

Office of the Child Advocate

Annual Report

Fiscal Year 2016



The Commonwealth of Massachusetts
Maria Z. Mossaides
Child Advocate

The Office of the Child Advocate

The mission of the Office of the Child Advocate (OCA) is to ensure all children in the Commonwealth receive appropriate, timely and quality services with full respect for their human rights. Through collaboration with public and private stakeholders, the OCA examines services to children to identify gaps and trends, and makes recommendations to improve the quality of those services. The OCA also serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth.

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Letter from the Child Advocate

February 8, 2017

Dear Governor Baker, Senate President Rosenberg, Speaker DeLeo, Legislative Leaders, and Citizens of the Commonwealth,

I am pleased to submit the Office of the Child Advocate (OCA) Annual Report. This is the first annual report released since I was appointed Child Advocate in October 2015. It provides an account of the OCA accomplishments and activities for Fiscal Year 2016 (FY16), the period from July 1, 2015 to June 30, 2016.

In Massachusetts, as in most states, children and families are impacted by a wide range of issues, including poverty, mental health, community violence, and the current substance abuse crisis. To better understand the depth of these issues and others, I began my new role with a statewide listening tour of a diverse group of stakeholders. I learned there is an unwavering commitment to the health, safety, and well-being of the children in the Commonwealth. However, there are several challenges to fulfilling this commitment. We are seeing an increase in the number of children with complex behavioral health needs, and children affected by their parents' substance use disorders. This has placed a strain on the capacity of our service system, especially on the skilled clinicians and staff across both public and private agencies. Further, our office often hears from families who would benefit from additional family engagement strategies from these agencies.

During this reporting period, the OCA continued to perform our core statutory functions. We responded to 477 Complaint Line inquiries, a 290% increase over the prior fiscal year. We reviewed 114 critical incidents, and 328 reports of abuse or neglect of children in out-of-home settings, such as school, child care, foster care, and residential treatment programs.

In addition to these reviews, the OCA responded to requests from the Legislature and Governor. We completed a legislatively mandated review and analysis of the office management, recordkeeping, and background record check procedures of the Department of Children and Families (DCF). We conducted a review of the involvement of state agencies and community providers in the life of Bella Bond, the young child whose body was discovered on Deer Island. The Governor also asked us to lead a review of residential treatment programs that serve children with behavioral, developmental, or educational challenges. In response, the OCA convened a group of senior staff from state agencies to review the business practices involved

in the licensing and oversight of these programs. We have met continuously since the spring of 2016, and this work is ongoing.

Internal to the OCA, my listening tour helped me establish priorities for the office, such as expanding the range of issues we dedicate our attention to, and focusing more broadly on outcome data. To align with this new focus, I updated the OCA mission and restructured staff positions.

I am honored to be the Child Advocate, and build on the strong foundation carefully laid by my predecessor and first Child Advocate, the Honorable Gail Garinger. I wish to thank the Governor, Legislature, and the leadership and staff of the state agencies who have supported my transition. Improving services to children is a goal shared by everyone who wants to ensure the Commonwealth's future. I also want to thank the OCA staff who work to improve services for our children.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Maria Z. Mossaides", followed by a horizontal line.

Maria Z. Mossaides
Director

Introduction

The Office of the Child Advocate (OCA) was established in 2007 as an independent agency and represents the commitment of the Governor and the Legislature to improve services to children and families in Massachusetts. Our mission is to ensure that all children in the Commonwealth receive appropriate, timely, and quality services with respect for their human rights. We fulfill this mission through our response to inquiries received on our complaint line, review of supported allegations of abuse or neglect of children in out-of-home settings, review of critical incident reports about the fatality, near fatality, or serious bodily injury of children receiving services, and review of issues affecting the Commonwealth's families.

The work of the OCA is grounded in what children need to succeed to live a full and productive life. The Centers for Disease Control *Essentials for Childhood Framework* highlights three qualities that make a critical difference in a child's development. They are:

- “Safety: The extent to which a child is free from fear and secure from physical or psychological harm within their social and physical environment.
- Stability: The degree of predictability and consistency in a child's social, emotional, and physical environment.
- Nurturing: The extent to which a parent or caregiver is available and able to sensitively and consistently respond to and meet the needs of their child.”¹

Children must have physical safety, stable and nurturing adults, and an environment that allows them to develop and grow. The children most at risk are those who do not have these basic needs met. The OCA serves as a neutral convener and facilitator, engaging a broad range of stakeholders, including state agencies, the courts, community providers, advocacy groups, and children and their families to understand the services needed to enable children to prepare for a successful adulthood.

This is the eighth OCA annual report published, and the first under the leadership of the new Child Advocate, Maria Z. Mossaides. The 2008 and 2009 reports were based on the calendar year (CY); in 2010 the OCA began reporting on our activities for the fiscal year (FY), though we

¹ Centers for Disease Control (2014). *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/essentials_for_childhood_framework.pdf

continued to analyze data for the previous calendar year. We will now report activities of the office and data collected on a fiscal year basis to be consistent with other state agencies. As such, this report focuses on OCA activities and data collected for FY16, the period from July 1, 2015 through June 30, 2016.

Fiscal Year 2016 Accomplishments

Increased Independence

Although established as an independent agency, prior to FY16 the OCA relied on the Governor's office to support our administrative functions. The General Appropriations Act of FY16 enhanced the OCA's independence by separating us from the Governor's office. Through collaboration with the offices of the Governor and Comptroller, the OCA achieved administrative independence by the close of FY16, establishing our office as a truly independent agency in all aspects.

Statutory Changes

In FY16 the OCA worked with legislative leaders to make key changes to our statute (Chapter 18C). These changes, which passed as outside sections to the FY17 budget, allow the OCA to fulfill our mission through enhanced independence and a broader focus on the totality of children's services in the Commonwealth. The highlights of these statutory changes include:

- The Child Advocate was originally a gubernatorial appointment made from a pool of three individuals chosen by a nominating committee. Now, the Child Advocate is appointed by a majority vote of the Governor, Attorney General and State Auditor from a pool of three individuals (identified by the nominating committee) and for a fixed term of five years. Removal of the Child Advocate can only be for cause by a majority vote of the same three individuals. The existing nominating committee remains in place, with the Executive Office of Health and Human Services (EOHHS) coordinating its work.
- The Advisory Board was changed to Advisory Council, and the Commissioner for the Deaf and Hard of Hearing and the Commissioner for the Blind were added as members.
- A "preamble" was added to the duties of the OCA:

The office shall act to investigate and ensure that the highest quality of services and supports are provided to safeguard the health, safety and well-being of all children receiving services. The office shall examine systemic issues related to the provision of services to children and provide recommendations to improve the quality of those services in order to give each child the opportunity to live a full and productive life.

- The OCA must now ensure the well-being of children “receiving services” from all executive branch agencies.
- The definition of “critical incident” was broadened to include incidents at all executive branch agencies and their constituent agencies; previously this was limited to the agencies within EOHHS. The definition now includes emotional injury as well.
- The OCA gained access to court records that are relevant to investigations undertaken by our office.
- The Child Advocate may now disclose information when such disclosure may be necessary to enable the Child Advocate to perform the duties of our office.
- The requirement of the OCA to formulate and update a comprehensive five-year plan regarding child welfare was removed. The comprehensive plan was replaced with the following:

The child advocate, in consultation with the advisory council, may from time to time, examine system-wide responses to child abuse and neglect, including related mental health, substance use and domestic violence issues, and shall file a report on any such examination with the governor, the clerks of the senate and house of representatives, the senate and house committees on ways and means and the joint committee on children, families and persons with disabilities. The child advocate's examination may include, without limitation, racial disproportionality and disparity, truancy and runaways, mandated reporting, screening of child abuse and neglect reports, social worker qualifications and caseloads, law enforcement involvement, health service needs, including behavioral health needs, of children at risk, criminal offender record information reviews, administrative and cost requirements, federal funding for child welfare purposes and the effectiveness of child abuse laws. The child advocate may seek advice broadly from individuals with expertise in child welfare in preparing a report under this section.

Bella Bond Review

At the request of Governor Baker, the OCA reviewed the involvement of DCF, other state agencies, and community providers during the short life of Bella Bond. The objective of this review was to identify areas for improvement in the Commonwealth's child welfare system. The OCA's observations and findings about DCF policy and case practice was consistent with other reviews conducted by the OCA² and DCF.³

The OCA made the following recommendations specific to the Bella Bond review:

- DCF intake policy must mandate that when a report of abuse or neglect is filed concerning a parent whose parental rights were terminated on other children, this report will be screened in for an investigation, and a managerial case review and legal consultation will occur.
- DCF shall develop a protocol that provides expectations and guidance about completing the risk assessment tool. The protocol should clearly identify action steps to be taken depending on whether the results show a child is at low, moderate or high risk of abuse or neglect. If the result shows a child is at high risk, the protocol should mandate that a managerial case review and legal consultation occur.
- The DCF assessment policy should mandate that information collected from prior assessments needs to be properly labeled with the date of the prior assessment clearly identified.
- DCF should enhance its electronic record keeping system to include the capacity to date stamp information that is copied from one report to another. This feature would prevent old information from appearing as current information in reports.
- The DCF case practice policy should include guidance about working with parents who have a history of substance abuse, including how to assess for current substance use, the appropriateness of the parent relapse prevention plan, and the parent's ability to safely care for their child.

² OCA review concerning Jeremiah Oliver, released January 23, 2014. OCA review concerning Chase Gideika, released May 2, 2014.

³ DCF review concerning Jeremiah Oliver, released December 30, 2013. DCF review concerning Jack Loiselle, released September 4, 2015. DCF review concerning the foster home of Kimberly Malpass, released September 30, 2015.

During the OCA review of Bella Bond, and as a result of the lessons learned in other reviews, DCF was vigorously rebuilding their management structure, revising their supervision and clinical oversight, issuing new policies for intake, assessment, service planning and case closing, enhancing their training of staff, and implementing a robust system of quality assurance. The OCA continues to monitor DCF's development, implementation, and progress in all of these areas.

The Bella Bond report may be found on the OCA website.

<http://www.mass.gov/childadvocate/docs/bella-bond-final-report.pdf>

Department of Children and Families Management Review

Outside Section 219 of the FY15 budget directed the OCA, in consultation with the Office of the Inspector General, to survey DCF employees and consumers, and to conduct an emergency review and analysis of the office management, recordkeeping, and background record check procedures of DCF. This review spanned two fiscal years, and resulted in four reports:

- On March 26, 2015, the OCA filed its first Interim Report to the Legislature. 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.
- On June 30, 2015, the OCA filed a second Interim Report with the Legislature. The report details the results of the 2014 DCF parent and guardian survey.
- On September 9, 2015, the OCA filed a third Interim Report informing the Legislature on the progress of the management review and preliminary findings.
- On November 20, 2015 the OCA filed its final report with the Legislature. The comprehensive report contains 22 recommendations across four areas: management infrastructure, continuous quality improvement (CQI) and data analysis, policy and practice, and recordkeeping practices. The OCA is pleased to report that progress is being made across all areas, and we will continue to monitor DCF's development, implementation and progress. A summary of the recommendations and DCF's reported progress is attached as Appendix C.

Review of Residential School Programs and Substantially Separate Special Education Programs

After supported allegations of abuse and neglect at the Eagleton and Peck schools, Governor Baker asked the OCA to lead a review of public and private residential and therapeutic day programs that provide educational services to children and young adults whose complex needs require them to be served in a residential or substantially separate educational setting. The goal of this ongoing review is to examine how current state practices relating to licensing and monitoring can be improved to more quickly identify programs that are at risk of operational challenges, and how to provide appropriate support and technical assistance to these programs to ensure the best outcomes for children.

