MASSACHUSETTS
Office of the Child Advocate

Office of the Child Advocate Annual Report

FISCAL YEAR 2022

APRIL 2023
THE COMMONWEALTH OF MASSACHUSETTS
MARIA Z. MOSSAIDES, DIRECTOR

Contents

Letter From the Child Advocate

MARIA Z. MOSSAIDES
DIRECTOR

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE CHILD ADVOCATE
ONE ASHBURTON PLACE, 11TH FLOOR • BOSTON, MA 02108
MAIN: (617) 979-8374 • WWW.MASS.GOV/CHILDADVOCATE

April 5, 2023

I am pleased to present the Fiscal Year 2022 (FY22) report of the activities of the Office of the Child Advocate (OCA). The OCA was established by the Massachusetts Legislature in 2008 to serve both as an ombudsperson to ensure that children and their families receive quality, effective, and timely services that meet their needs, as well as an independent overseer charged with identifying gaps in needed services and conducting investigations when necessary. The OCA performs these statutory functions while also working on issues that require deeper review through a project-based approach.

We have done so during a time of deep stress and trauma for both children and families as well as the community and state service systems that are here to support them. The onset of the COVID-19 pandemic challenged all of us in the Commonwealth -- but as the emergency orders were lifted, we entered a new phase of the crisis. We are seeing children and families coming to our service systems with higher intensity and more complex needs, particularly behavioral health needs, than ever before, while at the same time our service systems are struggling with staff burnout, high rates of turnover, and workforce shortages.

All of the above has impacted the work of the OCA in FY22 and beyond in a variety of ways, including increases in the volume of calls we receive from families needing help as well as increases in the complexity and acuity of the cases coming to our attention.

This year's Annual Report includes data related to the OCA's core mandated functions over the past two fiscal years including our reviews of Critical Incident Reports and reports of child abuse and neglect in out-of-home settings, and our operation of a Complaint Line to respond immediately to concerns about the delivery of state services to children. Although it is normally the practice of the OCA to publish this data annually, publication of FY21 data was delayed due to the need to shift resources to prioritize responding to the urgent needs of children during the pandemic. This data helps inform our policy work and we hope the work of others.

In FY22, the OCA also published a report on **our formal investigation into the case of Harmony Montgomery.** In that report, we made a variety of recommendations designed to address systemic challenges and failures that, in the OCA's view, contributed to the deeply tragic decision to return Harmony to her father's custody. Although the state has made progress on some of those recommendations,

particularly those directed at the Department of Children and Families (DCF), the OCA continues to be concerned that the welfare and best interest of the child is not adequately presented in care and protection cases, putting some children in unsafe situations. We continue to call on our partners in the Legislative and Judicial branches to address this situation.

Beyond our work on individual cases, the OCA devotes significant resources to our role as overseer, using our unique position and access to information that allows us to see the system of child services with a bird's eye view such that we can map where the system works well and identify where there are gaps. In FY22, this included:

- Our March 2022 report on the **status of implementation of recommendations made following our 2021 investigation into the death of David Almond**.
- Our work as chair of the legislatively created **Juvenile Justice Policy and Data (JJPAD) Board** and **Childhood Trauma Task Force**, both of which released a variety of reports with recommendations for improvements to the juvenile justice and other child service systems, including a Fall 2021 report specifically focused on the impact of the pandemic on the juvenile justice system.
- System reviews focused on DCF's **family support & stabilization** and **foster care review programs.**

Finally, we continue to expand our partnership with state agencies on projects designed to improve service quality, including:

- Our partnership with UMass Chan Medical School to launch the **Center on Child Wellbeing & Trauma.**
- Our partnership with the Department of Youth Services (DYS) to create the **Massachusetts Youth Diversion Program.**
- Our partnership with the Department of Public Health (DPH) to improve the **Child Fatality Review** process.
- Our partnership with the Executive Office of Health and Human Services (EOHHS) on a project to provide **housing support services to youth aging out of foster case** to prevent youth homelessness.

I would like to thank the Governor, the Legislature, our public sector colleagues, advocacy organizations, and families who bring their concerns and ideas to us on a daily basis. Without your support and partnership, the OCA could not successfully carry out its mission. Finally, I am grateful to the OCA's staff for their tireless efforts on behalf of the Commonwealth's children.

Sincerely,

Maria Mossaides Director,
Office of the Child Advocate

Fiscal Year 2022 Staff List

Maria Mossaides, Child Advocate

Crissy Goldman, Legal Counsel and Director of Policy
Gabriel Sultan, Policy and Research Analyst

Jessie Brunelle, Legislative and Communications Director

Jean Clements, Office Manager

Christine Palladino Downs, Senior Director of Quality Assurance
Alicia Raphalian, Quality Assurance Supervisor
Kelsey O'Sullivan, Clinical Specialist
Lorimar Mateo, Clinical Specialist
Jordan Reinwald, Clinical Specialist
Karen Marcarelli, Program Assistant
Janice Neiman, Senior Data and Research Analyst
Taylor Loyd, Data Analyst

Melissa Threadgill, Director of Strategic Innovation
Kristine Polizzano, Juvenile Justice Program Manager
Alix Riviere, Research and Policy Analyst
Jessica Seabrook, Research and Policy Analyst
Morgan Byrnes, Project and Research Coordinator

About the Office of the Child Advocate

The OCA is an independent executive branch state agency with oversight and ombudsperson responsibilities, established by the Massachusetts Legislature in 2008. The OCA's mission is to ensure that children receive appropriate, timely and quality state services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children can have the opportunity to thrive. Through collaboration with public and private stakeholders, the OCA identifies gaps in state services and recommends improvements in policy, practice, regulation, and/or law. The OCA also serves as a resource for families who are receiving, or are eligible to receive, services from the Commonwealth.

The OCA executes its mission by:

- Overseeing and monitoring the services delivered by child-serving state agencies
- Improving the collection, use, and transparency of state agency data
- Identifying gaps in and concerns with how state agencies and systems serve at-risk children, and recommending and advocating for solutions, including changes to improve coordination across agencies
- Advising on and leading efforts for systemic change in policies, programs, and practices affecting vulnerable and at-risk children
- Partnering with state agencies to improve service quality through the development and launch of innovation and incubation projects
- Serving as an ombudsperson, including providing information and referral support, for families who are receiving, or are eligible to receive, services from the Commonwealth
- Promoting child and family well-being

Guide to Acronyms

DCF	Department of Children and Families
DDS	Department of Developmental Services
DESE	Department of Elementary and Secondary Education
DMH	Department of Mental Health
DPH	Department of Public Health
DYS	Department of Youth Services
EEC	Department of Early Education and Care
EOE	Executive Office of Education
EOHHS	Executive Office of Health and Human Services

Executive Summary

The Office of the Child Advocate (OCA) is an independent executive branch state agency with oversight and ombudsperson responsibilities, established by the Massachusetts Legislature in 2008. The OCA's mission is to ensure that children receive appropriate, timely, and quality state services, with a particular focus on ensuring that the Commonwealth's most vulnerable and at-risk children have the opportunity to thrive. Through collaboration with public and private stakeholders, the OCA identifies gaps in state services and recommends improvements in policy, practice, regulation, and/or law. 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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- Advising on and leading efforts for systemic change in policies, programs, and practices affecting vulnerable and at-risk children
- Serving as an ombudsperson, including providing information and referral support, for families who are receiving, or are eligible to receive, services from the Commonwealth
- Promoting child and family well-being

This report provides an account of the OCA's activities from July 1, 2021 to June 30, 2022. It also includes data related to the OCA's core statutory functions for FY2021 and FY2022.[1]

Core Statutory Functions of the OCA

The OCA has a number of statutorily mandated responsibilities; fulfilling these core functions is our top priority. The OCA's statutory functions include:

Complaint Line: The OCA operates a Complaint Line which responds to individual service concerns about children. Family members, foster parents, advocates, attorneys, and other various individuals contact the OCA Complaint Line to express concerns, ask questions, or receive resources and information about a service a child or young adult is receiving, or eligible to receive. There was a 21% increase in the number of Complaint Line inquiries the OCA received from FY21 to FY22.

[1] Data from FY21 was not included in last year's Annual Report due to a need to prioritize resources toward addressing urgent needs of children during the pandemic.

Critical Incident Reports: The OCA statute requires state agencies providing services to children or young adults to notify the OCA if a child or young adult suffers a fatality, near fatality, serious bodily injury, or emotional injury. These are called critical incident reports (CIRs). From FY19 to FY21, there was a steady increase in critical incident reports received, from 196 in FY19 to 347 in FY21. FY22 reflects the first year-over-year reduction, with 320 critical incident reports received.

Supported Reports of Abuse and Neglect: The OCA receives, and reviews reports from the Department of Children and Families (DCF) of supported allegations of abuse and neglect of children in out-of-home settings. In FY22, the OCA received 300 supported reports of abuse and neglect involving 588 children in out-of-home settings. This volume of reports is the highest since FY19. In all reported years, reports most frequently came from congregate care settings, followed by foster care, childcare, and public-school settings. Less than 1% of foster care placements were involved in a supported report of abuse or neglect.

OCA By the Numbers

	FY21	FY22
Complaint Line Calls Received	430	519
Critical Incident Reports Received	347	320
Supported Reports of Abuse & Neglect in Out-of-Home Settings Received	211	300
Report of Abuse and/or Neglect (51A) Filed by OCA	5	0
Issues Raised[2]	239	247

OCA Led Commissions

Since the agency's inception, additional statutory mandates have been created which charge the OCA with chairing several state commissions, either in the form of permanent functions or temporary assignments. In FY22, these included:

- **Juvenile Justice Policy and Data (JJPAD) Board:** The JJPAD Board is charged with evaluating juvenile justice system policies and procedures, including the implementation of new statutory changes to the juvenile justice system, and making recommendations to improve outcomes. The JJPAD Board's FY22 reports can be found here.

[2] The issues that the OCA raised to state agencies related to 53 complaints, 33 supported reports of abuse and neglect and 153 CIRs in FY21 and 58 complaints, 51 supported reports of abuse and neglect, and 138 CIRs in FY22.

- **Childhood Trauma Task Force (CTTF):** The CTTF is charged with determining how the Commonwealth can better identify and provide services to youth who have experienced trauma, with the goal of preventing future juvenile justice system involvement. The CTTF 2022 report on identifying childhood trauma can be found here.

