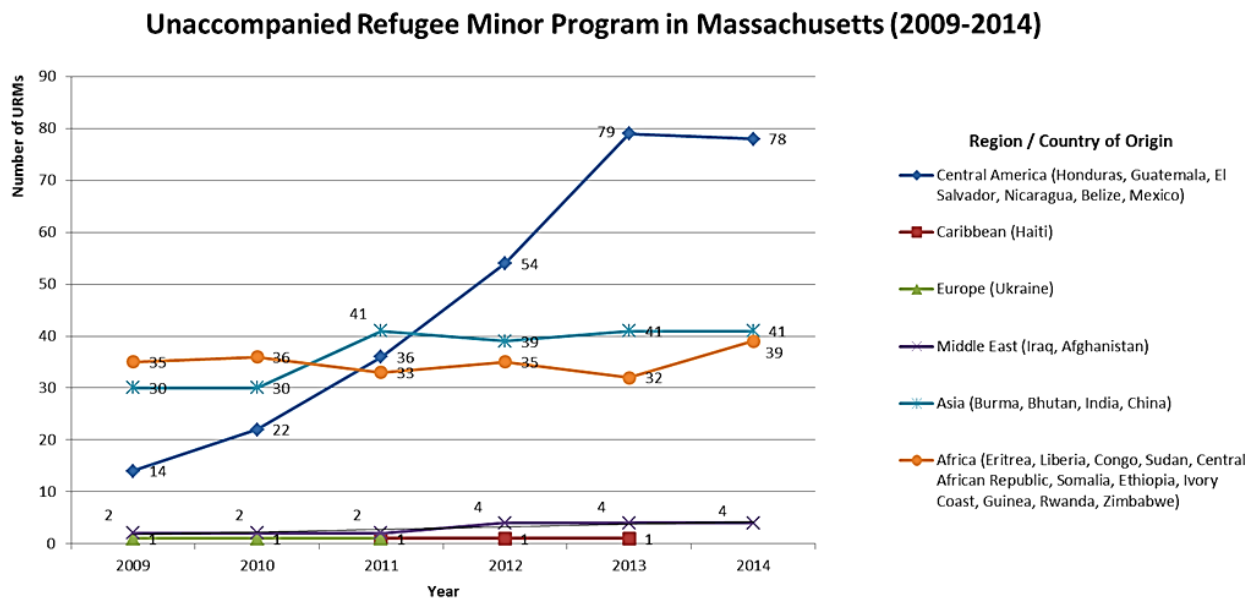
The primary responsibility of ORI is to administer the Massachusetts Refugee Resettlement Program, which is funded through the federal Office of Refugee Resettlement (ORR). Services are designed to help refugees adjust to their new home in the U.S. and achieve social and economic self-sufficiency as quickly as possible after arrival. Annual enrollment in the program is about 2,500.

The Unaccompanied Refugee Minor (URM) Program, which exists in Massachusetts and 14 other states, is a component of the Massachusetts Refugee Resettlement Program. The URM Program provides foster care, group home care, and specialized therapeutic placements for unaccompanied refugee minors under age 22 who enter the U.S. without a parent or guardian. These minors include refugees, asylees, Special Immigrant Juveniles (SIJ), Victims of Human Trafficking, Cuban Haitian Entrants, and victims of crime who have been granted U visa nonimmigrant status. Direct client services are provided pursuant to an agreement between ORI and DCF. DCF subcontracts with Ascentria Care Alliance, which places the minors in foster care with specially trained families, or in therapeutic residential settings, and provides culturally and linguistically appropriate support. As of May 2015, the program has the capacity for 180 youth, and approximately 160 youth are receiving care. About half of these youth are refugees from outside the U.S., about half are Special Immigrant Juveniles (SIJ), and a few are asylees or Victims of Human Trafficking.