The OCA convened a Steering Committee comprised of the Child Advocate, Undersecretaries of the Executive Office of Education (EOE), EOHHS, and a representative from the Governor's Office to plan this work. The Steering Committee decided to focus first on children who are placed in residential care with approved special education programs. These children are among the most vulnerable due to their complex service needs, and because they are not living at home with their families.⁴

A Working Group of agencies responsible for licensing, monitoring, or investigating residential schools was created. The Working Group includes the Steering Committee members as well as key staff from the following state agencies:

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

The Working Group agreed on two tasks: to conduct a status review of residential school programs, and to follow that review with a comprehensive assessment of the current business practices of the involved state agencies to identify opportunities for the Commonwealth to provide better support, quality improvement, and risk identification.

⁴ The Steering Committee expects to focus next on substantially separate public school programs once the residential school review is complete.

To achieve the first task, the Working Group sought input from the provider community. In May 2016, the Working Group convened a meeting with representatives from several residential school programs to understand the challenges they face in serving children with complex needs. Among the issues identified were hiring, retention, and training of a quality workforce. The programs also reported that there is confusion and misinformation regarding key state requirements, resulting in both under and over-reporting of abuse or neglect and critical incidents. As a result, the Steering Committee met with organizations that represent human service providers⁵ to plan and implement a series of outreach opportunities to support program staff in meeting the challenges of serving this population.

To accomplish the second task of improved licensing, monitoring, and evaluation, the Working Group hired a consultant to conduct a review of current state business practices, including interagency collaboration and information sharing. The consultant was also asked to research national best practices to recommend opportunities and strategies for the Commonwealth to adopt best practices identified. This review is ongoing.

Mapping of Children's Services

The OCA mapping project arose from our acknowledgement that to fulfill our broad mandate and mission, we need to develop a deeper understanding of the services available to the children and families of the Commonwealth, as well as specific internal processes of the five EOHHS agencies (DCF, DDS, DMH, DPH, DYS)⁶ responsible for the majority of these services. To accomplish this goal, the OCA met with senior staff at each EOHHS agency and asked them to provide information in five key areas:

- services available to children and families
- age and eligibility criteria for these services
- agency definition of a critical incident
- licensing
- data collection
- continuous quality assurance processes

To assist us in reviewing the information, the OCA hired an independent research consultant with expertise in the analysis and evaluation of child-serving agencies and programs.

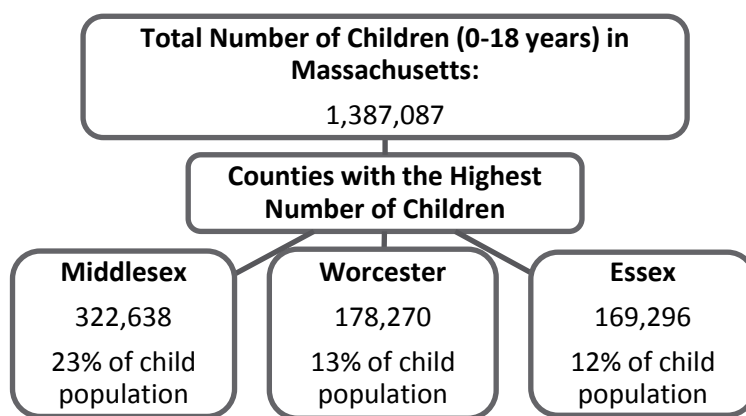
⁵ Massachusetts Association of Behavioral Health; Massachusetts Association of Approved Private Schools ; The Children's League of Massachusetts; Provider's Council

⁶ Department of Children and Families (DCF), Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH), Department of Youth Services (DYS)

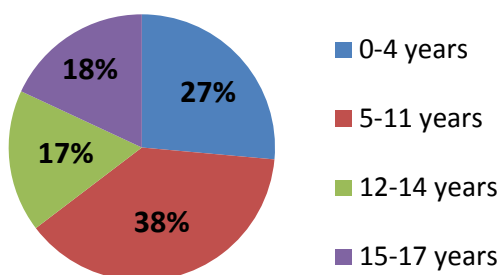
Massachusetts provides a wide range of services and supports to children and families, and these services are provided across multiple public agencies and their contracted providers. This mapping exercise is the first step towards our understanding of the complex system of children's services in the Commonwealth. The OCA is currently finalizing our first phase of analysis and version of the maps. When complete the OCA will share them with the public, and determine next steps to clarify the current landscape of children's services in the Commonwealth.

Data Snapshot of Children in Massachusetts

We believe that public policy should be made while having the best available information. The OCA is providing this snapshot data from the Kids Count Data Center to provide a framework for the information provided in this report. Kids Count uses a wide variety of sources to collect their data, including Census data, the American Community Survey, and the National Survey of Children's Health, among others. All data are from 2015 unless otherwise noted. For more information regarding data sources, please visit kidscount.datacenter.org.



Ages of Children in Massachusetts



Racial/Ethnic Breakdown of Children in Massachusetts

- 64% of children are white (non-Hispanic)
- 17% of children are Hispanic or Latino
- 8% of children are black (non-Hispanic)
- 7% of children are Asian (non-Hispanic)
- 4% of children are of two or more racial groups (non-Hispanic)
- American Indian/Alaskan Native and Native Hawaiian and Other Pacific Islanders each make up less than 1% of the population of children

Fast Facts on Children in Massachusetts

- 28% of children are in immigrant families
- 87.5% of students graduate from high school in four years, though this varies by race and by school district
- 44% of students are enrolled in free or reduced-price lunch programs
- 14.9% of children live at or below the poverty line
- 312,000 of children have special health care needs, including physical, developmental, behavioral, or emotional needs (2011-2012)
- 275,300 children have experienced two or more adverse events in their lifetime (2011-2012)
- 69,000 children have had a parent incarcerated (2011-2012)

Complaint Line (formerly Helpline)

A core responsibility of the OCA is to receive complaints about services provided to children in Massachusetts by state agencies. Anyone who needs help finding resources related to a child's health, safety, and well-being may contact the OCA. Family members, foster parents, advocates, attorneys and others can contact the OCA to express concerns about the treatment of a child receiving services, and ask for assistance. OCA staff is available to help identify services or resources, make referrals, and assist with resolving a problem that involves a state agency. The OCA maintains the confidentiality of all information shared with our office.

In FY16, the OCA made changes to our Complaint Line to provide clarity about the role of our office, improve public access to our office and resources, and to develop a better understanding of the service needs and issues facing the children and families of the Commonwealth. These changes include:

- We changed our name from “Helpline” to “Complaint Line”. The OCA is mandated to receive “complaints” about services provided to a child or family, and this new name is consistent with our statutory language.
- We dedicated a tab on our website to our Complaint Line, which includes an explanation of our role. Many individuals who contact our office are unclear of our mandate, and our ability to assist them or intervene on their behalf. By having a dedicated tab on our website, the OCA seeks to provide clarity about what we can and cannot do.
- We developed an online complaint form, easily accessed under our *File a Complaint* website tab. It is important the public have easy access to our office. In addition to contacting us by phone, e-mail, fax or mail, the OCA encourages use of this form as another means of contact.
- We updated the resources on our website, available under the *Resource* tab. Individuals can find information about children and family support, mental, physical and behavioral health, education, legal support for children and families, parent and caregiver support, youth support, and juvenile justice. It is our goal to provide useful information and resources to allow the public to best advocate for themselves’ and resolve their concerns.

- We reexamined and improved our internal policies, procedures, and data tracking methods. To provide better assistance and serve as a resource, the OCA is committed to continuously examining and improving our internal processes. The OCA is working to improve our data collection methods, which enhances our ability to identify service gaps and trends, as well as make recommendations for improvements.

Overview of OCA Complaint Line Contacts – FY16

In FY16, the OCA received 477 Complaint Line contacts. As shown in Figure 1, contact to the OCA increased significantly (290%) between FY15 and FY16. This increase may be a result of public attention to children’s issues, and new awareness of the OCA.

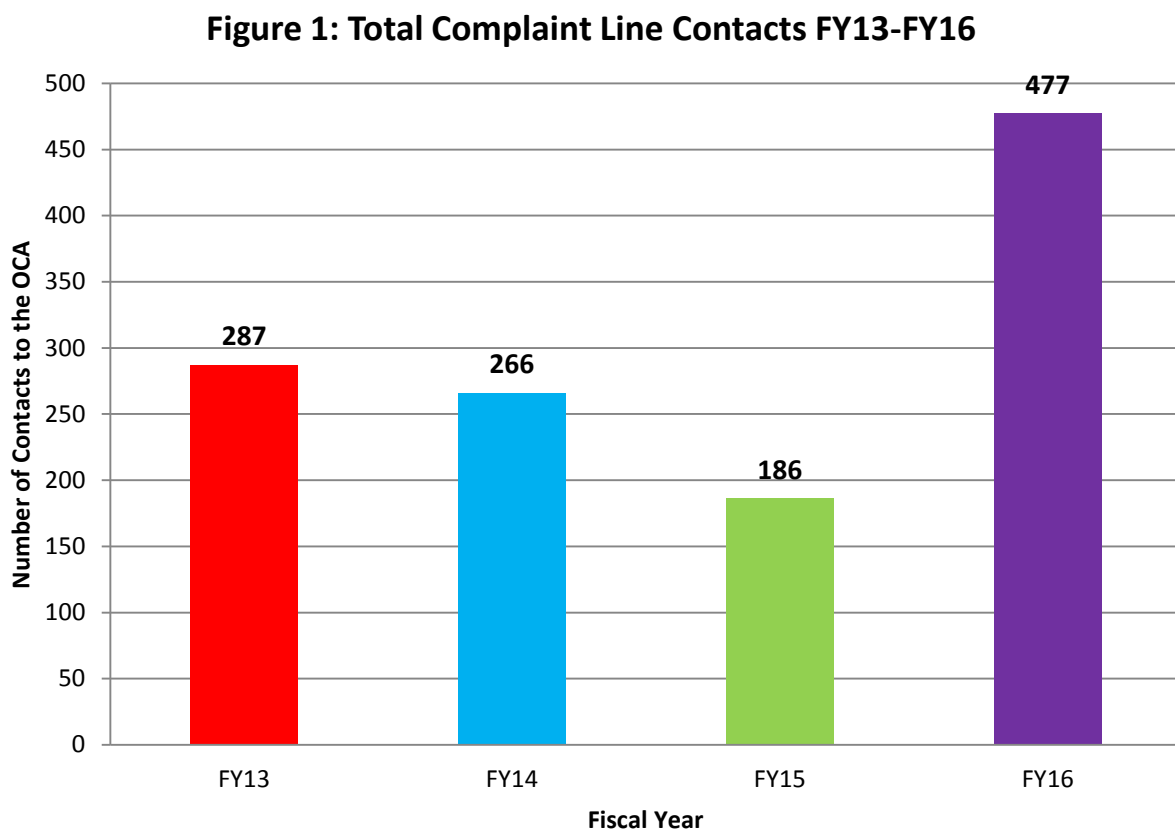
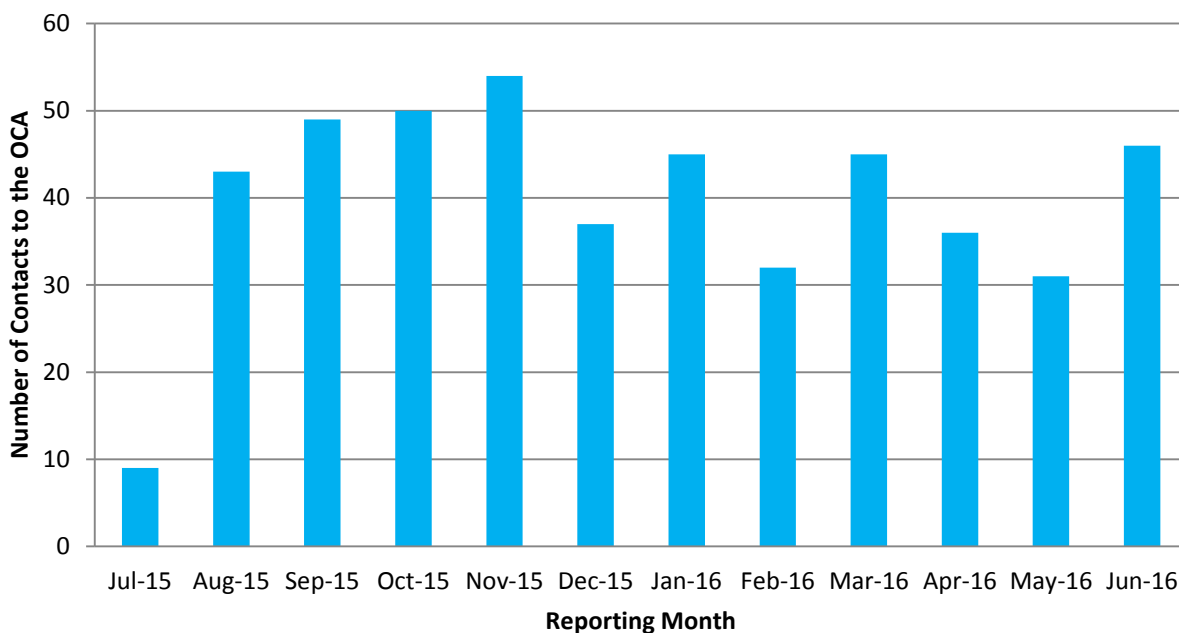