- **Child Welfare Data Work Group (DWG):** The DWG, which the OCA co-chaired with DCF, was charged with reviewing the list of legislatively mandated DCF reports and issuing recommendations on the elimination of unnecessary reports and the design of new reports that would present information of the children and families served by DCF. The DWG report can be found here.

Reviews of State Service Systems

In addition to the functions the OCA is explicitly required by statute to perform, the OCA is also authorized to review, report on, and make recommendations with respect to system-wide improvements. The OCA regularly uses the results of our research and investigations to make recommendations to our partners in the Executive and Legislative branches. Major FY22 projects included:

- **Investigations:** When the OCA determines the actions or inactions of a reporting agency were egregious and may have contributed to the harm of a child or young adult and/or a family did not receive quality services to meet their needs, the OCA may initiate a formal investigation.

    - *Investigative Report on David Almond:* On March 31, 2021 the OCA publicly released our formal investigation into the death of 14-year-old David Almond. The OCA made 26 recommendations for policy, procedure, and practice improvements across many state and local agencies. On March 22, 2022 the OCA released a status report detailing the actions taken to implement our recommendations, finding widespread change in Massachusetts which improved the services the state provides.

    - *Investigative Report on Harmony Montgomery:* On May 4, 2022 the OCA publicly released a formal investigation into the case of Harmony Montgomery. The key finding in the OCA's investigation and report was that Harmony's individual needs, wellbeing, and safety were not prioritized or considered on an equal footing with the assertion of her parents' rights to care for her in any aspect of the decision making by any Massachusetts state entity. The OCA's report details 11 recommendations for changes to the Massachusetts state system of services provided to children and families beyond the recommendations made in the

investigative report on the death of David Almond. Although the state has made progress on some of those recommendations, particularly those directed at DCF, the OCA continues to be concerned that the welfare and best interest of the child is not adequately presented in care and protection cases and that without some rebalancing of interests' children will be put in unsafe situations. The OCA continues to call on our partners in the Legislative and Judicial branches to address this situation.

- **Family Support and Stabilization Services Redesign:** In 2020, DCF announced it would launch a redesigned Family Support and Stabilization program. To support this effort and ensure the redesigned program would meet the needs of children and families, in January and February 2022, the OCA hosted a series of focus groups with individuals who have lived and/or professional experience with the child welfare system more generally, and family support & stabilization services more specifically.

- **Foster Care Review Improvement:** In FY22, the OCA monitored the progress of improving the Foster Care Review (FCR) program, including conducting surveys and sitting in on a sampling of FCRs once changes had been made to ensure that all participants were fully included.

- **Youth Suicide:** In FY22, the OCA continued its work on youth suicide, following up on a September 2020 Youth Suicides in Massachusetts: A Cohort Perspective in National Context report on the topic. The OCA surveyed child-serving state entities and organizations that serve youth to better understand state and local youth suicide prevention services, and shared information and recommendations based on the survey with DPH.

Partnerships with State Agencies to Improve Service Quality

- **Center on Child Wellbeing and Trauma (CCWT):** The CCWT, which is a partnership between the OCA and the UMass Chan Medical School funded by an appropriation in the state budget, supports child-serving organizations and systems in becoming trauma-informed and responsive through training, technical assistance, professional learning opportunities, and other practice advancement support. The CCWT launched in the fall of 2021. Learn more here.

- **Child Fatality Review Program:** The OCA is an active participant in the Massachusetts Child Fatality Review (CFR) program. The purpose of child fatality review is to decrease the incidence of preventable child fatalities and near fatalities.

- **Collaboration with the Office of the Inspector General (OIG):** The Office of the Inspector General (OIG) has been working with DCF for several years to improve the administration of the agency's contract with the Baker Center, formerly the Judge Baker Children's Center, to run DCF's after-hours child abuse and neglect hotline. The OCA has been a part of this work through FY21 and FY22.

- **Massachusetts Youth Diversion Program (MYDP):** The MYDP is a state-funded youth diversion initiative that provides high-quality, evidence-based youth programming that can serve as an alternative to arresting youth or prosecuting them through the Juvenile Court. The OCA launched this in partnership with the Department of Youth Services (DYS) in the fall of 2021.

- **Mandated Reporting Survey and Training Pilot for Educators***:* The OCA is working in partnership with DCF and the Department of Elementary and Secondary Education (DESE) to launch an evidence-based online training on mandated reporting of child abuse and neglect specifically for kindergarten through 12th grade educators. This online training is intended to cover aspects of mandated reporting of child abuse and neglect relevant to all mandated reporters in the Commonwealth, but also have information that is specifically designed to address common issues regarding educators' responsibilities and experiences with reporting. This work follows concerns raised through the OCA-Chaired Mandated Reporter Commission about the volume and nature of child abuse and neglect reports (51A) filed by educators. In FY22, the OCA conducted a survey of educators to help guide the Commonwealth-specific curriculum design of the mandated reporter training and took other steps toward the completion of this project.

- **Residential School Program Project***:* Residential special education schools play a vital role in the life of children with autism, behavioral, and developmental challenges. The Approved Special Education Residential Schools Programs (ASERPS) serve some of the most vulnerable youth on behalf of the Commonwealth. Since 2016, the OCA has been working in partnership with the Executive Branch on a variety of projects designed to improve collaboration and sharing of information across Commonwealth agencies involved with ASERPs, with the goal of improving the safety and well-being of youth receiving services in residential schools.

- **Transition-Age Youth:** The OCA, EOHHS and the Unaccompanied Homeless Youth Commission launched the first phase of the Housing Stability and Support Program in 2021, connecting young adults who were previously DCF-involved to housing, education, employment, transitional assistance programs, and other supports. In FY22 this program was expanded to 11 organizations providing services statewide. This led to significant

increases in youth receives services securing housing, employment, and a source of income. A high percentage of young adults referred to the pilot were successfully served by the providers, as reported in a UMass evaluation of the program. For the full evaluation, see here.

Legislative Affairs

As an independent state agency, the OCA routinely communicates with the Massachusetts Legislature on pending legislation or any policy matter relevant to the OCA's work and/or expertise. The OCA championed the following pieces of legislation in the 2021-2022 session, and our work to advocate on behalf of many of these bills continues. The following is a description of our work in the 2021-2022 Legislative session.

- **Center on Child Wellbeing and Trauma:** The CCTF recommended the creation of a Center on Child Wellbeing and Trauma (CCWT), supported with state funding, that would ensure all child-serving systems in Massachusetts are trauma-informed and responsive by providing child-serving systems with training, technical assistance, coordination, and practice advancement support. The Legislature appropriated $1 million in the FY22 state budget to support the creation and initial operation of the Center, which launched in October 2021. (The FY23 budget substantially expanded the Center's appropriation to $3.5 million.)

- **Child Fatality Review Transfer:** The OCA is an active participant in the Massachusetts Child Fatality Review program and a member of the State Child Fatality Review Team. The OCA supported legislation effectuating a transfer of chairmanship of the State Child Fatality Review Team from the Office of the Chief Medical Examiner to a joint chairmanship between the OCA and the Department of Public Health (DPH). This transfer would adequately reflect the role that DPH currently plays in facilitating the program, as well as the funding and the policy-setting specialization provided by the OCA. Legislation advanced through the legislative process several times, and was most recently included in H.88, *An Act relative to accountability for vulnerable children and families*, which passed the Massachusetts House of Representatives in March 2021. In the 2023-2024 Legislative Session, the Child Fatality Review Transfer was filed as HD3350 / SD1084.

- **Child Marriage Ban:** On July 28, 2022, Governor Baker signed a law that raises the legal age of marriage to 18 with no exceptions. The OCA was an active participant in the movement to end the practice of child marriage in Massachusetts, which prior to this law was allowed with consent from a parent and judicial approval from the Massachusetts Probate and Family Court.

- **Access to Juvenile Court Records:** The OCA currently has statutory authority to access court records as well as criminal offender record information (CORI) reviews. Although the courts have permitted the OCA access to individual files on a case-by-case basis for the purposes of investigations, we have been denied access to data on juvenile court records held by the state Department of Criminal Justice Information Services (DCJIS) because the OCA's statute does not explicitly authorize access to juvenile records from DCJIS. The OCA believes that such access is critical to our work in the field of juvenile justice. Having access to this data would also allow us to better-fulfill requests for information we have received from the Legislature. Legislation to this effect is currently filed as HD3353/SD1083 in the 2023-2024 Legislative session.

- **Bail Procedures for Justice-Involved Youth:** In 2019, the JJPAD Board recommended eliminating the $40 administrative bail fee imposed on justice-involved youth and amending juvenile arrest procedures to require the Bail Magistrate, rather than the Officer in Charge, to make the decision about whether an arrested youth should be released or held on bail. This bill proposes codifying this JJPAD recommendation into law. Under current law, the Officer in Charge at the police station is given the authority to release a youth or call the Bail Magistrate to make a bail determination. This has led to confusion and inconsistent practices across the state. The legislation passed the Senate in June of 2022. In the 2023-2024 Legislative session, this bill is currently filed as HD2969/SD186.

Initiatives and Committees

In addition to the OCA's statutorily required work and leadership of various commissions, Director Mossaides and OCA staff participate as a member on many diverse boards, councils, and initiatives across the state that work toward improving the lives of children and young adults in the Commonwealth. 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. Learn more about these efforts in the full report.

Data Snapshot of Children in Massachusetts

As a framework for the information provided in this report, the following statistics provide an overall snapshot of the demographics of children residing in Massachusetts. The data below was retrieved from the Massachusetts Kids Count Data Center and is an estimate for calendar year 2021 (January 1, 2021- December 31, 2021) unless otherwise noted.