There are two sources for ORR placement into the URM Program: overseas (refugee minors) and domestic (Special Immigrant Juveniles, Victims of Human Trafficking, asylees, Cuban-Haitian Entrants and victims of crime who have been granted U Visa nonimmigrant status). All refugees coming from outside the U.S. are in ORR's legal custody prior to their placement in the URM Program. Almost all domestic referrals are youth who are in federal custody by reason of their immigration status, and for whose care and placement ORR is responsible. The domestic referrals are children who were receiving services in the Unaccompanied (Alien) Children's program, an ORR program for youth under 18, who do not have a legal immigration status, and who either do not have a parent/legal guardian in the U.S. or do not have a parent/legal guardian who is able to assume custody. An example would be a minor from Guatemala who crosses the U.S. southern border without a parent or guardian and who is apprehended by U.S. Immigration and Customs Enforcement and referred to ORR for care and placement. The majority of youth ORR places in the Unaccompanied (Alien) Children's Program are subsequently released to family members or other sponsors in the U.S. for their

continued care. Only a small percentage lacks a reunification option and may become eligible for the URM Program.

In a very few cases a child or youth might not have been in federal custody prior to placement in a URM Program. For example, an attorney or nongovernmental organization (NGO) in the community might identify a minor Victim of Trafficking who could be staying with friends or living on the street. If ORR issues the minor a Letter of Eligibility as a Trafficking Victim (or the Department of Homeland Security issues the minor a T-visa), that child could be eligible for URM Program placement, without ever having been in the ORR Unaccompanied Alien Children's program.



Fiscal Year 2015 Legislative Projects

In July 2014, as part of the General Appropriations Act for Fiscal Year 2015, the Legislature directed the OCA to review DCF management practices and evaluate the DCF administrative Fair Hearing system. The OCA received an appropriation of \$200,000 for each project to retain an independent evaluator to assist with the reviews. The Legislature created a multidisciplinary Sexual Abuse Prevention Task Force and appointed The Child Advocate to co-chair the group.

DCF Management Review

Outside Section 219 directs the OCA, in consultation with the Office of the Inspector General, to survey DCF employees and clients and to conduct an emergency review and analysis of DCF management in seven areas. The OCA retained the Ripples Group to assist in the emergency review. The final report from the review is due November 2, 2015.

Interim Reports on Surveys: On March 26, 2015, the OCA filed its first Interim Report to the Legislature regarding Outside Section 219. The interim report details the results of the DCF employee survey, DCF's iPad survey, and a preliminary review of DCF's recordkeeping systems and background check procedures. Suffolk University's Moakley Center for Public Management, in collaboration with the OCA, designed, implemented, and analyzed the results of the DCF employee survey. Emerging themes from the open-ended questions were further analyzed by the OCA. Copies of the interim report, as well as the results of the survey, are available on the OCA website: <http://www.mass.gov/childadvocate/docs/interim-report.pdf>.

On June 30, 2015, the OCA filed a second Interim Report informing the Legislature of the results of the 2014 DCF Parent and Guardian Survey and suggesting improvements to the survey design and administration. Twelve community representatives from the DCF Family Advisory Committee administered the survey by phone to DCF parents and guardians whose cases were closed during the eight-month period ending August 2014. The results of the survey were aggregated and analyzed by the DCF Continuous Quality Improvement Unit. The OCA and the Moakley Center worked together to develop the survey methodology and analysis plan. A copy of the second Interim Report is available on the OCA website: <http://www.mass.gov/childadvocate/docs/the-oca-review-dcf-2014-parent-and-guardian-survey.pdf>. A copy of the DCF's survey results report is available from the OCA upon request.

DCF Fair Hearing Evaluation

In Line Item 1599-7771 of the FY 2015 budget, the Legislature tasked the OCA with selecting an independent evaluator to assess DCF's Fair Hearing system and report on whether DCF's regulations, funding, staffing and processes allow for an administrative hearing system that is timely, independent, and fair. The OCA retained the Ripples Group to conduct the evaluation. Over the course of seven months, the Ripples Group conducted a comprehensive assessment

of DCF Fair Hearings by utilizing DCF's internal database, interviewing experts, surveying appellants, reviewing DCF's internal documents, listening to the recordings of Fair Hearings, and studying regulations from other states. The consulting group reported to the Legislature with updates through three quarterly progress reports and a preliminary report. The Ripples Group submitted its final report on June 29, 2015. The reports are found on the OCA's Reports section of the website: <http://www.mass.gov/childadvocate/reports/>.