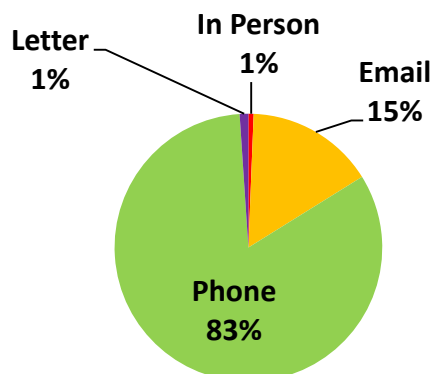
Figure 2 shows the number of contacts the OCA received by month in FY16. The OCA received the most contacts between September and November, which we attribute to the public attention to child welfare during this time period, and the OCA release of the Bella Bond review.

**Figure 2: Complaint Line Contacts Received by Month
(n=477 contacts)**



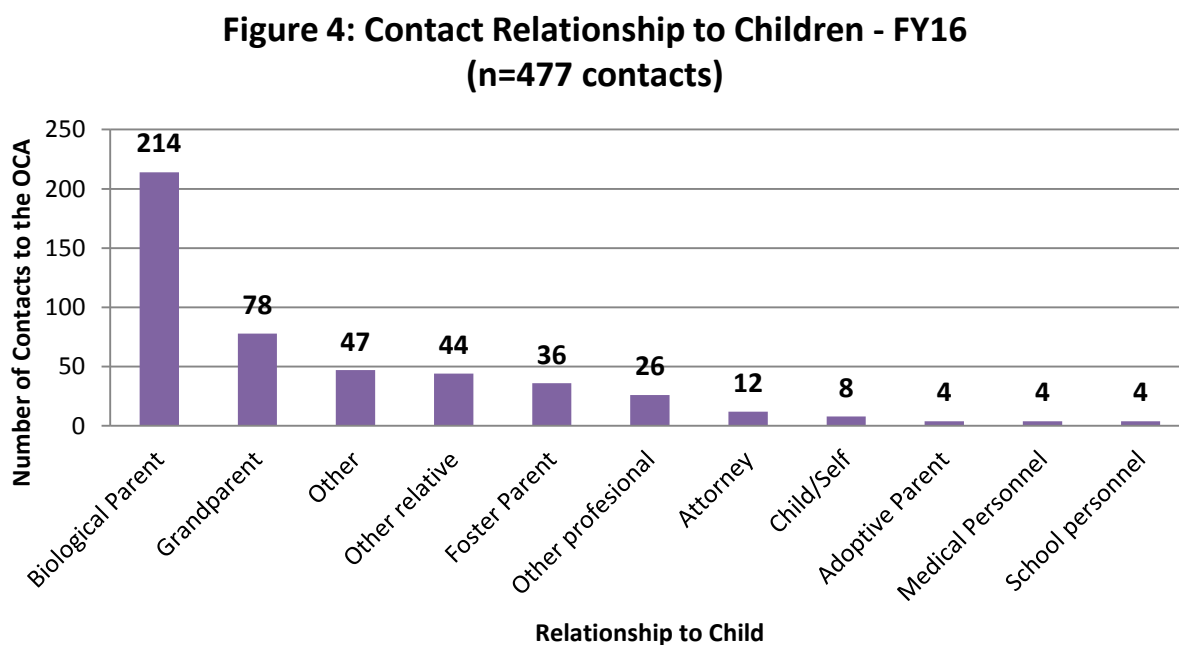
Finally, Figure 3 shows the different methods individuals used to contact the OCA. The OCA primarily receives inquiries via telephone. However, in July 2016 the OCA launched a new online complaint form, available on our website, so we may have an increase in the number of email inquiries in FY17.

**Figure 3: Method of Contact - FY16
(n=477 contacts)**



Who Contacted the OCA?

Parents and grandparents are the majority of individuals who contacted the OCA for assistance, as shown in Figure 4. The OCA also received calls and emails from other relatives (e.g., aunts and uncles), other adults in the child's life (e.g. friends and neighbors), foster parents, and professionals who have contact with the child (e.g. attorneys, teachers, therapists). Consistent with prior years, few children contacted the OCA on behalf of themselves.

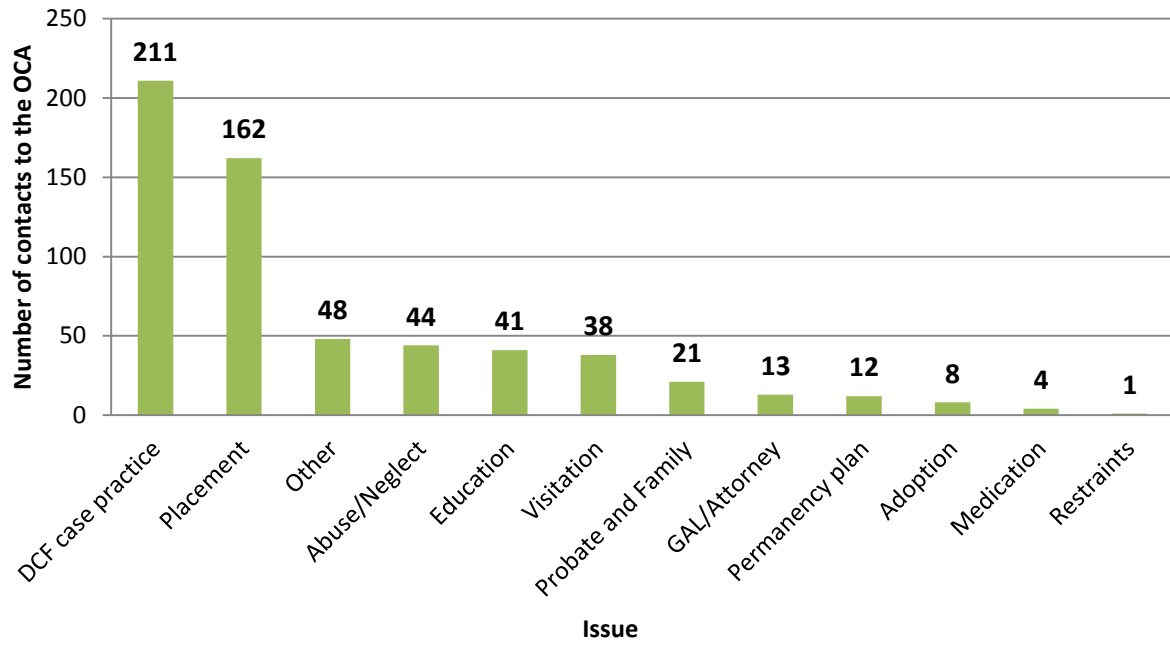


Issues Identified During OCA Contact

As displayed by Figure 5 on the next page, the OCA received questions and concerns on a number of topics. The most common issues identified in these inquiries were DCF case practice and placement of a child. Examples of specific concerns include:

- failure to place a child with a relative or sibling when a child is taken into state custody
- perceived lack of responsiveness by DCF social workers to calls from biological parents regarding reunification planning
- objections to the removal of children from parents or relatives

**Figure 5: Issues Identified - FY16
(n=477 contacts)**



Abuse or Neglect in Out-of-Home Settings

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

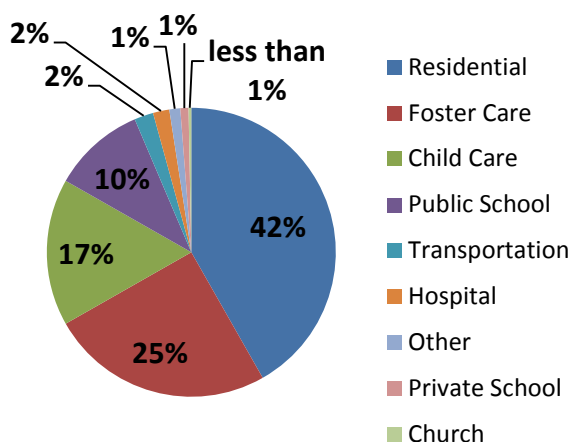
On the basis of our reviews, in FY16 the OCA contacted a number of state agencies to discuss issues and trends that emerged. Examples of these contacts include:

- DCF regarding concerning trends within foster care and decisions regarding specific foster homes.
- DCF concerning staffing and programmatic issues in residential treatment programs used by DCF for placement of children and youth in state custody.
- 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 to their services to children.
- The Child Advocate visited a provider agency residential treatment program to learn more about its staffing and programmatic improvements.

Overview of Abuse or Neglect Reports – FY16

In FY16, the OCA reviewed 328 51A reports of abuse and/or neglect that occurred in out-of-home settings. Of these reports, 829 allegations were supported. The reason that there are more supported allegations than number of reports is because in each 51A, there can be more than one type of allegation (neglect, physical abuse, sexual abuse, etc.) and/or more than one child or alleged perpetrator involved in the report. Figure 6

Figure 6: Number of Reports Received by Type of Institution (n=328 reports)

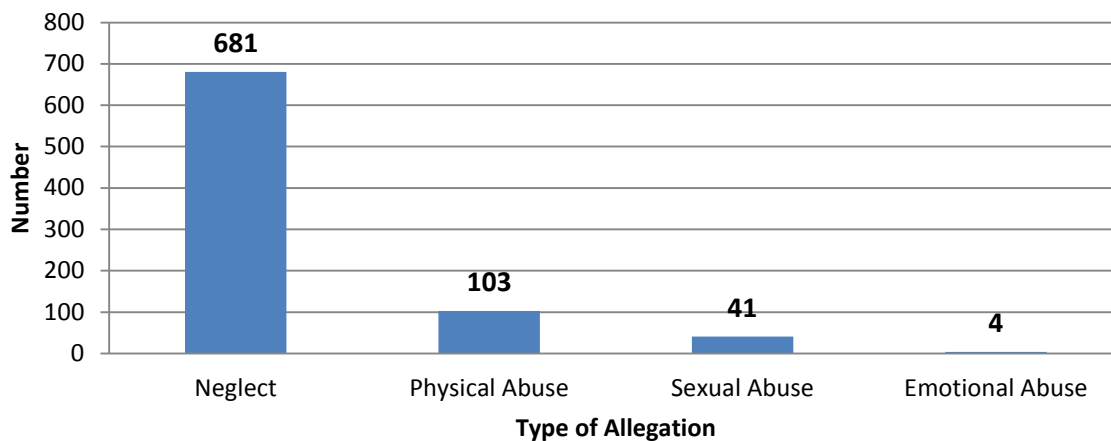


shows the distribution of supported allegations across the different types of settings. The OCA received the most reports for residential treatment programs (137), followed by foster care (82), and child care (54).