Fast Facts on Children in Massachusetts

- 13% of children under the age of 18 live below the poverty line.
- 14% of children have experienced two or more adverse experiences in their lifetime (Kids Count 2019-2020).
- 24% of children speak a language other than English at home (Kids Count 2021).
- 32% of children are foreign-born or reside with at least one foreign-born parent (Kids Count 2021).
- **Total Number of Children under 18 in Massachusetts: 1,362,133**

Figure 1:
Massachusetts Children by Age Group

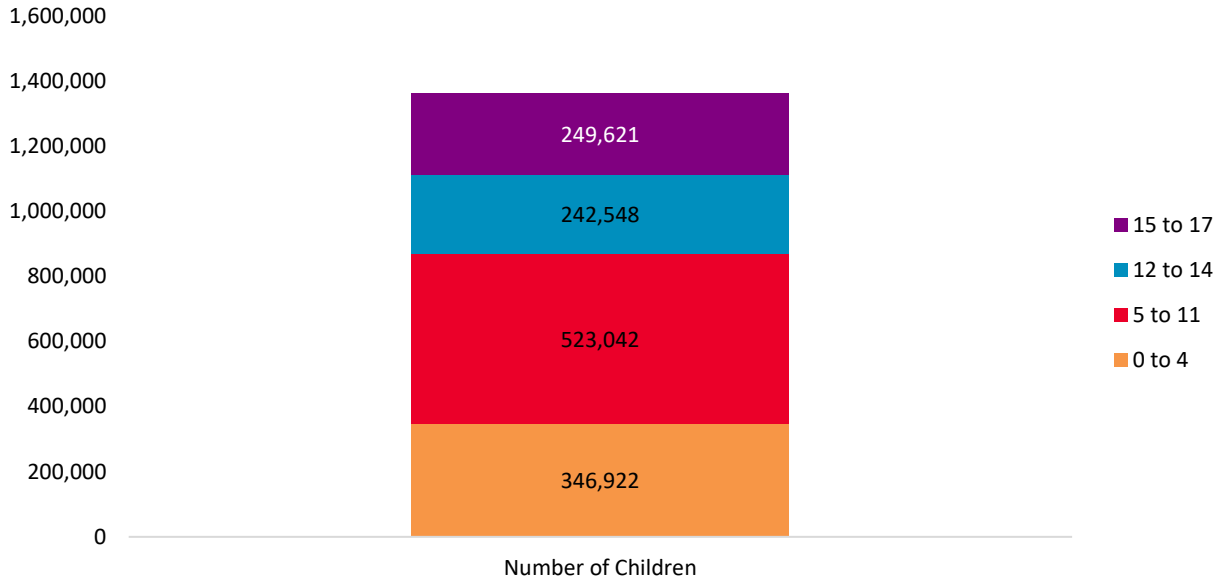
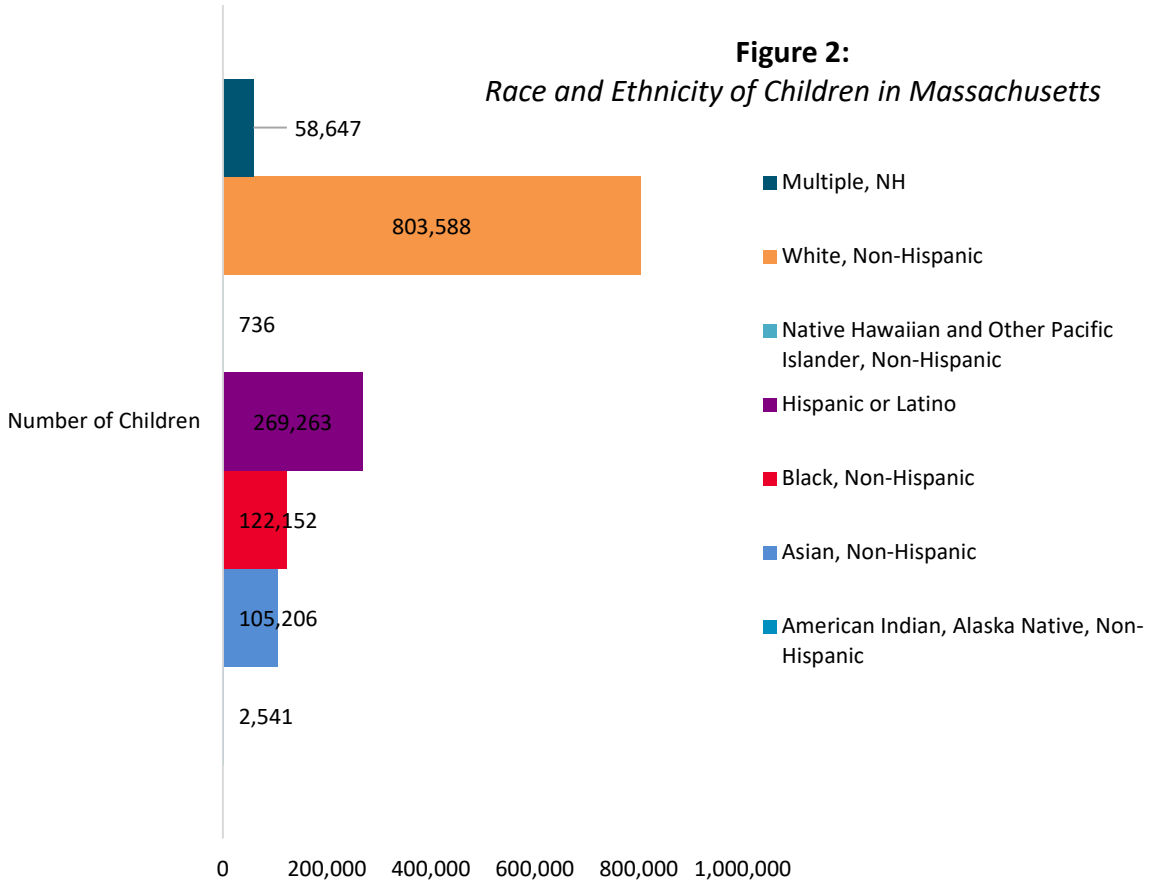


Figure 2:
Race and Ethnicity of Children in Massachusetts



Statutory Functions

The OCA is required by statute (Chapter 18C of the Massachusetts General Laws) to perform several core functions to ensure that children involved with an executive agency, particularly children served by the child welfare or juvenile justice systems, receive timely, safe, and effective services. Fulfilling these core functions is our top priority and include the following:

- **Complaint Line:** Respond to concerns about state services provided to individual children or families. Family members, foster parents, advocates, attorneys, and other various individuals contact the OCA Complaint Line to express concerns, ask questions, or receive resources and information about a service a child or young adult is receiving, or eligible to receive.

- **Critical Incident Reports**: Receive and review reports from state agencies regarding children or young adults receiving services who die or experience a serious bodily injury, a near fatality, or an emotional injury.

- **Supported Reports of Abuse and Neglect**: Receive and review Department of Children and Families (DCF) reports of supported allegations of abuse and neglect of children in out-of-home settings.

- **Investigations:** The OCA may initiate a formal investigation when the OCA determines the actions or inactions of a reporting agency were egregious and significantly contributed to the harm of a child or young adult. Typically, it is a critical incident report that brings cases to our attention for investigation though the OCA has discretion to investigate any matter that aligns with our statutory oversight obligations.

Information learned from our Complaint Line and review of critical incident reports and supported reports of abuse and neglect in out-of-home settings serves a several purposes. We use the information to identify case practice concerns specific to the child and family involved, as well as system-wide patterns and trends about child maltreatment, injury, suicide, and other issues or associated risk factors. More broadly, the information helps us:

- Determine policy and/or practice changes that could be instituted or refined to prevent future risks to children
- Determine whether there are trends or patterns that may need to be addressed by new policies or procedures
- Identify trends where the Commonwealth would benefit from greater data gathering and analysis

Findings from the examination of these data are shared with relevant agencies with recommendations for action or changes and inform the OCA's various initiatives. The OCA's findings and recommendations in the March 2021 publicly released Multi-System Investigation into the Death of David Almond, the March 2022 Multi-system Investigation Status Report Regarding the Implementation of the OCA Recommendations into the Death of David Almond and the April 2022 Multi-system Investigation into the Disappearance of Harmony Montgomery are representative of the continuous feedback and accountability presented to the agencies as part of the OCA's core functions.

The following section of this report explains these core functions, findings, and actions taken based on data received through these three core functions in FY21 and FY22.[3] Additional years of data are presented where possible to provide context and elucidate trends. In aggregate, these data inform OCA's special initiatives and oversight of state agencies.

Complaint Line

One of the most critical OCA statutory functions is responding to concerns about state services provided to children. The OCA Complaint Line is available Monday through Friday 9am to 5pm for anyone to express concerns or seek information and resources about a state service a child or young adult[4] is receiving or eligible to receive.

When an individual contacts the Complaint Line, OCA staff most often provide support and resources for the individual to address their concerns directly with the state agency involved. When the OCA is concerned for the imminent safety of a child and/or determines that the decision-making of an agency places or could place a child at risk, the OCA will immediately contact the appropriate state agency to seek more information and/or assist in the effort to resolve the concern.

In FY22, 54% percent of initial contacts[5] to the Complaint Line were made by parents, which is consistent with prior years. Grandparents and other relatives made up 13% of initial contacts while foster parents comprised 4%. The remaining 29% of individuals had various roles and relationships, including but not limited to attorneys, school and medical personnel, state employees, neighbors, and unknown or anonymous callers.

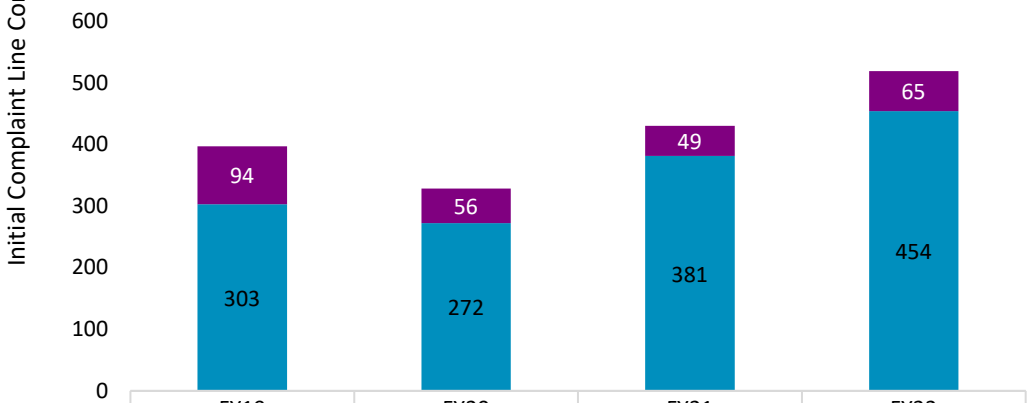
[3] The FY21 Annual OCA Report indicated a separate data supplement would be released to describe FY21 data findings. The data in this section of the FY22 report contains both FY22 and FY21 data and fulfills that commitment.
[4] Some state agencies provide services up to age 22 and therefore fall under the oversight purview of the OCA.
[5] An i**nitial contact** on the OCA Complaint Line is defined as an individual's first contact with the OCA Complaint Line. Any follow-up contact with the same individual about the same issue is not included.