Sexual Abuse Prevention Task Force

In Chapter 431 of the Acts of 2014 the Legislature created a multidisciplinary task force on the prevention of child sexual abuse. The Child Advocate and the executive director of the Children's Trust serve as co-chairs. The task force is charged with the following:

- Develop guidelines for the development of sexual abuse prevention and intervention plans by organizations serving children and youths.
- Develop tools for the development of sexual abuse prevention and intervention plans by organizations serving children and youths.
- Recommend policies and procedures for implementation and oversight of the guidelines.
- Recommend strategies for incentivizing such organizations to develop and implement sexual abuse prevention and intervention plans.
- Develop a 5-year plan for using community education and other strategies to increase public awareness about child sexual abuse, including how to recognize signs, minimize risk and act on suspicions or disclosures of such abuse.

The task force is meeting regularly and will submit recommendations to the Governor and the Legislature.



Legislation and Regulation

During FY 2015, The Child Advocate and OCA staff frequently reviewed and commented on proposed legislation and regulations relating to child welfare and juvenile justice issues. This work included the following:

- **Child-Centered Family Laws:** The Child Advocate was part of a working group convened by the Governor that met from 2012-14 to review probate and family court custody laws. The group drafted legislation to place children at the center of parental custody decisions, resulting in Senate Bill 834. The Child Advocate urges enactment of this bill.
- **Restraint and Seclusion:** Since its inception, the OCA has advocated for the reduction of restraints and seclusion in programs and schools. The OCA offered [written comments](#) to DEEC and DESE endorsing adoption of proposed regulations governing restraint and seclusion in public schools and licensed programs.
- **Office of the Child Advocate:** Senate Bill 103 would amend M.G.L. Chapter 18C with respect to the appointment, term of office, and removal of The Child Advocate. The bill also adds language regarding the OCA's overall role and alters the composition of the OCA's Advisory Board. House Bill 76, referred to as the "Foster Care Omnibus Bill" contains provisions that would add many responsibilities for The Child Advocate and the OCA. The Child Advocate supports legislation that would enhance the independence of the OCA.
- **Interagency Child Welfare Task Force:** Two bills would create a new interagency child welfare task force co-chaired by the EOHHS Secretary and The Child Advocate with the goal of improving system-wide coordination of services for children and families. The Child Advocate has testified and urges that the statutory responsibility of the OCA to develop a comprehensive plan as provided in M.G.L. Chapter 18C (11) be re-examined in light of these bills.

In addition to the above, the Child Advocate and OCA staff often met with legislators and advocates to discuss issues reflected in pending bills. Some of these issues include creation of a mental health ombudsman program, improved juvenile justice data collection, mandated reporter training, treatment of juvenile sex offenders, juvenile records expungement, advocating for best interests of children, and student discipline.



Outreach

The Child Advocate engaged in substantial outreach during FY 2015 lecturing and presenting information to interested groups, giving interviews, and participating in conferences and symposia related to child welfare and juvenile justice. The Child Advocate and the OCA staff presented at the following venues:

- Boston Foundation
- Child Welfare League of America, Washington D.C. Annual Conference
- Department of Children and Families Conference on Infant Fatalities
- Harvard University Schools of Law and Education and Kennedy School of Government
- Massachusetts Continuing Legal Education, Juvenile Delinquency and Child Welfare Law Conference
- Massachusetts Health Law Advocates Committee
- Massachusetts School of Professional Psychology
- Middlesex County Bar Association
- More Than Words
- New England School of Law
- Parent/Professional Advocacy League
- Providers' Council, "Chat with the Commissioners"
- Tufts Medical Center
- WBUR and WGBH interviews

The Child Advocate and OCA staff also attended numerous conferences and meetings addressing a broad range of topics related to child welfare and juvenile justice, including early education, child protection and family strengthening, nurturing fathers, interdisciplinary approach to investigating child abuse, medical child abuse, psychotropic medications, improving delivery of justice in the probate and family court, justice and mental health collaboration, adoption, sex trafficking, juvenile detention alternatives initiative, juvenile life without parole, fair sentencing for youth, expungement of juvenile court records, targeted interventions for unaccompanied youth, transition planning, permanency, and child fatality review. In addition, The Child Advocate and OCA staff engaged in youth outreach through meetings with Teens Leading the Way, staff and clients at More Than Words, and representatives from a DCF foster care alumni association.