Supported Allegations by Type

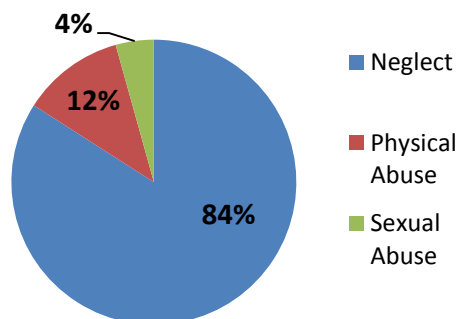
Figure 7 shows the number of supported allegations by type: neglect, physical abuse, sexual abuse, and emotional abuse. Neglect is the most commonly supported allegation, representing 82% of the supported allegations in out-of-home settings. Physical abuse is the second most common, but only represents 12% of supported allegations. Sexual abuse represents 5% of the supported allegations, followed by emotional abuse, which is less than 1%.

Figure 7: Supported Allegations by Type (n=829 supported allegations)



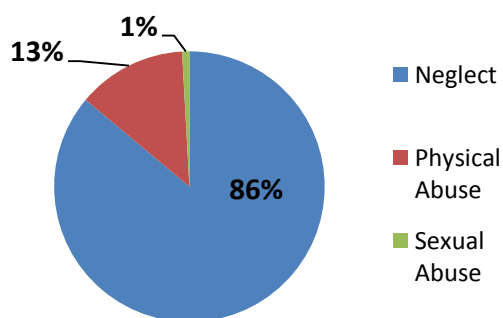
Given that residential treatment programs, child care, and foster care are the three settings frequently identified in these reports, it is important to identify what type of allegations were supported.

Figure 8: Type of Supported Allegations for Residential Treatment Programs (n=370 supported allegations)



Residential treatment programs had 370 supported allegations of abuse and/or neglect. Figure 8 shows the distribution of these supported allegations. Neglect was the most common supported allegation (311), followed by physical abuse (45) and sexual abuse (16). There were no supported allegations of emotional abuse.

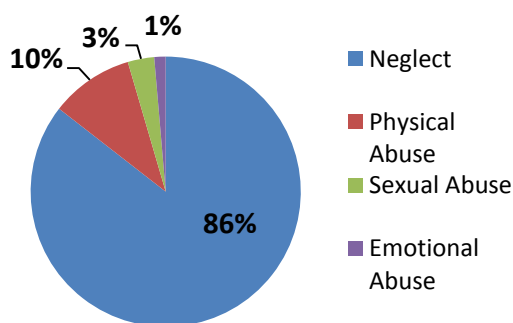
Figure 9: Type of Supported Allegations for Child Care (n= 115 supported allegations)



Child care had a total of 115 supported allegations of abuse and/or neglect, and 99 of those allegations were for neglect. There were 15 supported allegations of physical abuse, and one of sexual abuse. As with residential treatment programs, there were no supported allegations of emotional abuse. This count includes child care licensed by EEC and those operating without a license. It also includes family and center-based child care. Figure 9 shows the distribution of these supported allegations.

Foster care had 221 supported allegations of abuse and/or neglect. Figure 10 shows the distribution of supported allegations for all types of foster care homes, including DCF child-specific, kinship, unrestricted, and comprehensive foster care. Neglect is the most common supported allegation (189), followed by physical abuse (22), sexual abuse (seven) and emotional abuse (three).

Figure 10: Type of Supported Allegations for Foster Care
(n= 221 supported allegations)



OCA Analysis of Supported Neglect Allegations in Foster Care

During FY16, the OCA wanted to understand the different types of neglect that were appearing in foster care 51A reports. To identify trends within and across the different types of foster homes, and to identify potential gaps in support services, the OCA conducted a detailed analysis of supported neglect allegations. Table 1 lists the types of foster homes, the number of children placed in each type of foster home at the end of FY16, along with a brief description of each.

Table 1: Types of DCF Foster Care and Comprehensive Foster Care

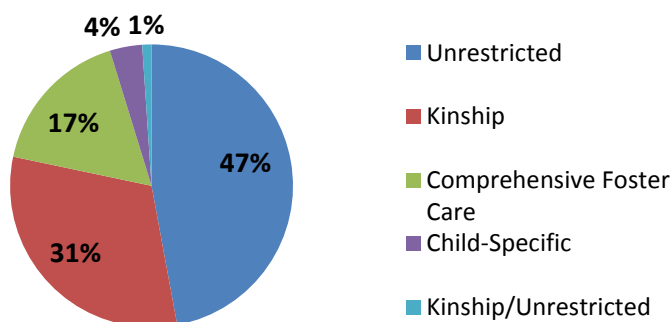
Type of Foster Care	Children in Foster Care as of July 1, 2016
DCF Kinship/Child-Specific	3,407
DCF Unrestricted	2,151
DCF Pre-Adoptive	480
DCF Independent Living	4
Comprehensive Foster Care (CFC)	1,466
Total Foster Care	7,508

Based on the information available in the 51A reports, it can be difficult for the OCA to determine if a DCF foster home is pre-adoptive or independent living. As a result, for the purpose of this analysis, all pre-adoptive and independent living foster homes are incorporated into the DCF unrestricted foster care category of homes.

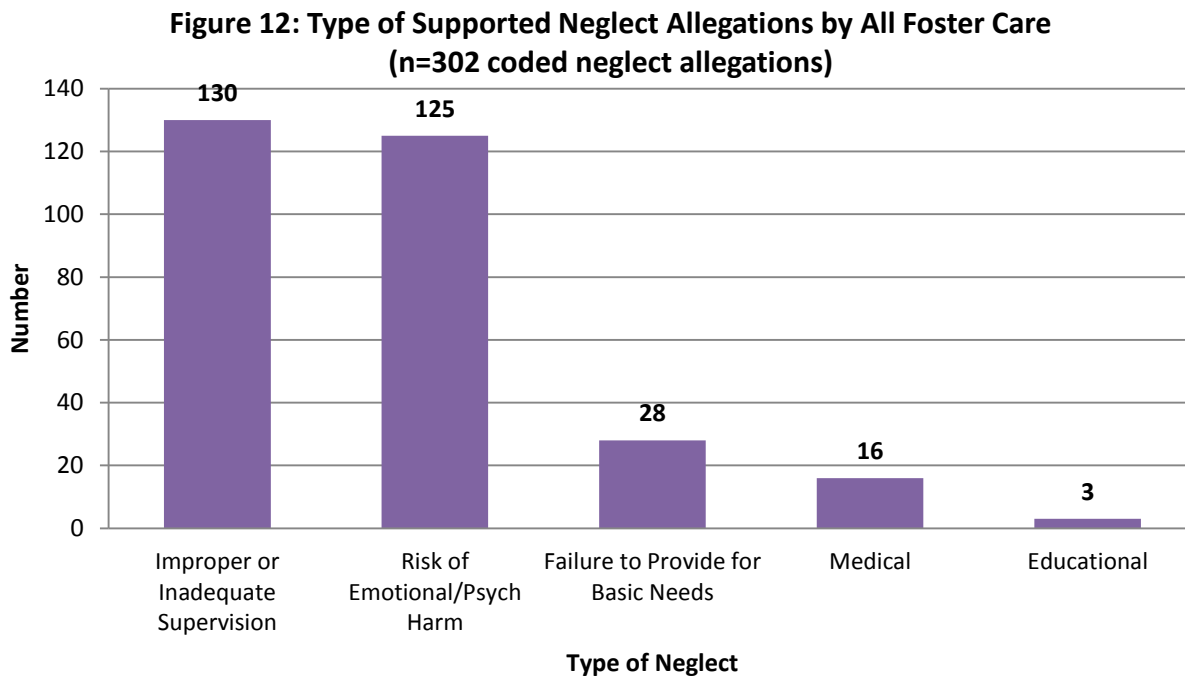
To conduct our analysis, the OCA engaged in a qualitative review of supported neglect allegations to create a coding structure that would categorize types of neglect. During the coding process, OCA staff classified all instances of neglect present in the investigation, as one 51A report with supported neglect allegations may involve multiple types of neglect. For example, if the investigation concludes that a foster parent left a child home alone, and also did not bring a child to a doctor appointment, these incidents would be coded under both Improper/Inappropriate Supervision and Medical. These codes, and examples of the types of behaviors that are classified under each one, can be found in Appendix D.

As noted earlier, 86% of all supported allegations in foster care are for neglect (189), and there are variations by type of foster home. Figure 11 shows that DCF unrestricted foster homes have the highest number of supported neglect allegations (89), followed by kinship foster homes (59) and comprehensive foster care homes (32). One foster home had a dual designation as a DCF unrestricted and kinship foster home.

**Figure 11: Number of Supported Neglect Allegations
by Type of Foster Care
(n=189 supported neglect allegations)**



OCA staff reviewed all 189 supported neglect allegations and coded 302 incidents of different types of neglect. Figure 12 on the next page shows the number of supported neglect allegations by type. Improper/Inadequate Supervision is the most common type of neglect (43%), followed closely by Risk of Emotional/Psychological Harm (41%).



In addition to identifying trends across foster care, the OCA looked at the patterns within the different types of foster homes, including DCF kinship, child-specific, unrestricted, and comprehensive foster care. Since the OCA received so few supported allegations from child specific foster homes, and all seven allegations fell under the category Improper/Inadequate Supervision, this group was not included in this part of the analysis.

Figure 13 shows the types of supported neglect allegations in DCF unrestricted foster homes. Risk of Emotional/Psychological Harm are the most common (63), followed by Improper/Inadequate Supervision (58). Medical, Educational, and Failure to Provide for Basic Needs represent a small portion of supported neglect allegations in DCF unrestricted foster care.

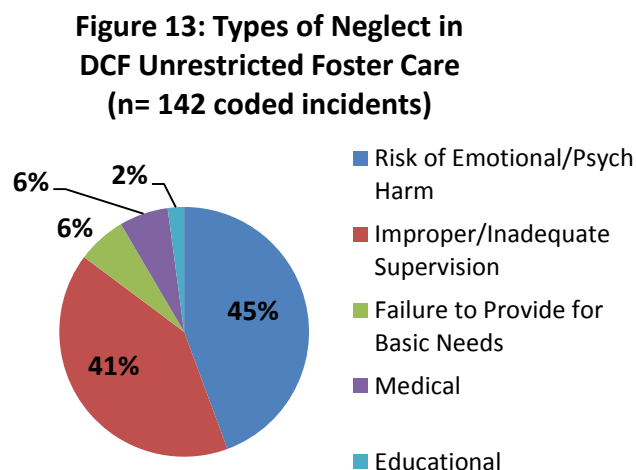
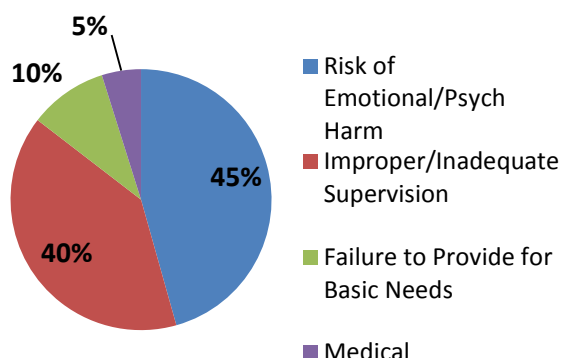


Figure 14 shows the types of supported neglect allegations in kinship foster care. Similar to DCF unrestricted foster care, the most common types of supported allegations are Risk of Emotional/Psychological Harm (47), followed by Improper/Inadequate Supervision (41). Compared to DCF unrestricted foster care, kinship care showed a slightly higher percentage of incidents that are under the category of Failure to Provide Basic Needs.