Overview of Complaint Line Inquiries

The number of initial contacts to the Complaint Line increased year over year from FY20-FY22, resulting in a 31% increase from FY19 compared to FY22. While there was a slight decrease in volume at the outset of the pandemic in FY20, volume consistently increased after that time. The increase is driven primarily by complaints; the number of information and referral requests declined as a portion of all calls since FY19, but the total number remains relatively stable.[6]

The increase over the past three fiscal years may be attributed in part to the OCA's ongoing outreach. The OCA reaches out to legislators, service providers, advocates, caregivers, and others who work with children and families to provide them with information about the Complaint Line and asks them to contact the OCA if they have trouble accessing state-sponsored services, are concerned about a child receiving state-sponsored services or have a concern about the wellbeing of any child. This increase may also reflect greater need for support and resources since the beginning of the COVID-19 pandemic in March 2020. This increase in call volume may be related to improved awareness of the OCA following the David Almond investigation report and other high-profile work conducted in recent years.

Figure 3:
Initial Complaint Line Contacts by Record Type and Fiscal Year



	FY19 (n=397)	FY20 (n=328)	FY21 (n=430)	FY22 (n=519)
Information/Referral	94	56	49	65
Complaint	303	272	381	454

[6] A **complaint** is defined as contact with the Complaint Line to express dissatisfaction about services provided to a child or young adult in the Commonwealth. An **information and referral** is defined as contact with the Complaint Line to request information, referrals, or education on a specific topic and does not express dissatisfaction with any agency or program that provides services to a child or young adult of the Commonwealth.

Complaints Received Through the Complaint Line

The number of initial contacts filing a complaint increased from 272 in FY20 to 454 FY22. Each of these initial contacts represent substantial back and forth conversations and information gathering between the OCA and the complainant. While data on the back-and-forth conversations are not reflected in this report, the OCA is working to improve our record collection systems to capture the number of follow-up calls that occur for each complaint.

Consistent with prior fiscal years, many individuals who filed a complaint during FY22 expressed more than one concern. Therefore the 454 complaints received in FY22 resulted in the documentation of 558 concerns. Those concerns are categorized as:

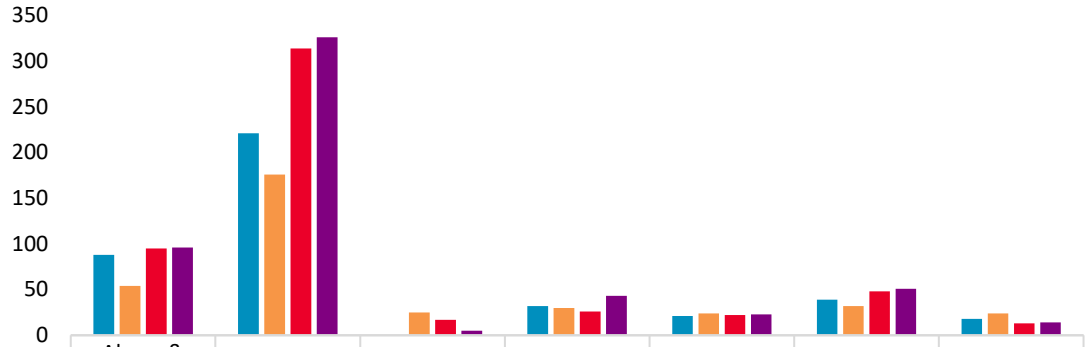
- **Abuse and Neglect**: DCF's response to a report of abuse and neglect; maltreatment of a child at home or in an out-of-home setting
- **Child Welfare**: Related to a lack of responsiveness from DCF staff; placement of a child in DCF care and custody; parent or grandparent visitation rights; adoption or guardianship process
- **COVID-19**: Concerns arising from a lack of adherence to COVID-19 protocols
- **Education**: Bullying; lack of an Individualized Education Plan (IEP) for a child; special education
- **Healthcare**: MassHealth coverage; extended stays in emergency rooms for behavioral health reasons; children not receiving services and support for their healthcare needs
- **Legal**: Concerns about a court appointed attorney; delays in court proceedings
- **Other**: Child support and other concerns not elsewhere classifiable

The number of initial contacts and the number of reported concerns increased in FY22. The topics of concern[7] remained consistent with previous years, with the most frequently occurring concerns in all reported years being Child Welfare and Abuse and Neglect. Child Welfare is consistently the most prevalent concern from FY19 through FY22.[8]

The other complaint types including COVID-19, education, healthcare, the legal system and other represent less than 10% of the initial contacts regarding a complaint in each reported year and collectively represent less than a third of all complaint-related initial contacts.

[7] COVID-19 was added as a category in FY20, when the emergency order for the pandemic began.
[8] Child welfare complaints do not necessarily involve the DCF but can involve any child-serving state agency and relate to child wellbeing.

Figure 4:
Initial Complaint Line Contacts by Fiscal Year (FY19 – FY21)



	Abuse & Neglect	Child Welfare	COVID-19	Education	Healthcare	Legal	Other
FY19 (n=419)	88	221	0	32	21	39	18
FY20 (n=365)	54	176	25	30	24	32	24
FY21 (n=535)	95	314	17	26	22	48	13
FY22 (n=558)	96	326	5	43	23	51	14

Child Welfare/Wellbeing Complaints

Child Welfare related complaints during the reporting period fell into the following subcategories, in order of prevalence in both FY21 and FY22:[9]

- **DCF Case Management:** Response to a report of abuse and neglect; removal of a child; service coordination or case oversight; frequent changes in social workers
- **Placement/Permanency:** Complaints of this nature increased in FY22 following the release of the David Almond investigation report. Complaints included length of stay in out-of-home placement; delays in reunification; foster care placement and/or denial of placement with kin; concern for the wellbeing of a child in foster care or congregate care
- **DCF Personnel:** Delay or lack of response to a parent or caregiver's questions or concerns; unprofessional communication; non-adherence to home visiting requirements as outlined in the DCF Ongoing Casework and Documentation Policy
- **Visitation**: Concerns about the frequency of visits with children in DCF custody; concerns about interactions between a child and parent during DCF supervised visits
- **Payments/Voucher**: Assistance with childcare tuition and eligibility for guardianship subsidy

[9] In FY21, of the 314 child welfare complaint concerns, there were 616 subcategories identified. In FY22, of the 326 child welfare complaint line concerns, 611 specific complaints were identified and categorized.

The OCA in Action: Education & Child Welfare

Christian and Amanda* called the OCA Complaint Line regarding Julian, their five-year old foster son. Julian was placed with Christian and Amanda when he was a newborn due to parental substance use and ongoing violence in his birth home. Christian and Amanda expressed concern that Julian was going to be reunified with his biological mother the following week without special educational services. The foster parents and biological mother lived in two different school districts, which meant Julian would transfer to a new school. Unfortunately, at the time the reunification was scheduled to occur, Julian's special education evaluation had not been completed by the sending school. Both school districts requested for this to be complete before the reunification occurred to ensure that Julian would receive educational services and with minimal interruptions of these required services. Without the proper educational services, Julian would have to transition to a general education classroom, instead of a smaller size class with a teacher and an aide. The OCA shared Christian and Amanda's concerns with DCF and DCF briefly delayed the reunification to ensure Julian's special education evaluation was completed prior to transferring to his new school. This effort to support the child's need through a transition improved the likelihood of a successful reunification.

*The names in this and all subsequent vignettes have been changed.

Abuse/Neglect, COVID-19, Education, Healthcare, Legal System, and Other Complaints

Abuse and Neglect complaints included concerns about the safety, wellbeing, and maltreatment of a child at home, at school, in foster care, or in any other child-serving setting.[10]

Initial complaint contacts regarding **COVID-19** declined year over year since the initial high in FY20, when the pandemic emergency was declared. During the reporting period, COVID-19 related complaints included concerns about delays in Juvenile Court proceedings, restricted visitation policies for children placed in congregate care, lack of access to COVID-19 testing for children in foster care and congregate care, lack of access to technology for remote education and the impact of COVID-19 on academic achievement and the overall social and emotional wellbeing of children. The OCA also received numerous complaints from parents and providers

[10] To report suspected child abuse and/or neglect, contact the Department of Children and Families (DCF). During regular business hours (8:45am – 5:00pm Monday-Friday), call the DCF Area Office that serves the city or town where the child lives. Nights, weekends, and holidays, call the Child-At-Risk-Hotline at 1-800-792-5200. For more information, visit: Report Child Abuse or Neglect

about children with complex medical needs; the primary concern was that a child may be left without care should their caregiver become ill with COVID-19.

Education complaints included parents concerned their child was not receiving eligible or needed special education services and a general lack of responsiveness by school personnel.

Healthcare complaints included parents, caregivers, and/or providers concerned for a delay in a child receiving necessary medical care, a general lack of mental health services, and children's lengthy stays in emergency departments while waiting for inpatient mental health treatment.

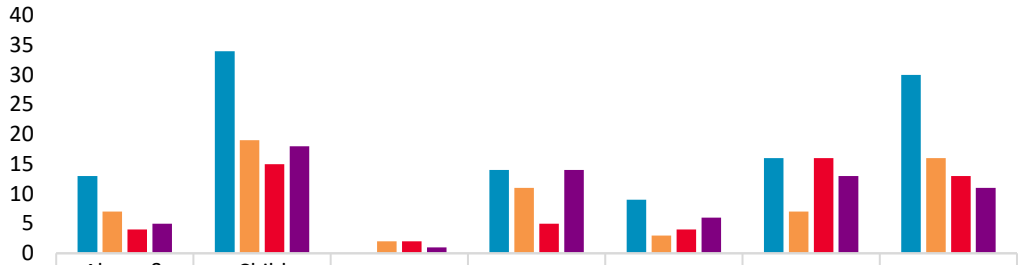
Legal complaints include delays in scheduled Juvenile Court proceedings, contested custody issues, ineffective legal representation, and infrequent contact between the attorney and client (child or parent in Juvenile Court proceedings).

Other complaints included a child not receiving necessary medical, educational and/or mental health services while in out-of-home care.