Gail Garinger (right) receives Citizens for Juvenile Justice 2014 Leadership Award from Naoka Carey (left).

Recommendations

Child Fatality Review Program: The Child Fatality Review Program is a critical component of the state's efforts to prevent child deaths and injuries and should receive adequate resources to enable the work of both the state and local teams.

Sudden Unexpected Infant Deaths and Safe Sleep: Our goal is for every parent of every newborn to hear the safe sleep message during pregnancy, at birth, and at doctor visits. The Child Advocate encourages all state organizations to offer clear and consistent information to the public about safe sleep practices for infants.

Psychotropic Medications for Children in DCF Custody: The Child Advocate urges DCF to develop a process for authorizing and overseeing psychotropic medication for children in DCF custody that places medication in the context of individualized behavioral health treatment plans and incorporates evidence-based practices.

Juvenile Court Jurisdiction for Homicides: The Child Advocate strongly supports legislation that would restore jurisdiction to the juvenile court for youths under age 18 charged with homicide.

Due Process for Youth Found Incompetent to Stand Trial: The Child Advocate urges policy-makers to ensure the constitutional rights of juveniles who have been found incompetent to stand trial are guaranteed, and their needs for assessment, education, and treatment are met.

Expungement of Juvenile Court Records: The Child Advocate supports legislation that would allow the automatic expungement of juvenile court records for first-offense nonviolent misdemeanors and allow youth to petition a court for expungement for other offenses.

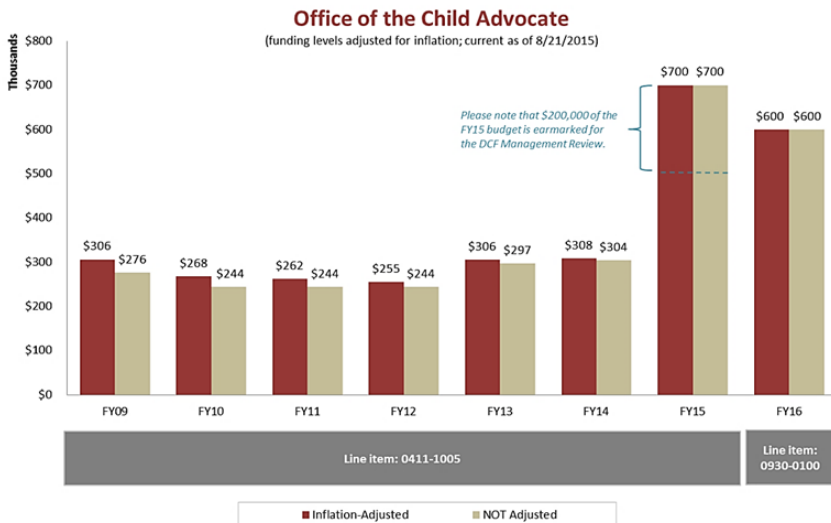


OCA Administration and Advisory Board

Since 2008, Gail Garinger has served as the first Child Advocate for the Commonwealth. Before her appointment, she served as a juvenile court judge for 13 years, including eight years as First Justice of the Middlesex County Juvenile Court. She also served as General Counsel at Children's Hospital Boston. Judge Garinger is assisted in her duties by a staff of four employees with collective experience in law, social work, nursing, human services, and research.

Budget: The OCA line item appropriation for FY 2016 is \$600,000. The General Appropriations Act for Fiscal Year 2016 removed the OCA's line item (0411-1005) from the Governor's Office budget and created a new line item (0930-0100) separate from the Governor's Office. Until now the OCA has relied on the Governor's Office for administrative support such as human resources, payroll, IT, and purchasing. The change in funding structure will require the OCA to develop internal resources for administrative support.