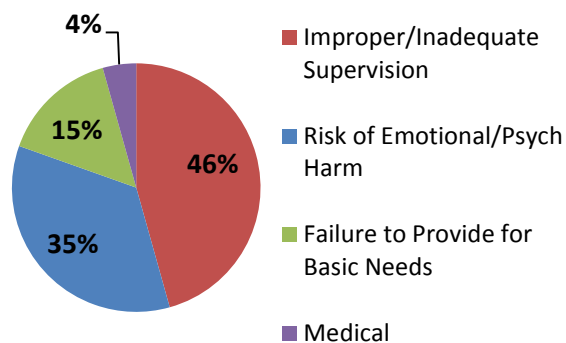
However, when looking at the actual counts, kinship homes had ten instances of neglect under this category, as compared to nine instances in DCF unrestricted homes, so the difference is rather small. There were no supported allegations of educational neglect in kinship foster care.

Figure 14: Types of Neglect in DCF Kinship Foster Care (n=103 coded incidents)



Finally, Figure 15 shows the types of supported neglect allegations found in comprehensive foster care. In this category, Improper/Inadequate Supervision is the most common type of supported neglect allegation (21), followed by Risk of Emotional/Psychological Harm (16) and Failure to Provide for Basic Needs (seven). Again, there were no supported allegations of Educational neglect in comprehensive foster care.

Figure 15: Types of Neglect in Comprehensive Foster Care (n=46 coded incidents)



Foster parents provide care for some of the Commonwealth's most vulnerable children, and they require ongoing training and agency support to meet the diverse needs of this population. This is the first fiscal year the OCA has conducted a detailed analysis of foster care. Going forward, the OCA will continue to revise and refine our foster care coding structure so that we are able to identify issues that emerge from our review, and make specific recommendations that will support foster parents and result in improvements to the foster care system. In addition, the OCA will develop a similar coding structure for incidents of neglect in residential treatment program to understand the types of neglect occurring in those settings.

Critical Incident Reports

When a child receiving services from a state agency dies or is seriously injured, that agency is required to send a critical incident report (CIR) to the OCA. When the OCA receives the report, we conduct a careful administrative review of the circumstances surrounding the incident, and collaborate with the reporting agency to learn from the reported situation. The definition of a critical incident is:

Fatality: When a child receiving services from a state agency dies. (OCA statute, Chapter 18C)

Near Fatality: When a child receiving services from a state agency suffers an act that places them in critical or serious condition.

Serious Bodily Injury: When a child receiving services sustains an injury which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress. (OCA statute, Chapter 18C)

Other: Sometimes agencies report incidents that they are not required to, but feel the incident is important for the OCA to know about. For example, an altercation between youth placed in institutional settings, or incidents of violence in the community that involve children or youth receiving services.

Only eleven states have similar agencies to the OCA, including Rhode Island, Connecticut, and Maine. Most of those other agencies focus solely on their state's child welfare agency, or a combination of child welfare and juvenile justice agencies. Massachusetts is unique in that the OCA is mandated to examine the work being done by all state agencies serving children. In FY16, the agencies organized under the EOHHS reported critical incidents 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 preceding six months.
- DDS reports critical incidents involving children and youth receiving services in the community.
- DMH reports critical incidents involving children who are DMH clients in the community, acute care, residential treatment 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 detained or 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.

During FY16 the OCA recognized that in order to improve consistency in reporting, there should be greater clarity between our office and the EOHHS reporting agencies about what we expect to receive as a near fatality and serious bodily injury critical incident report. The OCA is meeting with each agency to strengthen our shared understanding of reporting requirements in these areas, as well as our collaboration to improve the services provided to children and families of the Commonwealth.

Outside sections to the FY17 budget broadened the OCA definition of critical incident reporting to include all executive agencies and their constituent agencies. In addition to the EOHHS agencies, this will now include those agencies organized under the Executive Office of Education and others. The definition now includes emotional injury as well.

OCA Administrative Review Process

The death or serious injury of a child is a sentinel event that deserves prompt attention. When the OCA receives a critical incident report, we conduct an immediate administrative review to learn more about the circumstance of the incident, and the reporting agency involvement with the family. For children receiving services from DCF, we focus our review on whether or not maltreatment may have contributed to the death or injury, and whether there was a missed opportunity for DCF to assist the family and protect the child. 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 agencies other than DCF, OCA staff request additional information in select cases to review case management practices.

When the OCA is concerned that the actions or inactions of a reporting agency may have contributed to the incident; OCA staff may request investigation reports from the agency, speak with staff, and review case records to learn more about the family history and involvement with the agency, and promote accountability.

The OCA maintains a database of all critical incident reports, which contains important information about the incident, such as: child-specific and family information, state agency history with the family, past or current allegations of abuse or neglect, and any follow-up the OCA has conducted with the agency involved. We use this information to identify case practice

concerns specific to the child and family involved, as well as system-wide patterns and trends about child maltreatment or associated risk factors.

Overview of Critical Incident Reports – FY16

The OCA received 122 critical incident reports regarding 114 critical incidents in FY16. In some instances, we received two reports concerning the same incident. When a child is receiving services from more than one state agency, each agency must submit a critical incident report to the OCA. The total number of CIRs is higher than FY15, when the OCA received 106 reports regarding 99 incidents. Figure 16 shows the distribution of critical incident reports by all categories: fatalities, near fatalities, serious bodily injuries, and other types of incidents.

In total, the OCA received 64 CIR fatality reports. This was a slight decrease from FY15, when 68 fatalities were reported. This fiscal year, there were also 15 reports of near fatalities and eight reports of serious bodily injuries, compared to ten reports of near fatalities and eight serious bodily injuries in FY15.

Figure 16: CIR Categories for All Reporting Agencies (n= 122 reports)

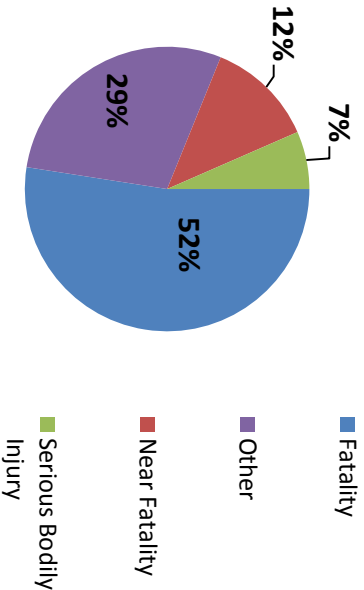


Figure 17 shows the number of critical incident reports that were submitted by each agency.

**Figure 17: Total Number of CIRs Submitted by Agency
(n=122 reports)**

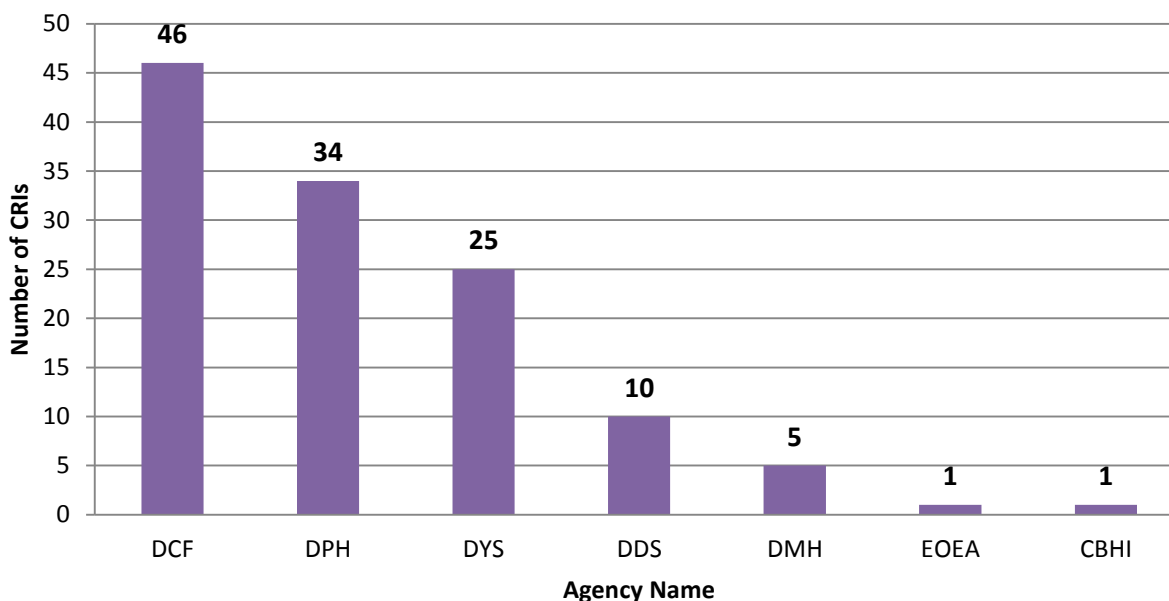
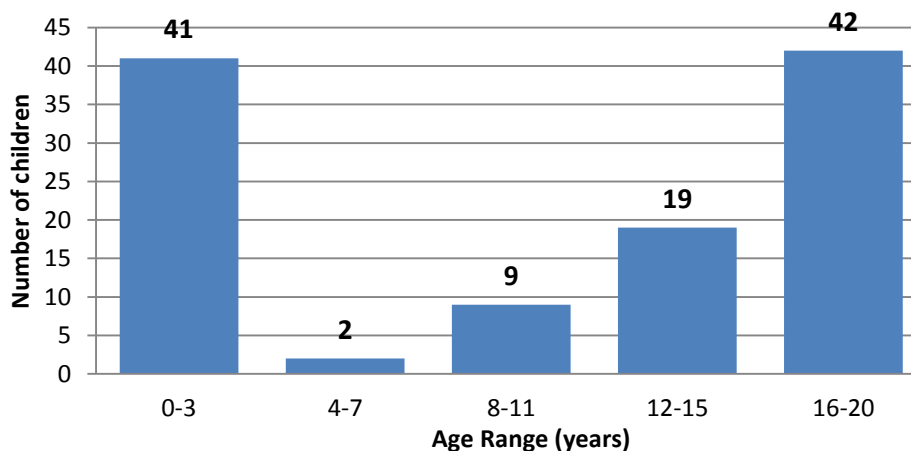


Figure 18 shows the age distribution for the 113 children who were identified in the reports and for whom age information is available. While most agencies consistently include age information in their CIR reports, sometimes the ages of the children or youth involved are missing, particularly when the CIR is reporting an incident involving multiple individuals. Children between the ages of zero to three-years-old and adolescents between the ages of 16-20 years-old were identified the most in the CIRs.

**Figure 18: Age Range of Children in all CIR Reports
(n=113 children)**



Overview of Critical Incident Reports by EOHHS Agency – FY 16

Department of Children and Families

The OCA receives CIRs from DCF when a child is either in their care or custody, or when the child's case closed within the preceding six months. Custody means that a judge has granted legal custody, which includes the right to determine the placement of a child, to DCF. Children in the custody of DCF may be placed with their parents, with kin, in licensed foster care, group homes, or in residential treatment programs. Children in the care of DCF are those whose families have an open case with the agency, but who remain at home with their parents or caregivers rather than being placed out of the home.

The OCA received 46 critical incident reports from DCF involving 47 children. Three of these CIRs were also filed by DPH. DCF reported a total of 35 fatalities, ten near fatalities, and two serious bodily injuries. Figure 19 presents the distribution of these categories. According to the most recently available data, DCF had 9,225 children in all types of out-of-home placements at the end of FY16, and another 40,447 in their caseload. The number of children identified in DCF CIRs is less than 1% of the most recently reported DCF population.