Information and Referral Requests Received Through the Complaint Line

The number of initial contacts for information and referral requests increased from 49 in FY21 to 65 in FY22, which is a 33% increase. Even with this increase the information and referral inquiries are still lower than they were pre-pandemic; in FY19, there was a high of 94 information and referral inquiries received. These inquiries reflect opportunities for improved information sharing and communication by relevant state agencies and programs.

Figure 5:
Information and Referral Requests by Concern Category (FY19-FY22)



	Abuse & Neglect	Child Welfare	COVID-19	Education	Healthcare	Legal	Other
FY19 (n=116)	13	34	0	14	9	16	30
FY20 (n=65)	7	19	2	11	3	7	16
FY21 (n=59)	4	15	2	5	4	16	13
FY22 (n=68)	5	18	1	14	6	13	11

Like complaints, each information and referral request contact are categorized, and one initial contact can represent more than one request for information or referral. The types and

proportions of requests remained consistent year over year. Child Welfare requests are the most frequently occurring and reflect a quarter or more of all information and referral calls. Another quarter of the information referral requests are categorized as "other," which reflects the variety of needs of parents and caregivers in the Commonwealth. FY21 data show an increase in information and referral calls related to the legal system, which may reflect growing awareness of the OCA's services through the OCA's juvenile justice work and the David Almond investigation report. Request for information related to education increased from five calls in FY21 to 14 calls in FY22.

During the reporting period, **Child Welfare** information and referral requests included individuals seeking information about how to file a report of abuse and/or neglect and information about DCF policies and procedures.

Other requests for information were individuals seeking general information about the OCA, the OCA Complaint Line, and/or the OCA's position on legislation. Individuals also sought information about getting an advocate for themselves and asked how to obtain DCF records.

Education related requests were generally individuals seeking information about how to obtain an educational advocate for a child with special needs and information about how to file a complaint against a school district.

Legal information and referral requests included individuals seeking legal advice and resources, as well as how to obtain legal representation for a Probate and Family Court matter, how to find out who their Juvenile Court appointed attorney is and/or how to file a complaint against them. While the OCA does not provide legal advice, the office does supporter callers in getting connected with relevant providers and understanding the resources available.

The OCA in Action: Information and Referral

Jasmine* called the OCA to inquire how to seek guardianship of her 16-year-old niece, Zoe. According to Jasmine, Zoe had been residing at her house for the past several months and she wanted to legally formalize the arrangement but was not sure of the process to do so, nor could Jasmine afford an attorney. Zoe wanted her aunt, Jasmine, to be her legal guardian as she did not want to live with her biological mother. Although the OCA cannot provide any legal advice, the OCA provided the contact information of the family and probate court closest to where they lived. The OCA explained the general court process and provided information for the lawyer of the day program, where the family could obtain free legal advice. Likewise, the OCA provided information for the nearest Family Resource Center to help connect the family to the local food pantries and therapeutic supports to help with the transition.

*The names in this and all subsequent vignettes have been changed.

Actions Resulting from Complaint Line Inquiries

The OCA responds to and offers guidance to all individuals who contact our office. After an in-depth assessment of the situation related to each contact and after the provision of guidance and referrals to support the individual, the OCA may also decide to take action to address an issue. When the OCA decides to act, the office continues regular communication with the relevant state agency until all concerns are alleviated.

The OCA acted on 53 of the 381 complaints in FY21 and 58 of the 454 complaints in FY22. Most frequently, the OCA contacted DCF in OCA's oversight capacity; a substantial portion of the follow-up related to visitation and/or reunification of a child with a parent. Being mandated reporters, the OCA also filed five reports of abuse and neglect with DCF based on complaints in FY21. Action also took place with the following state agencies regarding the following matters in FY21 and FY22:

- **Department of Mental Health (DMH)** regarding access to mental health services
- **Department of Public Health (DPH)** regarding a breach in confidentiality of a health care provider
- **Department of Youth Services (DYS)** regarding programmatic concerns at a residential treatment facility
- **Department of Early Education and Care (EEC)** regarding programmatic issues at a congregate care facility
- **Executive Office of Health and Human Services (EOHHS)** regarding complex case resolution

The OCA in Action: Responding to Children with Complex Medical Needs During the Pandemic

Since the beginning of the pandemic in March 2020, the OCA has reached out to legislators, service providers, advocates, caregivers, and others who work with children and families to provide them with information about the OCA Complaint Line and asked them to reach out if they have trouble accessing services or have a concern for a state agency's involvement with a child and family. As a result, the OCA received numerous complaints from parents and providers about children with complex medical needs. The primary concern was that a child may be left without care should their caregiver become ill with COVID-19. In response, the OCA worked with the Department of Public Health's Division for Children & Youth with Special Health Needs, MassHealth, and a pediatric nursing facility to ensure that children with complex medical needs had emergency care plans in place. This collaboration also produced a website dedicated to emergency care planning for COVID-19 and beyond, which is accessible here: Emergency Care Planning for Children & Youth with Special Health Needs during COVID-19 and Beyond

For up-to-date Complaint Line contact information, please visit the OCA's website at OCA Complaint Line or contact us by telephone at (617) 979-8360 or by email at childadvocate@mass.gov.

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

A critical part of the OCA's responsibility is to ensure that children are safe and protected from harm across all settings, but particularly in out-of-home settings. As part of that duty, the Massachusetts system of investigating child abuse and neglect[11] includes a mandatory report to the OCA when DCF[12] has found that a child has been abused or neglected in an out-of-home setting. Out-of-home settings include foster care, congregate care programs, childcare facilities, public schools, private schools, after-school and summer programs, school-funded transportation companies, and hospitals.

The OCA quality assurance staff review and analyze each report to evaluate the safety and wellbeing of the child(ren) involved in the incident, policy and/or practice concerns with the institution, the quality of the DCF investigation, and trends and patterns about the care of children in out-of-home settings. If the OCA identifies a concern in any of these areas, the OCA will immediately follow-up with DCF or the licensing agency (EEC in the case of childcare, congregate care, and foster care, DMH for inpatient psychiatric units) to gather more information and ensure the concerns are addressed.

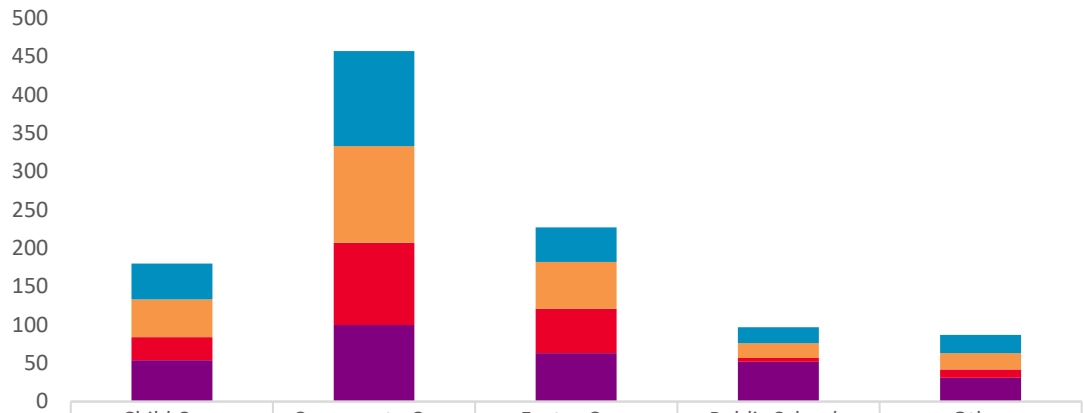
Overview of Supported Reports Received by the OCA

The OCA received 211 supported reports of abuse and neglect of children in out-of-home settings in FY21 involving 346 children in out-of-home settings. In FY22, the OCA received 300 supported reports of abuse and neglect involving 588 children in out-of-home settings. This volume of reports is the highest since FY19. In all reported years, reports most frequently came from congregate care settings followed by foster care, childcare, and then public-school settings. Those settings represent 90% of the 300 supported reports of abuse and neglect which is consistent with the proportion of reports in previous years. Reports were also received from hospitals, transportation companies, private schools, and other settings, such as after-school programs.

[11] The Massachusetts system is governed by M.G.L. c. 119 § 51B(l)
[12] Only DCF is mandated to send abuse and neglect reports to the OCA. However, the OCA may request reports of abuse and neglect from other agencies, such as EEC, as necessary.

Figure 6:

Supported Reports of Abuse and/or Neglect by Type of Out-of-Home Setting (FY219-FY22)



	Child Care	Congregate Care	Foster Care	Public Schools	Other
FY19 (n=261)	47	124	45	21	24
FY20 (n=276)	49	126	61	19	21
FY21 (n=211)	30	107	58	5	11
FY22 (n=300)	54	100	63	52	31

Findings by Care Setting

Congregate Care

Congregate care is a term that represents a wide range of out-of-home group placements for children that provide 24-hour supervision in a variety of structured settings. This includes group homes, residential treatment programs, and secure facilities for those involved in the juvenile justice system. These placements offer both short-term stabilization as well as longer-term group care. Parents and caregivers can place their child in select congregate care programs though children are commonly placed in congregate care through DCF, DMH, DYS or other state agencies within or outside of Massachusetts.

Congregate care is the most frequent setting for supported reports of abuse and neglect in out-of-home settings. In FY22, the OCA received **100 supported reports** of abuse and neglect in congregate care settings involving approximately **139 children.** This is seven fewer cases than the OCA received in FY21 involving congregate care settings; the OCA received **107 supported reports** of abuse and neglect in FY21, involving approximately **159 children**.[13] This is the third year of a downward trend in the number of supported reports involving congregate care settings. Of the 100 supported reports in FY22, 99% involved neglect, 31% involved physical abuse, and 6% involved sexual abuse.[14]

[13] See **Appendix A: Data and Definitions Regarding Out-of-Home Settings** for more information.
[14] Some cases involve more than one type of abuse; sums will not equal 100%

In both FY21 and FY22, incidents resulting in supported reports of **neglect** mostly involved situations in which youth ran away from the program, engaged in sexual contact with one another, and/or used illicit substances after congregate care staff either fell asleep on the overnight shift or did not properly supervise youth. Incidents resulting in supported reports of neglect also include staff communicating with children on social media, allowing children to use staff's cell phone, providing children illicit substances, and an inappropriate response or attempt to modify a child's behavior such as yelling, demeaning, and/or physically grabbing, shoving, or improperly restraining a child (when such contact does not rise to the level of abuse).