In FY 2015, the Legislature appropriated \$500,000 for the operation of the OCA and \$200,000 for an emergency review of DCF management in consultation with the Inspector General (Outside Section 219). An additional \$200,000 was placed in reserve with the Executive Office for Administration and Finance (ANF 1599-7771) for the OCA to select an independent evaluator to assess DCF's administrative Fair Hearing process. These projects are described in "FY 2015 Legislative Projects," on pp. 34-35.



As shown in the graph to the left the OCA's budget has increased from \$276,000 in FY 2009 to \$600,000 in FY 2016.

The DCF oversight projects and the increase in funding convey an acknowledgment of the OCA's work over the last seven years.

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 OCA Advisory Board. The appointees include an advocate, a grandparent raising a grandchild, and a former foster youth. The Child Advocate chairs the meetings, during which OCA staff present findings from the special projects, update board members, and elicit their input on OCA activities. Information concerning our Advisory Board and past meetings is available on the OCA website: <http://www.mass.gov/childadvocate/advisory-board>.

Issues and Initiatives from Previous Reports

This is the seventh annual report published since the OCA was created in 2008. Our 2008 and 2009 reports were based on the calendar year (CY); in 2010 we began reporting on our activities for the fiscal year (FY), though we continue to analyze data for the previous calendar year. Past reports have included discussions of the following issues and initiatives:

- Alternative Lock-up Programs – CY 2008-09
- Child Fatality Review Program – CY 2008-09, FY 2011-14
- Child's Counsel and Child's Voice – CY 2008-09, FY 2011-13
- Competency of Juveniles in Delinquency Cases – CY 2009, FY 2011-12, FY 2014
- Comprehensive Plan – CY 2008-09, FY 2011
- Continuous Quality Improvement in the Children's Behavioral Health Initiative – FY 2014
- Disproportionate Minority Contact and Data Collection – CY 2009
- Expert Consultation in the Investigation of Child Abuse – CY 2009
- Implementation of Child Requiring Assistance Law – FY 2013
- Juvenile Court Record Expungement – FY 2011-12
- Juvenile Detention Alternative Initiatives – CY 2008-09
- Fair Sentencing & Juvenile Life Without Parole – CY 2009, FY 2011-14
- Kin Raising Kin – CY 2009
- Legislation and Regulation – CY 2009, FY 2011-12
- Online Mandated Reporter Training – CY 2008-09, FY 2012
- Permanency and Transition Planning – CY 2008, FY 2011-13
- Psychotropic Medication and the Rogers Process – CY 2009, FY 2011-14
- Public Investigations – CY 2008, FY 2014
- Restraints and Seclusion – CY 2008-09, FY 2011-12
- Raise the Age Legislation – FY 2011-13
- Review of Agency Investigations – CY 2008
- Review of Agency Policies – FY 2012
- Substance Exposed Newborns – FY 2012-14
- Sudden Unexpected Infant Deaths – FY 2012-14
- Use of Aversives at Judge Rotenberg Center – CY 2009
- Violence in the Community – FY 2011-12
- Zero Tolerance and Dropout Prevention – CY 2008-09

Please visit the annual report page of our [website](#) to review any of these discussions. We welcome [feedback and questions](#).

Committees, Boards, and Councils

In addition to the OCA's committee work discussed within this report, The Child Advocate participates as an *ex officio* member on many boards and councils. OCA staff also attend meetings of selected working groups and initiatives. Involvement with these groups helps to inform and educate staff, so that the OCA can share information and help synchronize policy for child welfare and juvenile justice.

Child Welfare and Juvenile Justice Leadership Forum: The Child Welfare and Juvenile Justice Leadership Forum (the Forum) is a collective impact group comprised of key government and nonprofit sector stakeholders who believe that promoting the positive development of young people and families is the best path to child well-being, healthy communities, and public safety. The Forum includes high-level participation from key stakeholders in the child welfare and juvenile justice systems in Massachusetts. The Child Advocate is an active member of the Forum.

Children's Behavioral Health Initiative Advisory Council: The Children's Behavioral Health Initiative (CBHI) is an integrated system of state-funded behavioral health services for children and youth insured by MassHealth. CBHI provides for early periodic screenings, diagnosis, and community-based treatment of behavioral, emotional, and mental health disturbances. The Child Advocate is a member of the CBHI Advisory Council. For information visit: www.mass.gov/masshealth/cbhi.