**Figure 19: DCF CIR Categories
(n=46 reports)**

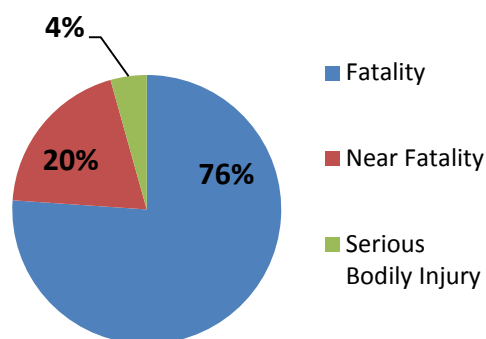
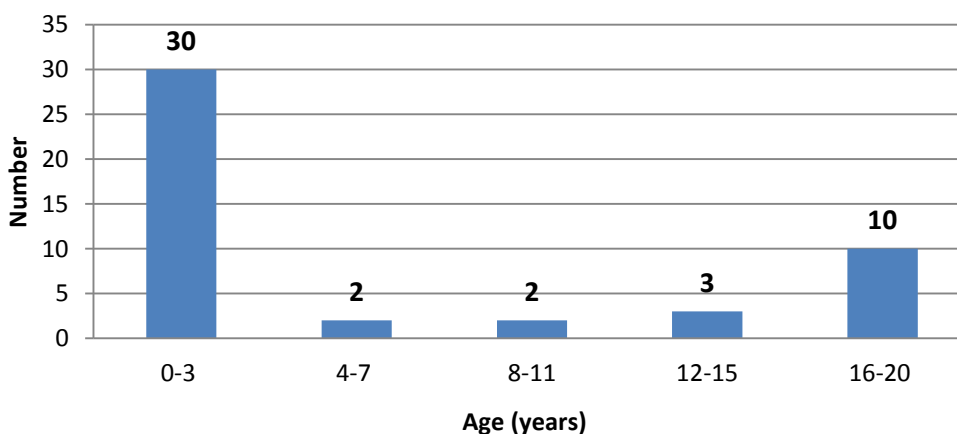


Figure 20 displays how many children were in each age category. The majority are between the ages of zero to three—years-old (64%). Of this group, 23 were fatalities, five were near fatalities, and two were serious bodily injuries.

**Figure 20: Age Range of Children in DCF CIRs
(n=47 children)**



The OCA analyzed the two age groups most represented in the DCF CIRs to identify patterns or trends associated with known risk factors for abuse or neglect.

Zero to three-year-olds:

- Of the 23 deaths, 17 children were under the age of one
- Eight children who died under the age of one were born with a life-limiting medical condition
- Eight children who died under the age of one were found in an unsafe sleep environment at the time of their death
- Twelve children who died were substance exposed newborns
- Two children died as a result of suspected physical abuse
- Of the five near fatalities, two were the result of physical abuse, two were the result of an accidental overdose of un-prescribed medication, and one was due to an unidentified reason.
- Two infants suffered serious bodily injuries as a result of physical abuse

16 to 20-year-olds:

- Of the ten CIR's, eight were fatalities and two were near fatalities.
- Two youth died in car accidents
- Four youth died as a result of community violence, such as gun or knife
- Two youth committed suicide
- The two youth near fatalities were attempted suicide

Department of Developmental Services

DDS provides services on a voluntary basis to children and custody remains with the parent or guardian, even when the child is placed in a hospital or acute treatment setting. In FY16, DDS reported ten critical incidents to the OCA. Three of these were also filed by DPH. All ten reports were regarding fatalities of children between the ages of 9-16 years old, and the cause of death in each incident was a pre-existing medical condition.

Department of Mental Health

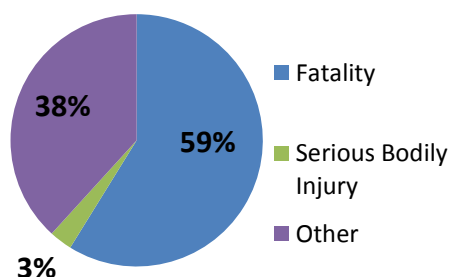
DMH provides services on a voluntary basis to children and custody remains with the parent or guardian, even when the child is placed in a hospital, group home, or residential treatment program. DMH reported five critical incidents to the OCA involving youth between the ages of

13-17. Two reports were for near fatalities resulting from suicide attempts. The other three reports involved youth who ran from a DMH facility or outing organized by a DMH program.

Department of Public Health

DPH provides services on a voluntary basis to children while custody remains with the parent or guardian, even when the child is placed in a hospital or acute treatment setting. DPH reports critical incidents involving children receiving DPH-funded services in the community and in residential treatment programs licensed and funded by DPH.

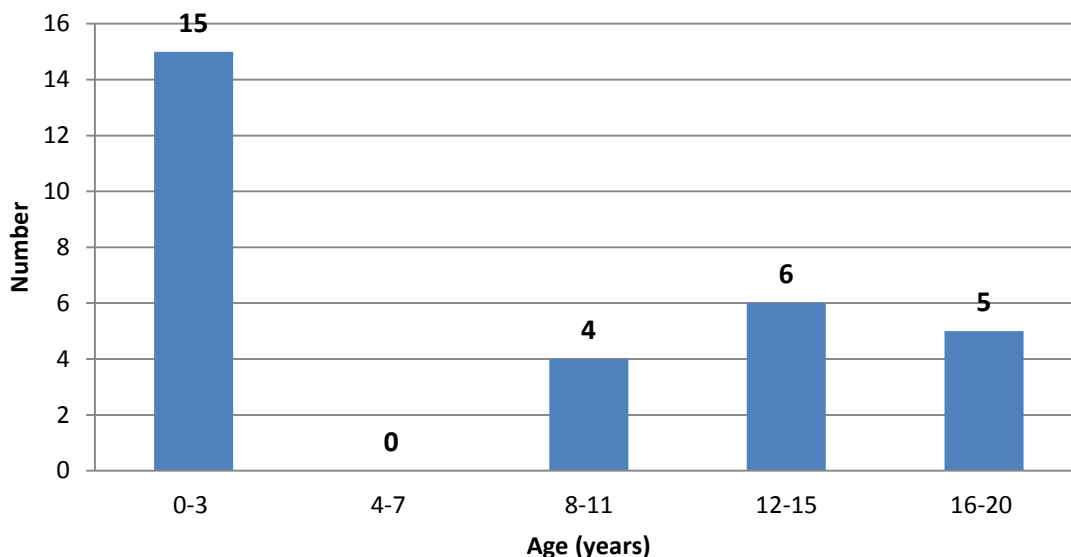
**Figure 21: DPH CIR Categories
(n=34 reports)**



DPH reported 34 critical incidents to the OCA. Three of these were also filed by DCF, three were also filed by DDS, and three were also filed by DYS. Twenty of these reports included fatalities, one reported a serious bodily injury, and the remaining 13 fall into the “other” category. There were no reports of near fatalities. The distribution of these reports is represented in Figure 21.

The majority of reports received from DPH concern children between the ages of zero to three-years-old, as shown in Figure 22. The second most common age group is youth between the ages of 16-20.

**Figure 22: Age Range of Children in DPH CIRs
(n= 30 children)**



Review of the DPH critical incident reports shows that the majority of the fatalities (nine) involved children who were born with life-limiting medical conditions. Fatalities reported by DPH frequently involved a child receiving care coordination services provided by DPH's Bureau on Family Health and Nutrition. Care coordination services are for families with a child or youth (up to age 23) who has special health care and complex coordination needs and is experiencing difficulty in obtaining or maintaining services. The remaining fatality reports involved infections, accidents and sudden unexpected infant death.

Finally, of the 13 reports that fall under the "Other" category, five are incidents that involve more than one youth, including physical altercations between youth in substance abuse/mental health programs. Examples of other reports include:

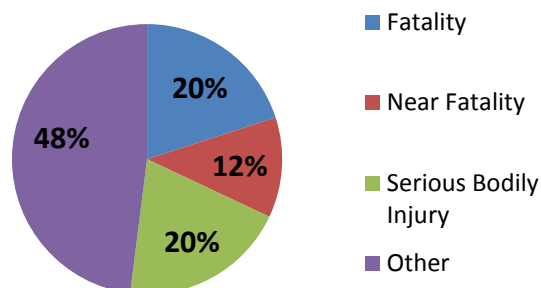
- Allegations of inappropriate behavior by staff
- Allegation of suspected abuse by a parent while the parent and her children were at a DPH facility
- An instance of a child biting his younger brother in a shelter
- One instance of filing a 51A on a parent due to concern that the parent would be unable to care for her medically complex child due to her own health issues
- One instance of a youth trying to hurt himself in facility
- One instance of a parent alleging neglect against a DPH program

Department of Youth Services

DYS reports critical incidents involving youth detained or committed by the Juvenile Court to DYS who are receiving services in the community or are in a foster home, group home, residential treatment programs, and secure treatment centers. 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.

DYS reported 25 critical incidents to the OCA. One of these was also filed by DPH. DYS reported five fatalities, three near fatalities, and five serious bodily injuries. The remaining 12 reports were placed in the "other" category, as they were not statutorily required.

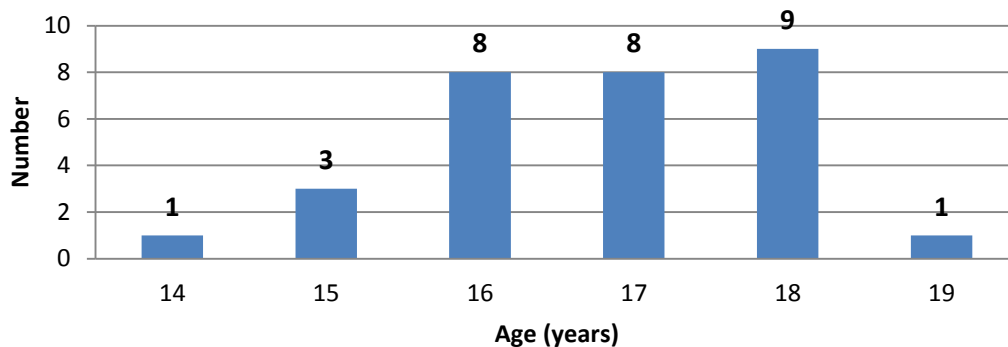
**Figure 23: DYS CIR Categories
(n= 25 reports)**



DYS served 2,243 youth during calendar year 2015. The CIRs received by the OCA reflect less than 1% of the most recently reported DYS population. Figure 23 presents the distribution of these categories.

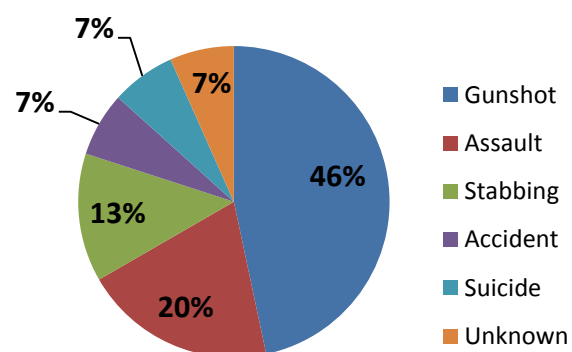
Since DYS primarily serves adolescents and young adults, we calculated the age analysis differently than the other agencies. Figure 24 shows how many youth from the ages of 14-19 were involved in a DYS CIR reports. Similar to DPH, we do not have the ages for every youth involved in these reports; two of these reports involved more than one youth, but the CIR did not have complete age information. That said, the graph does demonstrate that the vast majority of youth (83%) identified in these reports are between the ages of 16 and 18.