Supported reports of **physical abuse** include injuries to the child due to a staff person's negligent behavior or inappropriate response to the child's behavior. Incidents resulting in supported reports of **sexual abuse** related to staff engaging in sexually explicit conversation and/or an emotional or physical relationship with a youth in the program.

Child Care

The Department of Early Education and Care (EEC) licenses approximately 9,000 childcare programs, residential facilities, and foster care/adoption placement agencies across the Commonwealth.[15] Of these, about 2,847 are center-based childcare programs, 4,899 are family-based childcare providers, meaning that care is provided in someone's home and the caretaker is not related to the children, and 425 are licensed residential and placement sites. Reports of abuse and/or neglect in childcare settings received by the OCA include center-based, independent home-based, and provider affiliated home-based programs.[16]

In FY22 there were **54 supported reports** of abuse and neglect in childcare settings involving approximately **114 children**. This is a sizable increase compared to FY21, when **30 reports** were received from childcare settings, involving approximately **74 children**. Reports came from center-based, independent home-based, and provider affiliated home-based programs. [17] Of those 54 supported reports, 98% involved neglect, 33% involved physical abuse, and 2% involved sexual abuse.[18]

Consistent with prior fiscal years, nearly all supported reports in childcare involved **neglect**. Major themes in both FY21 and FY22 relate to inadequate supervision, emotional abuse, or delaying medical care. Inadequate supervision reports mostly resulted from staff leaving a child

[15] See: About the Department of Early Education and Care
[16] For this report, childcare centers are referred to as center-based while family childcare homes are referred to as home-based. Definitions of **childcare center** and **family childcare home** can be found in the Department of Early Education and Care statute (M.G.L. c. 15D § 1A)
[17] For more information about childcare setting classifications, see: M.G.L. c. 15D § 1A
[18] Some cases involve more than one type of abuse; sums will not equal 100%

or children alone for extended periods, leaving a child with an unapproved caretaker, or not noticing a child left a facility unattended.

Supported **physical abuse** reports relate to the childcare provider or employee's inappropriate response to a child's behaviors or inappropriate attempt to modify a child's behaviors, including corporal punishment. These cases often include grabbing, slapping, hitting, or pushing a child.

Supported **sexual abuse** reports in FY22 occurred only in homebased childcare settings and involved a child being sexually abused by a household member of the childcare provider.

Foster Care

When a child is removed from their home due to abuse and/or neglect, foster care is one type of setting in which they may be placed. As the Commonwealth's designated child protective services agency and the one that serves more children and families than any other EOHHS agency, most children are placed in foster care by DCF, howver DYS can also place children in foster care.[19]

In FY22 there were **63 supported reports** of abuse and neglect in foster care involving approximately **112 children**, which is similar to FY21 when **58 supported reports** were received involving foster care, reflecting approximately **92 children**. This figure should be compared to the 10,796 children and youth who received foster care services through DCF in FY21 and 10,515 in FY22[20]. Therefore, less than 1% of DCF foster care placements were involved in a supported report of abuse or neglect in FY21 and FY22. For each foster care category detailed below, no more than 3% of the total children in each care setting experienced a supported report of abuse and or neglect. Kinship foster care placements had the highest ratio of supported reports to children served.

	FY21	FY22
Supported Reports	58	63
Number of Unique Children	92	112
Total Number of Unique Children Served in Foster Care (excluding Independent Living)	10,796	10,515

[19] For definitions of the types of foster care settings, see **Appendix A: Data and Definitions Regarding Out-of-Home Settings**
[20] See **Appendix A: Data and Definitions Regarding Out-of-Home Settings** for more information.

Of those 63 supported reports in FY22, 91% involved neglect, 17% involved physical abuse, 11% involved sexual abuse, and 1% involved substance exposed newborn(s). In FY21 73% were related to neglect, 15% were substantiated concerns of neglect, 8% were related to physical abuse, 3% were related to sexual abuse, and 1% were related to human trafficking (i.e., sexually exploited children).[21] The number and type of complaint varied by foster care setting.[22]

Child-specific foster care: In FY21, there were three supported reports involving four children, out of 558 served. In FY22, there were three supported reports involving five children out of 588 children served. All reports related to **neglect**. Incidents of neglect included concerns about witnessing domestic violence/intimate partner violence, substance use by the foster parent, unreported runaway, truancy, exposure to adult content, and children left without proper supervision. There were no supported reports of **physical abuse** or **sexual abuse** in child-specific foster care in either FY21 or FY22.

Comprehensive foster care: In FY22, there were 13 reports involving 20 children out of 1,081 served. In FY21, there were five reports involving six children out of the 1,190 served. Incidents of **neglect** included concerns about domestic violence/intimate partner violence, the mental health of a caregiver, inadequate supervision, inappropriate contact with biological parents, access to food, and a foster parent's failure to seek necessary mental health treatment for a child. Supported report of **physical abuse** were the result of the foster parent's use of inappropriate physical discipline. Supported reports of **sexual abuse** related to inappropriate touch, language, and sexual coercion by foster fathers and a foster uncle. These reports all occurred in FY22.

Kinship foster care: In FY22, there were 34 reports involving 63 children out of 2,581 served. In FY21, there were 35 reports involving 58 children of 2,674 served. Incidents of **neglect** were the most frequently occurring supported reports and included concerns for delay in needed medical or mental health treatment for a child(ren), yelling and/or threatening a child(ren), domestic violence/intimate partner violence, substance use by the kinship foster parent(s), unapproved individuals living in the home, the use of unapproved caretakers for the child(ren), and allowing unapproved and/or unsupervised contact with the child(ren)'s biological parent. Supported report of **physical abuse** were the result of the foster parent's use of inappropriate physical discipline. Supported report of **sexual abuse** and **human-trafficking sexually exploited child** involved child(ren) being exposed to sexually explicit acts and/or content mostly by their foster father, and occasionally by a male visitor or relative.

[21] Percents will not sum to 100 because reports can include more than one type of allegation.
[22] For definitions of the types of foster care settings, see **Appendix A: Data and Definitions Regarding Out-of-Home Settings.**

DCF unrestricted or pre-adoptive foster care: There were 13 reports involving 23 children out of 2,401 children served. In FY21 there were 19 reports involving 27 children out of the 2,387 children served. Incidents of **neglect** included concerns for domestic violence/intimate partner violence, foster parent substance use, allowance of alcohol use by foster parents, use of unapproved or inappropriate caretakers for the child(ren), a lack of supervision resulting in injuries to a child, and a child running away. **Physical abuse** reports related to foster parent inappropriate discipline practices, and coercion to fight with siblings. One **sexual abuse** report was filed in FY22, related to inappropriate touch by a foster father.

Agency Actions Resulting from Supported Report Reviews

OCA staff review and analyze each report they receive. The purpose of this review is to evaluate the safety and wellbeing of the child(ren) involved and the quality of the investigation. After a review, the OCA may reach out to the reporting agency or a licensing entity to request and review investigations and corrective actions plans. The OCA requests this information to review any challenges the out-of-home setting is experiencing, such as workforce retention, training, or unclear programmatic policy. The OCA may also request this information to ensure that proper follow-up has been done to reduce or eliminate risk to children who remain in the setting or to prevent further harm. When the OCA conducts this follow-up, the OCA does not cease communication with the state agency until the OCA's concerns have been addressed. The OCA reached out to state agencies regarding 33 supported reports of abuse and/or neglect in out-of-home settings in FY21 and 51 in FY22. Those cases included the following concerns:

- **Department of Children and Families (DCF)** concerns included the safety and/or wellbeing of individual children, case practice by social workers and supervisors, and the licensing status of foster homes.
- **Department of Youth Services (DYS)** concerns included staffing and programmatic issues in detention and treatment programs.
- **Department of Early Education and Care (EEC)** follow-up included background record check processes, program mandated reporting responsibilities, the employment status of perpetrators of abuse and/or neglect and staffing and programmatic issues in EEC licensed congregate care or childcare settings.

Critical Incident Reports

In addition to receiving and reviewing DCF reports of abuse or neglect that have been investigated and supported regarding children in out-of-home settings, the OCA statute[23] requires state agencies[24] providing services to children or young adults to notify the OCA if a child or young adult suffers a fatality, near fatality, serious bodily injury, or emotional injury. These are called "critical incident reports" (CIRs). From FY19 to FY21, there was a steady increase in critical incident reports received, from 196 in FY19 to 347 in FY21. FY22 reflects the first year-over-year reduction in reports receiving since FY19, with 320 critical incident reports received.[25]

The number of critical incident reports submitted by each agency are not a qualitative comparison between agencies. The number of children and young adults served by each agency varies significantly as do the challenges faced by each agency's population. They should also not be interpreted as evidence of wrongdoing by an agency because a critical incident report can result from an accident, illness, community violence, or other reasons which may be unrelated to the services provided by the reporting agency.

Figure 7 shows year-over-year trends related to critical incident reports received from state agencies over the past four fiscal years. Given that DCF exclusively serves more children and families than any other EOHHS child-serving agency,[26] DCF unsurprisingly continued to submit the majority (84%) of the total number of critical incident reports to the OCA between FY19 to FY22. Furthermore, under federal law, DCF must track these cases. Additionally, a prime difference between DCF's critical incidents and those from other child-serving agencies is that DCF reports critical incidents involving children in its custody, children and young adults receiving services, and children and young adults whose families had DCF involvement within the preceding 12 months. Other EOHHS child-serving agencies[27] only report critical incidents to the OCA for children and young adults currently receiving services. This difference in reporting

[23] Office of the Child Advocate's (OCA) statute, M.G.L. c. 18C § 5

[24] Most often, the OCA receives critical incident reports from the state agencies organized under the Executive Office of Health and Human Services (EOHHS). During FY21, the OCA received critical incident reports from Department of Children and Families (DCF), Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and Department of Youth Services (DYS).

[25] The OCA attributes this, in part, to the FY18-FY19 *Critical Incident Definitions Pilot Project* between the OCA and DCF. The goal of this project was to establish a shared understanding of the emotional injury, serious bodily injury and near fatality definitions and OCA critical incident reporting requirements. Since this project, the understanding of critical incident definitions and reporting expectations has become more standard practice across all 29 DCF area offices, a process that can take some time to take effect. More detailed information about this project can be found in the OCA FY19 Annual Report and OCA FY20 Annual Report.