Children's Trust Board of Directors: Massachusetts Children's Trust, a public-private partnership, is a leader in efforts to prevent child abuse and neglect by supporting parents and strengthening families. Children's Trust funds over 100 family support and parenting education programs throughout Massachusetts and offers training and technical assistance to professionals who work with children and families. The Child Advocate is a member of the Board of Directors and serves as vice-chair of the Governance Committee. For information visit: <http://childrenstrustma.org/>.

Court Management Advisory Board: The Court Management Advisory Board (CMAB) advises and assists the Justices of the Supreme Judicial Court and the Chief Justice for Administration and Management on matters pertaining to judicial administration and management and all matters of judicial reform. The CMAB is comprised of twelve members, appointed according to the categories of experience set forth in [G.L. 211B §6A](#). The Child Advocate serves on the CMAB as the designated member with experience in juvenile justice. For information visit: <http://www.mass.gov/courts/court-info/commissions-and-committees/court-management-advisory-board-gen.html>.

Essentials for Childhood Leadership Action Team: Child maltreatment is a public health issue and is preventable. The Essentials for Childhood (EfC) framework uses evidence-based strategies to promote safe, stable, and nurturing environments and relationships and prevent maltreatment. Massachusetts is one of five states funded by the Centers for Disease Control and Prevention to implement EfC's core strategies. The OCA's Deputy Director and Counsel is a member of the EfC Leadership Action Team. For information visit: <http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html>.

Families and Children Requiring Assistance Advisory Board: An Act Relative to Families and Children Engaged in Services went into effect in November 2012. This law overhauled the Child in Need of Services system serving children who are runaways, truants, have serious problems at home or in school, or who are the victims of commercial sexual exploitation. The new law encourages families to seek services prior to going to court, and requires EOHHS to develop a network of child and family service programs throughout the Commonwealth to assist these children and families. The law also created the Families and Children Requiring Assistance Advisory Board to advise EOHHS on the development and implementation of the community-based service network and to monitor the progress. The Child Advocate is a designated member of the Advisory Board.

Governor's Child and Youth Readiness Cabinet: In 2008 Governor Patrick signed [Executive Order 505](#) establishing the Child and Youth Readiness Cabinet. The purpose of the Readiness Cabinet is to enhance collaboration across state departments and agencies that serve Massachusetts children, youth and families. The Readiness Cabinet recognizes the many environments in which children develop and is committed to improving the delivery and coordination of state services in all of these environments. The Child Advocate is a designated member of the Readiness Cabinet and supports its efforts to synchronize state policies regarding youth and families.

Governor's Council to Address Sexual and Domestic Violence: In 2007 Governor Patrick signed an executive order creating the Governor's Council to Address Sexual and Domestic Violence (GCSDV) . In April 2015 Governor Baker and Lieutenant Governor Polito relaunched the GCSDV, established through [Executive Order 563](#). The Council's charge is to advise the Governor on how to help residents of the Commonwealth live a life free of sexual assault and domestic violence by improving prevention for all, enhancing support for individuals and families affected by sexual assault and domestic violence, and insisting on accountability for perpetrators. Though not a member of the Governor's Council, OCA staff participate in the domestic violence fatality review team working group. For information visit: <http://www.mass.gov/governor/administration/groups/sexualassaultanddomesticviolencecouncil/>.

Interagency Restraint and Seclusion Prevention Initiative: In response to growing concern about restraint and seclusion in child-serving settings, the Commonwealth in 2009 organized a cross-secretariat effort to reduce and prevent their use. The Initiative brings together leaders from DCF, DDS, DMH, DYS, DEEC, and DESE to work in partnership with the OCA, parents, youth, providers, schools, and community advocates to focus on preventing and reducing the use of behavior restrictions that can be retraumatizing. The vision for the multiyear effort is that all youth-serving educational and treatment settings will use trauma-informed, positive behavior support practices that respectfully engage families and youth. For information: <http://www.mass.gov/eohhs/gov/departments/dcf/interagency-restraint-and-seclusion-prevention.html>