**Figure 24: Age Range of Children in DYS CIRs
(n=30 youth)**



Of the 15 reported fatalities, near fatalities, or serious bodily injuries, the majority were the result of an act of violence. This is similar to the common causes of death or injury of 16-20 year olds in DCF custody. The most common causes of death or injury were gunshots (seven), assaults (three) and stabbings (two). All causes of death or injury for DYS youth can be found in Figure 25.

**Figure 25: DYS Cause of Death or Injury
(n= 15 youth)**



Of the remaining 12 reports that fell into the “other” category, the majority of these reports involved DYS youth that were arrested for violent acts. Eight DYS youth were arrested for a variety of charges, including possession of a firearm, assault and battery, armed robbery, and murder. The remaining reports were for the following:

- One youth claimed that he was shot by a stray bullet while on a home pass; the findings were inconclusive.
- Two staff members were accused of abuse at a DYS facility
- Three DYS youth were questioned regarding a fire set in the community
- One parent alleged that there was a “fight club” in a DYS program; the program subsequently filed a 51A.

CIR Reports from Other Offices

Children’s Behavioral Health Initiative (CBHI)

CBHI is an interagency effort of the Commonwealth's Executive Office of Health and Human Services (EOHHS). Its mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care. This will ensure that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success in home, school, and community.⁷ The OCA received one critical incident report from CBHI. The report involved the near fatality of a child due to physical abuse by their caretaker. This incident was also reported by DCF.

Executive Office of Elder Affairs (EOEA)

The OCA received one critical incident report by EOEA. The report involved the suspected overmedication of a medically complex child.

⁷ Children’s Behavior Health Initiative website, <http://www.mass.gov/eohhs/consumer/insurance/cbhi/>

Website

The OCA website provides access to timely information and updates on the OCA's activities. During FY16, OCA staff worked to make the website more user-friendly by reorganizing and streamlining information. This included moving several tabs previously found on the OCA homepage, condensing the information under the *About the OCA* tab, and updating our list of resources. The newly designed website now has four tabs:

1. *About the OCA* – Information about the OCA mission and responsibilities, advisory council, staff, frequently asked questions and ways to contact the OCA.
2. *File a Complaint* – Information about the OCA complaint line, and a link that allows consumers to quickly share their concerns with the OCA.
3. *Resources* – Information about children and family support, mental, physical and behavioral health, education, legal support for children and families, parent and caregiver support, youth support and juvenile justice may all be found under our resource tab.
4. *Reports and Investigations* – Information and links to our previous annual reports, projects, investigations and reviews.

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

Twitter

In addition to the website, the OCA also utilizes Twitter. The Twitter account is 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 include tips for summertime safety, infographics on safe sleep for infants, and links to new reports.

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



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 about work being done across the state on issues involving children, and provides an opportunity for us to share information and help synchronize policy.

Caring Together Implementation Advisory Committee: This committee, composed of representatives from state agencies and human service providers, meets regularly to guide the implementation of the Caring Together Initiative. This is the first joint DCF and DMH procurement for residential services. The Child Advocate attends these meetings.

Child Fatality Review Program: The statewide Child Fatality Review Program (CFRP) 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. OCA staff members attend local team meetings. The Child Advocate is an *ex officio* member of the state CFRP team and OCA staff takes an active role on the state team. In FY17, the OCA is leading a needs assessment of CFRP with the goal of making recommendations for improvements to this statewide program.

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 Mass Health. CBHI provides for early periodic screenings, diagnosis, and community-based treatment of behavioral, emotional, and mental health needs. The Child Advocate is a member of the CBHI Advisory Council, which meets monthly. For information visit: <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-advisory-council.html>

The Children's League of Massachusetts: The Children's League of Massachusetts (CLM) is a non-profit association of over 80 private and public organizations, including many service providers and individuals that collectively advocate for policies and quality services in the best interest of the Commonwealth's children, youth and families. As a state agency, the Child Advocate is a "special member" of the CLM and attends its monthly meetings. In addition, OCA staff participates in CLM's Child Welfare Reform Taskforce and Transition Age Youth Task Force. <http://www.childrensleague.org/>

Children's Trust: Massachusetts Children's Trust 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. For information visit: <http://childrenstrustma.org/>

The Children's Mental Health Campaign: The Children's Mental Health Campaign (CMCH) is a coalition of families, advocates, health care providers, educators, and consumers from across Massachusetts dedicated to comprehensive reform of the children's mental health system. In FY16, the CMHC was focused on the issue of children "boarding" in emergency departments (ED). Boarding is when a child in crisis requires inpatient psychiatric care, but there is no available inpatient program, resulting in a prolonged stay in an ED or on medical units. OCA staff attend the CMHC to stay informed on this issue. For information visit: <http://www.childrensmentalhealthcampaign.org/>

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 created a new service system, replacing the Child in Need of Services system, to better serve 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 its progress. While prior years have focused on program design and start up, the primary focus this year was on expanding the number of children and families served, training staff to deliver evidence based programs, and developing a comprehensive information technology. The Child Advocate is a member of the Advisory Board.

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, the OCA's Director of Quality Assurance participates in a 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, in 2009 the Commonwealth organized a cross-secretariat effort to reduce and prevent their use. The initiative brings together leaders from DCF, DDC, 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 management techniques that can be re-traumatizing. The vision for the multi-year effort is that all youth-serving educational and treatment settings will use trauma-informed, positive behavior support practices that respectfully engage youth and their families. The OCA is an active participant. 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: Two years ago, 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. The grant supports 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 meets quarterly to guide and inform the work of the grant. This Advisory Board represents a cross-section of top leadership in the agencies and departments involved in supporting and protecting at-risk and trafficked youth. The Child Advocate is a member of the Advisory Board and the Director of Policy and Legal Counsel attends the quarterly meetings.

Massachusetts Law Reform Institute: The Massachusetts Law Reform Institute (MLRI) has convened an interdisciplinary committee of public and private members which is focusing on state policy and practice to prevent child abuse. State services available to support substance exposed newborns is the committee's first effort. The Child Advocate is a member of this committee. For information about MLRI, visit: <http://www.mlri.org/>

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. The goal of PAC is to ensure universal access to quality mental health services for all children and adolescents in Massachusetts. PAC makes recommendations to DMH, other child-serving agencies, and 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 attends meetings to discuss the concerns and ideas of this group of advisors.

Psychotropic Medication Task Force: Since 2012 the OCA and DCF Commissioner have collaborated to review and develop an oversight plan for psychotropic medications for children in DCF custody. In January 2016 the Office of the Medical Director was created at DCF. This office has taken an active role in supporting the Task Force by continuing to assess DCF's current psychotropic oversight for youth in state custody. Current projects include improving data analysis, developing psychotropic medication guidelines, and reviewing the medication consent process.

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 developing guidelines for sexual abuse prevention and intervention plans by organizations serving children and youths; tools for the development of sexual abuse prevention and intervention plans by organizations serving children and youths; recommending policies and procedures for implementation and oversight of the guidelines; recommending 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 meets regularly and provides recommendations to the Governor and legislature.

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.ecmh Matters.org/Pages/ECMHMatters.aspx>.

Conclusion

FY16 was a year of transition for the OCA. As we strive to fulfill the OCA's broad mandate of ensuring that the Commonwealth's children receive necessary services in a timely, safe and effective way, we continue to balance the need to look critically at both individual incidents and to identify systemic issues and propose changes to policy and practice. We will continue to review information we receive from all sources, investigate when necessary, and advocate for continued collaboration and increased resources when needed. Our goal is to ensure that we have the information needed to understand how services are provided and whether they can be improved to give each child the opportunity to live a full and productive life.

Our analysis of FY16 complaint line inquiries, reports of abuse or neglect in out-of-home settings, and critical incident reports from EOHHS agencies reaffirms areas of concern that have been identified by the OCA in the past. These include sudden unexpected infant death, substance exposed newborns, suicide, and community violence. We continue to support and advocate for state agency collaboration and dedicated resources to address these critical issues.

Analysis of these reports has also impressed upon the OCA the importance of screening, training, and supervising our child-serving workforce and adopting a trauma-informed approach to care. Children zero to three-years-old are the most represented population in our reviews, and the most vulnerable and at risk for maltreatment. The second most represented population is youth between the ages of 14-20, who are often the victims of an accident, suicide, or community violence. The OCA is well grounded in principles of child development and maltreatment, and the long-term impact of harmful childhood experiences. We apply this knowledge to our internal analysis of reports, and through our contributions on the multiple and diverse statewide task forces and councils dedicated to addressing risk factors associated with adverse experiences in childhood.

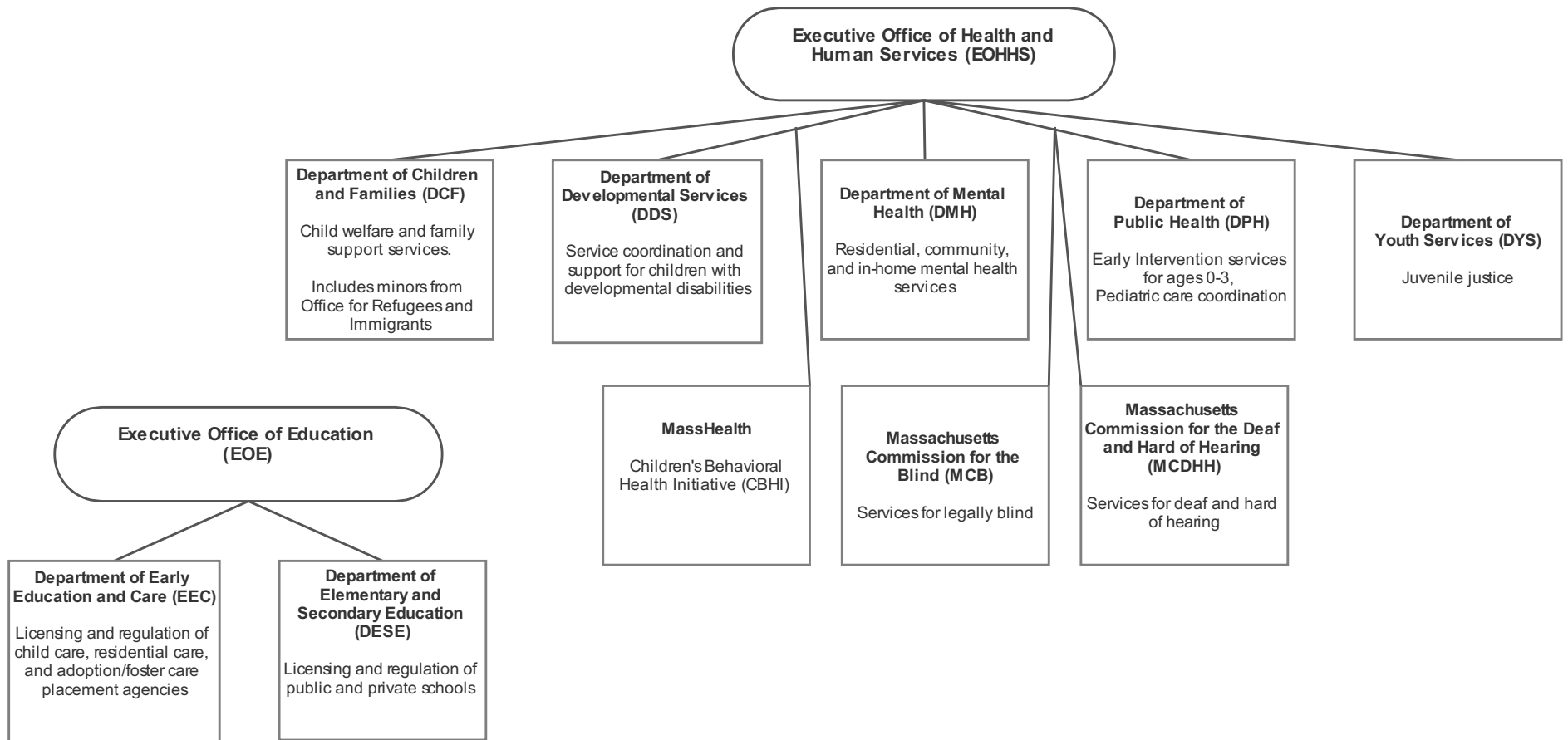
Internally, the OCA is rethinking our protocols and reevaluating our expectations for agency interaction. In Massachusetts, an unintended consequence of services for children being licensed, provided, and monitored by many agencies across two secretariats is that there is not a natural path for interagency collaboration. Added to this is a sense that agencies are currently unable to engage families in a way that feels responsive to the families. In the coming fiscal year, our goal is to make recommendations for improved agency collaboration and more meaningful family engagement.