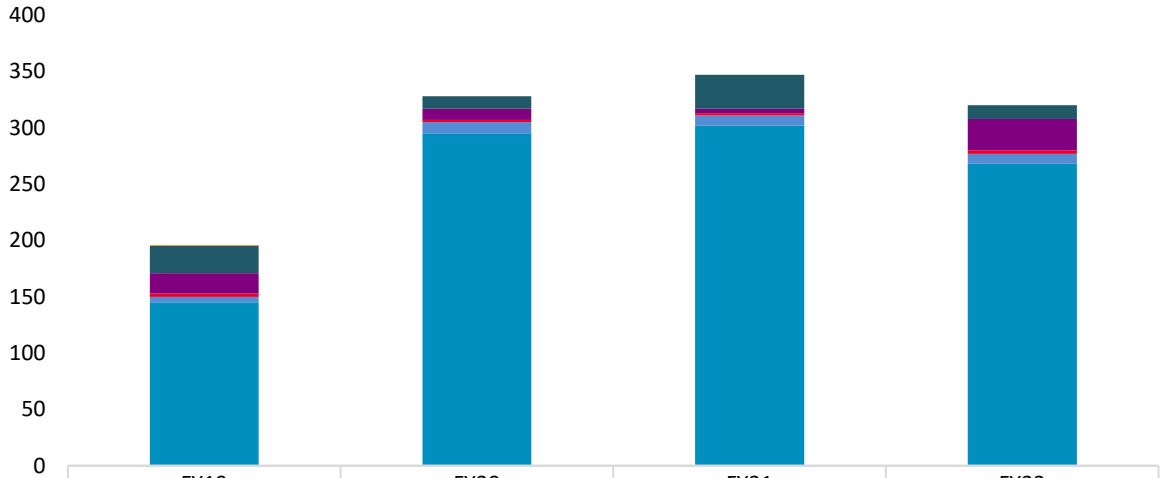
[26] At the end of FY21, DCF served 93, 802 children and adults involved in 26,307 protective cases that included 44,465 children aged 0-17. Of those 44,465 children, 81% (36,001) were maintained at home with services as needed. At the end of FY22, DCF served 86,453 families and young adults involved in 24,593 protective cases that included 41,263 children aged 0-17. Of those 41,236 children, 80% (33, 120) remained at home with services as needed.

[27] The Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and Department of Youth Services (DYS).

requirements also contributes to the larger number of DCF critical incident reports submitted to the OCA.

Other notable changes in the number of critical incident reports submitted between FY19 and FY22 is the low number of reports received from DPH in FY21 and the higher-than-normal number of reports received from DYS in FY21.

Figure 7:
CIRs Received by State Agencies (FY19-FY22)



	FY19	FY20	FY21	FY22
NA	1			
DYS	24	11	30	12
DPH	18	10	4	28
DMH	3	2	2	3
DDS	5	10	9	9
DCF	145	295	302	268

Overview of Critical Incidents

A critical incident report can contain more than one critical incident (fatality, near fatality, serious bodily injury, emotional injury) and/or more than one child.[28] Additionally, multiple agencies may submit a report regarding the same child or young adult if the child or young adult receives services from multiple agencies. For this reason, the number of critical incident reports does not equal the number of critical incidents, nor the number of children and young adults involved.

In FY21, the OCA received 347 reports involving **480 critical incidents** and **458 children/young adults**. Of the 458 children/young adults who were the subject of a critical incident, gender

[28] See **Appendix B: Critical Incident Reports** for more information.

data is available for 456 children. Approximately 55% were identified as male and 45% as female.[29] Age is available for all 458 children who appear in critical incidents during FY21, and the number of incidents are evenly distributed across age categories.

In FY22, the OCA received 320 reports involving **463 critical incidents** and **448 children/young adults**. Of those 448 children/young adults who were the subject of a critical incident, gender data is available for 346 children. Of those, approximately 56% were identified as male, 45% as female, and 1.2% as transgender or gender non-conforming.[30] Age is available for all the children who appear in critical incidents in FY22, and the number of incidents are evenly distributed across age categories.

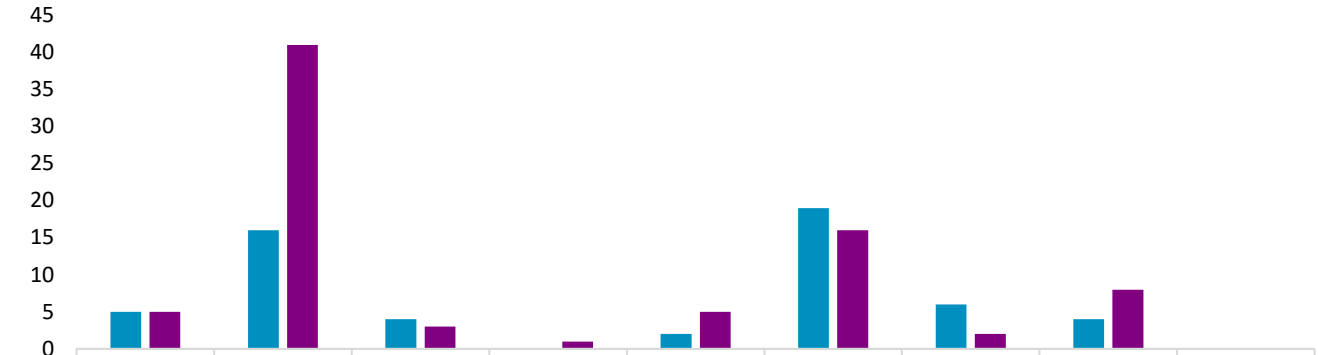
Across both years, race and ethnicity data are available for just over 80% of children and young adults. White youth made up most children involved in critical incidents (42%) followed by Hispanic/Latino youth (25%), multi-racial youth (11%), and Black youth (8%).[31]

Fatality: A fatality occurs when a child or young adult between the age of birth to 22 dies. Until FY21, the number of reported fatalities remained relatively stable between FY19 (61), FY20 (58) and FY21 (56). However, in FY22 the OCA received 81 fatality critical incident reports. All reporting agencies (DCF, DDS, DMH, DPH, DYS) reported at least one fatality in FY22, with the most coming from DCF (43) and DPH (24). Fatalities were lower in FY20 (the first year of the COVID-19 pandemic) compared to other years. This mirrors public health data as child fatalities increased to 446 in calendar year (CY) 22, compared to 389 in CY20.[32,33]

Figure 8 shows the causes of fatalities as reported in the critical incident reports from FY19-FY22. The most frequently reported fatality is medical, followed by Sudden Unexpected Infant Deaths (SUID). The reported SUIDS remained relatively stable from FY19 to FY22, with between 15 and 19 reported each year. The high number of fatality reports in FY22 was primarily driven by an increase in medical fatalities; from FY19-FY21 an average of 22 medical fatalities were reported annually, compared to 41 fatalities in FY22. The other causes remained stable year over year.

[29] Sex/Gender as reported by agency; sex/gender identification may vary by agency and may not reflect the child's identity or sex identified at birth.
[30] Sex/Gender as reported by agency; sex/gender identification may vary by agency and may not reflect the child's identity or sex identified at birth.
[31] Demographic information, such as age, gender, race, and ethnicity are collected at the time the report is received either from the critical incident report, a representative at the reporting agency or through DCF's electronic database.
[32] Registry of Vital Statistics, Open Death File. January 11, 2023.
[33] Massachusetts Child Fatality Review FY21 Annual Report

Figure 8:
Cause of Fatalities in CIRs, FY21 & FY22

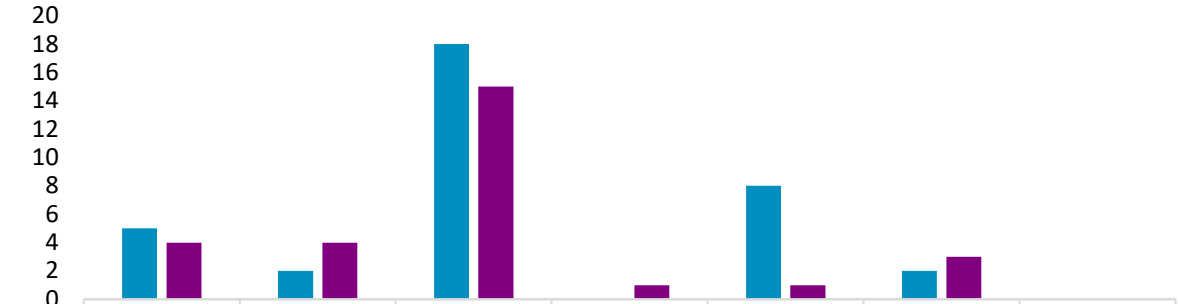


	Injury	Medical	Overdose	Physical Abuse	Suicide/Suicide Attempt	SUID	Violence	Other	Other Death/Injury
FY21	5	16	4	0	2	19	6	4	0
FY22	5	41	3	1	5	16	2	8	0

Near Fatality: Near fatalities are accidental, the result of a medical condition, or the result of abuse and/or neglect. A near fatality designation is dependent on verbal certification by a physician that the child or young adult's condition is considered life-threatening. Near fatalities more than doubled between FY20 (15) and FY21 (35). In FY22, DCF reported 25 near fatalities and DYS reported three for a total of 28.

Figure 9 shows the causes of near fatalities from FY21-FY22. Like emotional injury critical incidents, near fatalities primarily consist of an overdose. Nearly 50% of all near fatalities related to overdose from FY19 through FY22. These reports were more frequent in FY21 and FY22 than FY20 and FY19. Injury and suicide attempts are the next most frequently occurring near fatalities.