Leadership Advisory Board of the Massachusetts Child Welfare Trafficking Grant: Massachusetts received a five-year federal grant from the Administration for Children and Families to increase the capacity of the child welfare system to address child trafficking. Over the next five years, this grant will support efforts to build greater interagency collaboration, enhanced infrastructure, and new policies and practices to improve the prevention, identification, and response to trafficked youth across the Commonwealth. The Leadership Advisory Board will meet quarterly to guide and inform the work of the grant over the next five years. This Board represents a cross-section of top leadership in the agencies and departments involved in supporting and protecting at-risk and trafficked youth. The OCA's Deputy Director and Counsel is a member of the Advisory Board.

Professional Advisory Committee for Child and Adolescent Mental Health (PAC): PAC was founded in 1978 as a statewide group with representatives from professional, advocacy, trade, and family organizations. PAC's goal is to ensure universal access to quality mental health services for all children and adolescents in Massachusetts. PAC makes recommendations to DMH and other child-serving agencies and to the Legislature regarding service quality, best practices, access, system change and design, and public policies that will promote quality behavioral health services for children and adolescents. The Child Advocate and OCA staff attend meetings to discuss the concerns and ideas of this group of advisors.

Special Commission to Study the Commonwealth's Criminal Justice System: The Special Commission to Study the Commonwealth's Criminal Justice System was created by Outside Section 189 in the FY 2012 budget. The commission is tasked with exploring the feasibility of developing an application for technical assistance that would use a data driven approach to reduce corrections spending and utilize the savings to reduce crime, strengthen public safety, and fund other budget priorities. The Child Advocate serves on the commission as the designated member with experience in juvenile justice and also co-chairs the subcommittee on incarcerated persons. For information visit: http://www.mass.gov/bb/gaa/fy2012/os_12/h189.htm.

Support to End Exploitation Now Coalition: The Support to End Exploitation Now (SEEN) Coalition, an initiative of the Children’s Advocacy Center of Suffolk County and the Suffolk County District Attorney’s Office, is a collaboration of government and community-based agencies that has developed a multidisciplinary team approach to intervention when children and teens are victims of commercial sexual exploitation. The OCA Deputy Director and Counsel sits on the SEEN Coalition Steering Committee. The SEEN Coalition was instrumental in drafting and advocating for Safe Harbor provisions that redefined commercially sexually exploited youth as children requiring assistance rather than criminals, passed as part of “An Act Relative to the Commercial Exploitation of People.” For information visit: <http://www.suffolkcac.org/programs/seen/>.

Young Children’s Council: The Young Children’s Council (YCC) was formed in March 2010 to advise EOHHS, DPH, and the Boston Public Health Commission as they implemented two federal grants, MYCHILD and Project LAUNCH. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration funded the grants to expand early childhood mental health services in Boston, with an emphasis on children and families who have experienced toxic stress related to child abuse, neglect, domestic violence, or homelessness. The Child Advocate is a member of the YCC and values the opportunity to share information pertaining to mental health intervention for children younger than five years of age. For information visit: <http://www.ecmhmmatters.org/Pages/ECMHMMatters.aspx>.



Endnotes

¹ <http://www.mass.gov/eohhs/gov/departments/dcf/interagency-restraint-and-seclusion-prevention.html>

² <https://www.publiccounsel.net/>

³ <http://www.machildtraumaproject.org/>

⁴ Implementation of a workforce initiative to build trauma-informed child welfare practice and services: Findings from the Massachusetts Child Trauma Project. http://www.traumacenter.org/products/pdf_files/Trauma-informed_child_welfare_MA_G0001.pdf

⁵ <http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts>

⁶ National Center for the Review and Prevention of Child Deaths. <https://www.childdeathreview.org/cdr-process/cdr-principles/>

⁷ Veeral, Patrick, Bennett, and Spitzer, "Increasing Incidence of the Neonatal Abstinence Syndrome in U.S. neonatal ICUs," New England Journal of Medicine 2015; 372:2118-26 (May 28, 2015).

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From left to right: Heather Porriello, Christine Palladino-Downs, Gail Garinger, Elizabeth Armstrong, & Jane Lee