Lastly, as the OCA expands our lens to include schools, we hope to identify gaps in how children are served across systems. With this knowledge, our goal is to make thoughtful recommendations for policy or legislative change to maximize the impact of the work being done by all child-serving agencies.

Appendix A: 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
DPPC	Disabled Persons Protection Commission
DYS	Department of Youth Services
EOEA	Executive Office of Elder Affairs
EOE	Executive Office of Education
EOHHS	Executive Office of Health and Human Services
ORI	Office for Refugees and Immigrants

Appendix B: Child-Serving Public Entities



Appendix C: DCF Management Review - Status of OCA Recommendations

Recommendation	Completed	In Progress
DCF Management Infrastructure		
1) Analyze the staffing for human resources, fiscal and information technology to determine sufficient number needed to handle all of the changes underway and include the requisite number in the budget request.	<p>Analysis was completed.</p> <p>DCF has completed hiring of 271 additional social workers and supervisors along with 83 managers and other support staff.</p>	<p>DCF continues to hire social workers/supervisors in FY17.</p> <p>DCF plans to hire 125 social work techs in FY17.</p>
2) Analyze the legal office staffing allocation model and include the requisite number of attorneys required in DCF's budget request.	<p>Analysis was completed.</p>	<p>DCF currently hiring and plans to bring on 20 additional attorneys during FY17 and FY18.</p>
3) Conduct an analysis of salary compression and any issues that are disincentives to assuming managerial responsibilities.	<p>Analysis was completed.</p> <p>DCF reviewed and adjusted formulas used to determine pay for new managers.</p>	
4) Create a robust training program for a manager that includes training around supervision, performance evaluation, use of data for managing, and policy. The availability of management training programs through the state, universities or other resources should be explored, including contracting for management training to be provided onsite at DCF.	<p>Selected management training opportunities include:</p> <ul style="list-style-type: none"> ▪ New Area Program Managers 2 x year based on cohort size ▪ Experienced managers conference days 2 x year ▪ Tailored trainings for all new policy ▪ Admin, Budget & HR training for Directors/Managers 	<p>Data Fellows Training and Support program will be launched in Spring FY17.</p>

	<ul style="list-style-type: none"> ▪ Clinical managers conference day <p>DCF also partners with Suffolk University & University of Massachusetts for management and leadership trainings, certification and advanced degrees.</p> <p>DCF's new CQI unit is now in place and has completed regional CQI trainings for Managers and Quality Assurance Supervisors.</p>	
5) Request overhead funds to provide handheld technology (iPads and cell phones), office furniture and supplies and mileage reimbursement for each new staff person.	<p>Completed.</p> <p>DCF annually receives funds that provide sufficient overhead support and meet the IT needs of existing staff and new hires.</p>	
Continuous Quality Improvement (CQI) and Data Analysis	Completed	In Progress
1) By January 2016 update reports that provide a snapshot of caseload characteristics and post them on their website.	<p>Initial updated completed.</p> <p>Quarterly Data Profiles are posted.</p>	
2) By July 2016 implement a management report of key performance indicators and performance goals, including a system for reviewing the numbers monthly at the Commissioner, regional, area office and supervisory levels, with support of OMPA.	<p>Completed.</p> <p>AILT Caseload Management Profile developed and distributed monthly to Commissioner, regional, and area offices.</p>	<p>Fidelity metrics for all new policies are in place or in development including:</p> <ul style="list-style-type: none"> ▪ Protective Intake ▪ Supervision ▪ Family Assessment and Action Planning

	Weekly and monthly metrics distributed to managers and supervisors related to policy compliance.	<ul style="list-style-type: none"> ▪ Children Missing From Care ▪ In-Home ▪ Case Closing
3) By July 2016 develop and provide to the OCA, Secretary of EOHHS and Legislature a schedule of CQI reviews to be undertaken in calendar 2016 and 2017.	<p>Completed.</p> <p>FY17 CQI initiatives for Protective Intake Policy include:</p> <ul style="list-style-type: none"> ▪ Review of Screening and Response Decision-Making ▪ Case Closing/Reopening 	FY18 CQI initiative for new Family Assessment and Action Planning Policy
4) As DCF develops CQI methodology, it should clarify the connections between CQI review findings, individual performance evaluations, training, and policy development	<p>Completed.</p> <p>A comprehensive DCF CQI Plan was developed and has been rolled-out. Focused CQI reviews are being used to inform policy development/refinement.</p>	
5) DCF should work within policy and iFamilyNet capabilities to track substance abuse and other family issues, which are indicated. This would address the problem raised by federal reviews of DCF. This requires the Department, working with the SEIU Local 509, to codify in policy the requirement to use the drop down menus in order to improve data reliability. The same is true for the specific information required by the medical policy. Allergies and medications, in	<p>Completed.</p> <p>The capacity to track substance use, mental health, trafficking, and other risk factors was incorporated into the new iFamilyNet for Protective Intake and in Family Assessment and Action Planning.</p> <p>DCF routinely works with SEIU Local 509 in the development of social work and related policies.</p>	

particular, are important to track and are already in iFamilyNet and included in policy as a requirement to check relevant boxes.		
6) By July 2016 begin to provide quarterly performance reports to the OCA, Secretary of EOHHS and Legislature tracking DCF progress.	DCF is up-to-date on current reporting requirements for the OCA, Secretary and Legislature.	DCF is working with the OCA, Secretary, and members of the legislature to integrate and streamline current reporting requirements to provide a more succinct and informative picture of DCF demographics, performance metrics and progress on agency improvements.
Policy and Practice	Completed	In Progress
1) Because of issues identified in recent case reviews, these policies should be finalized and implemented as soon as possible: case closing, family resources, Ongoing casework policy, procedures and documentation, and policy changes identified during recent case reviews.	In FY16, DCF completed the following policies which incorporate recommendations from CWLA Quality Improvement and other reviews: <ul style="list-style-type: none"> ▪ Protective Intake ▪ Supervision ▪ Family Assessment and Action Planning ▪ In-Home Case Practice ▪ Children Missing from Care ▪ DA Referral 	DCF has begun work to identify changes needed for the following policies: <ul style="list-style-type: none"> ▪ Institutional abuse ▪ Family Resources <p>DCF has also begun work to identify related IT improvements to its iFamilyNet system.</p>
2) Analyze the available resources to develop policies, training programs and revise iFamilyNet. Seek additional staffing if warranted.	Completed.	DCF will hire one additional policy staff person in FY17. DCF and EOHHS IT have expanded the use of online training to support DCF policy implementation and IT updates.

3) DCF's policy manual should be continuously updated and available to all staff via the DCF intranet. MassIT and EOHHS should dedicate resources to work with DCF to do key word searches of the manual to assist in helping staff find relevant policies to guide their work in the field.	<p>Completed.</p> <p>All finalized, approved and negotiated policies have been posted to the DCF intranet.</p> <p>The DCF intranet may be searched using key words to local specific policy topics, and related online training and resource materials.</p>	
4) Training development should also consider ways to support employees in coping with the secondary trauma and stress encountered during their work with children and families.	<p>DCF workforce supports includes and extends beyond training as follows:</p> <ul style="list-style-type: none"> ▪ New AtHoc alert system that notify workers via cellphone, landline, and email of safety related emergencies in the office or in the community ▪ Case Practice Supports to help staff deal with emergency service needs. ▪ Safety and Lockdown training for staff statewide provided by Mass State Police. ▪ New online Safety Incident Reporting Capacity 	<p>Ongoing supports include:</p> <ul style="list-style-type: none"> ▪ An annual worker safety conference ▪ Annual trauma-informed care conference ▪ Area Offices Trauma Informed Leadership Teams, Wellness Committees and/or Staff Safety Committees comprised of staff at all levels. ▪ Statewide Safety Committee
Recordkeeping Practices	Completed	In Progress
1) DCF should reexamine the current medical policy and define an effective and efficient way to record medical information and upload electronic records in order to minimize the need to file	<p>Completed.</p> <p>DCF has on board 29 new Area Office Medical Social Workers. As a result, DCF is seeing significant improvements in</p>	

paper documentation in physical case records. The revised policy should stress the need to communicate current medical information to every caregiver.	medical documentation.	
2) Medical social workers should ensure that children receive all necessary medical treatment and their medical records are kept up-to-date.	<p>See above.</p> <p>A data analyst has been hired to track progress on efforts to meet the medical needs of children in DCF care.</p>	<p>Medical SWs work collaboratively with DCF Nurses and Ongoing Social Workers to:</p> <ul style="list-style-type: none"> ▪ coordinate medical care needs ▪ access specialized medical consultation ▪ ensure proper documentation
3) By July 1, 2016, DCF shall report to the OCA, Secretary of EOHHS and Legislature on the status of current photographs in the case files of children in the care or custody of the Department, and in accordance with policy.		DCF continues to monitor the presence of photographs in electronic case files for children in DCF custody and for other children where appropriate releases have been signed.
1) By July 2016 DCF should report to the OCA, Secretary of EOHHS and the Legislature on the implementation of the new regulation and iFamilyNet as they pertain to background record checks and approval of foster homes.	DCF has completed implementation of new requirements and iFamilyNet changes are in implementation.	
2) By July 2016 DCF should review all child placements in homes approved through the prior background check waiver	The BRC approval process now requires staff to document the rational for approval, and to identify specific plans for	

process, to identify those for heightened case monitoring, home visitation, supervision, or case oversight.	additional services to the family and/or heightened oversight as appropriate.	
3) By July 2016 DCF should report to the OCA, Secretary of EOHHS and the Legislature on its progress in enhancing BRC recordkeeping and should design a system for a centralized report of foster home approvals that can be used for CQI and auditing purposes.		DCF is currently developing new management reports in support of the new BRC/CORI process and IT changes, and to support management oversight and tracking of foster home approvals.

Appendix D: Codes for Supported Neglect Allegations in Foster Care

Code	Types of Behavior
Improper/Inadequate Supervision	<p>Permits contact with parents who are not approved by DCF or court system</p> <p>Leaves children with unapproved caretakers or allows unapproved persons into the home</p> <p>Substance abuse by caretaker impairs judgment or capacity</p> <p>Mental health of caretaker impacts judgment or capacity</p> <p>Leaves child unsupervised (depends upon child's age/maturity)</p>
Risk of Emotional/Psychological Harm	<p>Uses inappropriate discipline techniques</p> <p>Interacts with child in a derogatory/negative manner</p> <p>Fails to schedule or bring child to behavioral health appointments</p> <p>Fails to follow-up with recommended behavioral healthcare</p> <p>Allows child to witness violence</p> <p>Lack of appropriate boundaries</p> <p>Encourages children to lie to DCF</p>
Medical	<p>Failure to schedule or bring child to medical appointments, dental appointments, or lack of follow-up with recommended medical care</p>
Educational	<p>Failure to ensure school attendance, does not attend school meetings, or shows a lack of responsiveness to school requests</p>
Failure to Provide for Basic Needs	<p>Any issues regarding providing appropriate food, shelter, and clothing for the child.</p> <p>Safety concerns in the home (e.g. no baby gates or appropriate locks in place)</p>

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