Figure 9:
Cause of Near Fatalities in CIRs, FY21 & FY22



	Injury	Medical	Overdose	Physical Abuse	Suicide/Suicide Attempt	Violence	Other
FY21	5	2	18	0	8	2	0
FY22	4	4	15	1	1	3	0

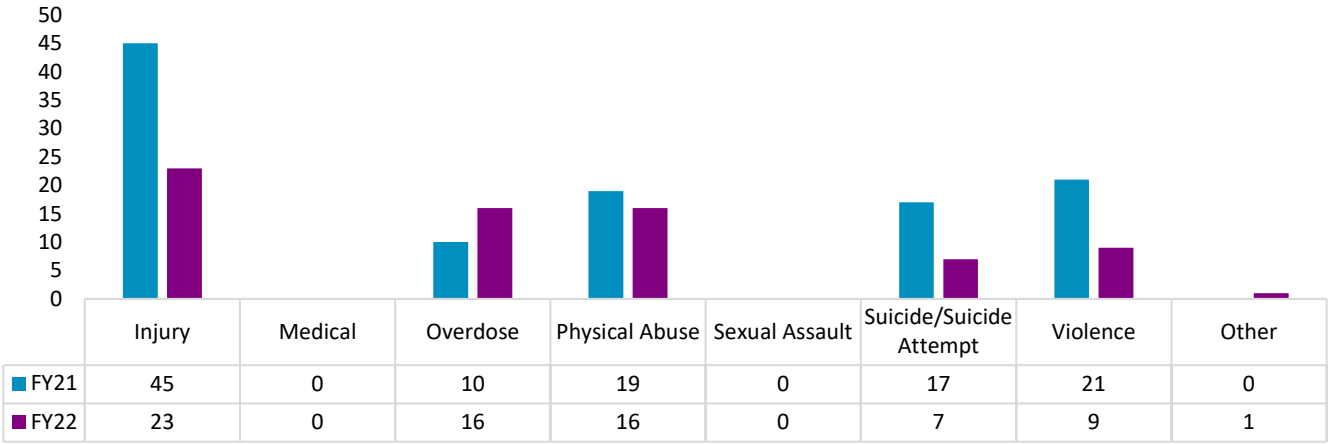
Serious Bodily Injury: Serious bodily injuries are accidental, the result of an underlying medical condition, or the result of abuse and/or neglect and lead to bodily injury "which involves a substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty or emotional distress."[34]

Serious bodily injury is the second most frequent critical incident reported behind emotional injury. Serious bodily injuries were reported more frequently in FY21 compared to other years, at 112 reports comprising 32% of all critical incidents that year. In FY21, DCF reported 91, DMH and DPH each reported one and DYS reported 19. In FY22, 72 serious bodily injury critical incident reports were received: DCF reported 63, DPH reported three, DMH reported two and DYS reported four.

Figure 10 shows the causes of serious bodily injuries from FY21-FY22. Of the serious bodily injury incidents, injury occurs most frequently. However, violence is more prevalent in these reports compared to CIRs related to fatalities, near fatalities and emotional injuries. Physical abuse, violence, and suicide attempt represent 51% of serious bodily injury critical incidents in FY21 and 44% in FY22.

[34] M.G.L. c. 18C § 5

Figure 10:
Cause of Serious Bodily Injury in CIRs, FY21 & FY22



	Injury	Medical	Overdose	Physical Abuse	Sexual Assault	Suicide/Suicide Attempt	Violence	Other
FY21	45	0	10	19	0	17	21	0
FY22	23	0	16	16	0	7	9	1

Emotional Injury: **An emotional injury occurs when a child or young adult is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.**[35] Emotional injuries are the most prevalent critical incident reported, comprising about 60% of all critical incidents from FY19 through FY22. In FY21 and FY22, the OCA received 277 and 280 emotional injury critical incidents respectively. In both fiscal years, emotional injuries are almost entirely reported by DCF, which is expected because DCF exclusively serves more children and families than any other EOHHS child-serving agency.

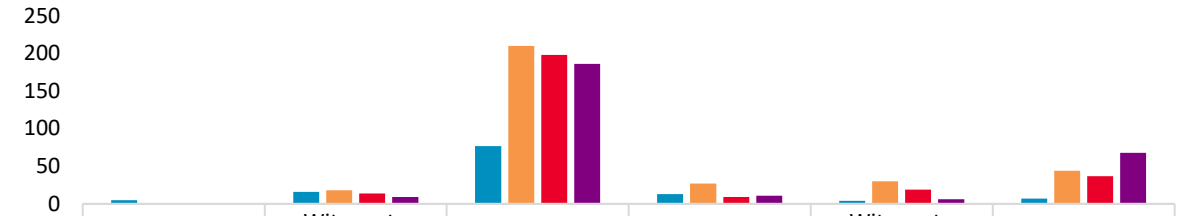
Figure 11 shows the emotional injury causes from FY19-FY22. Of the 480 critical incidents involving 458 children/young adults in FY21, 277 were emotional injury events involving 264 children/young adults. Of these events, children/young adults witnessed 161 near fatal events, with overdose (143) the most common followed by suicide attempt (three). Children and young adults witnessed 116 fatal events, with overdose (55) the most common followed by witnessing fatalities due to other causes not related to a suicide, violence, or unexpected medical event (36).

In FY22, there were 280 emotional injury events involving 278 children. Children and young adults witnessed a total of 113 fatal events with "other death or injury" occurring most

[35] The OCA term and definition of **emotional injury** is not consistently used in child welfare or scientific research. As such, emotional injuries are best understood as a type of Adverse Childhood Experience (ACEs), a term coined by the Centers for Disease Control (CDC) to describe examples of abuse, neglect, and household dysfunction that could be potentially traumatic for children and have a lifelong impact on their overall health, safety, and well-being. The OCA uses the term emotional injury to differentiate between a child witnessing an event (ex. seeing a caregiver overdose) from a child being the direct victim of the event (ex. overdosing themselves) in any setting, such as a home, community, or any other out-of-home setting.

frequently (58) followed by overdose (32), unexpected medical events (nine), violence (nine), and suicide (five). They also witnessed 167 near fatalities which resulted from overdoses (154), other injuries (10), violence (two), and suicide attempts (one).

Figure 11:
Causes of Emotional Injury (FY19-FY22)



	Other	Witness to Unexpected Medical Event	Witness to Overdose	Witness to Violence	Witness to Suicide/Suicide Attempt	Witness to Other Death/Injury
FY19	5	16	77	13	4	7
FY20	0	18	210	27	30	44
FY21	0	14	198	9	19	37
FY22	0	9	186	11	6	68

Causes of Critical Incidents

The OCA categorizes and analyzes all events that led to the injury or death of the child or young adult involved in the critical incident. The Office of the Chief Medical Examiner makes the final determination regarding the cause and manner of death and the critical incident report to the OCA provides information about the nature and circumstances of the event that led to the injury or death of a child or young adult.

Injury

Overall, the OCA observed a steady increase of injury-related critical incidents from FY19 through FY21, and a reduction in reported injuries in FY22. The FY20 OCA Annual Report observed an upward trend in injuries particularly from FY19 (14) to FY20 (44). While the number of injuries continued to increase from FY20 to FY21 (55), injuries decreased in FY22 (32).

Childhood injury is often preventable, but more than 7,000 children and adolescents aged zero to 19 died because of unintentional injuries in 2019, the most recently available national data. Nationally, some of the leading causes of child unintentional injury include motor vehicle

crashes, drowning, and falls.[36] These injuries are consistent with data from the Massachusetts Department of Public Health (DPH).[37]

During FY21 and FY22 across all injury-related critical incidents, falls (18 and 11 respectively) were the most common cause of injury, followed by motor vehicle crashes (13 and eight) and drowning (six and four), which is consistent with national and statewide childhood injury data Children zero to three years-old are most involved in falls and drownings, with youth between 12-15 years-old and 16 – 22 years old representing the majority in motor vehicle crashes.

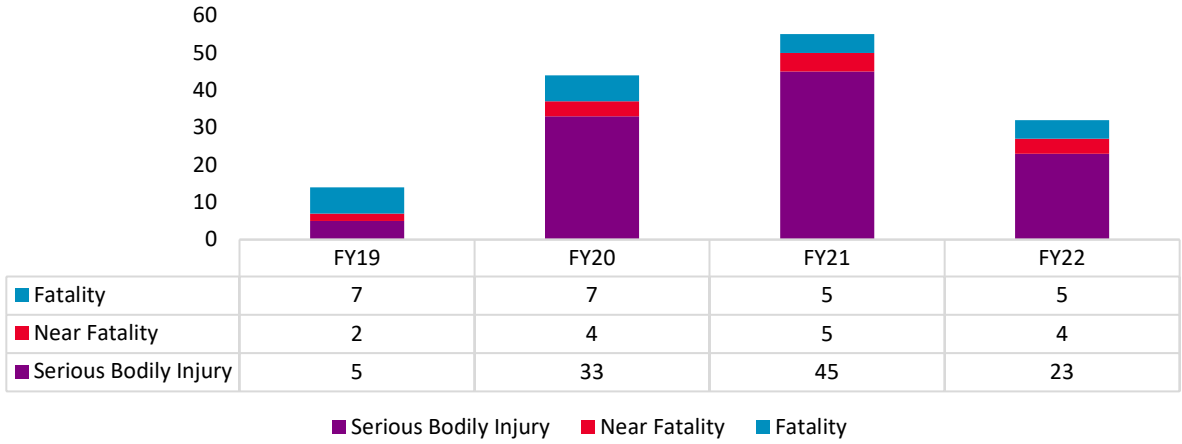
There were five injury-related **fatalities** in both FY21 and FY22, which is a slight decrease from seven in FY20 and FY19. Consistent with FY19 and FY20, FY21 and FY22 fatalities were the result of motor vehicle crashes, drowning, and an accident.

Injury-related **near fatalities** remained relatively stable since FY19 with between two and five reported each year. Of the five near fatalities in FY21, four were the result of near drownings and one was the result of a motor vehicle crash. This is consistent with FY20 in which of the four near fatalities, three were the result of near drownings and one was the result of a motor vehicle crash.

Serious bodily injuries increased substantially from FY19 through FY21 but decreased in FY22. Consistent with FY20, most of the injuries were the result of falls (four), by motor vehicle crashes (10), burns (four), dog bites (three), self-injury (two), accidents (two), drowning (one) and a broken bone during a restraint (one).

[36] Center for Disease Control and Prevention: Injury Prevention & Control.
[37] Massachusetts Child Fatality Review FY21 Annual Report

Figure 12:
Injuries in CIRs By Outcome (FY19-FY22)



	FY19	FY20	FY21	FY22
Fatality	7	7	5	5
Near Fatality	2	4	5	4
Serious Bodily Injury	5	33	45	23

Emotional Injury: Witness to Other Death/Injury

Witnessing the death or serious injury of another person was the second most frequently reported cause of emotional injury in critical incidents from FY20 through FY22. The number of those events increased substantially in FY22 to 68 events, compared to 37 in FY21 and 44 in FY20. These events predominately relate to a child witnessing someone's death. Ninety-seven percent of these events in FY21 and 85% of these events in FY22 related to witnessing a fatality.

Emotional Injury Outcome	FY21	FY22
Near Fatality	3%	15%
Fatality	97%	85%
Total	*100%*	*100%*

Overdose

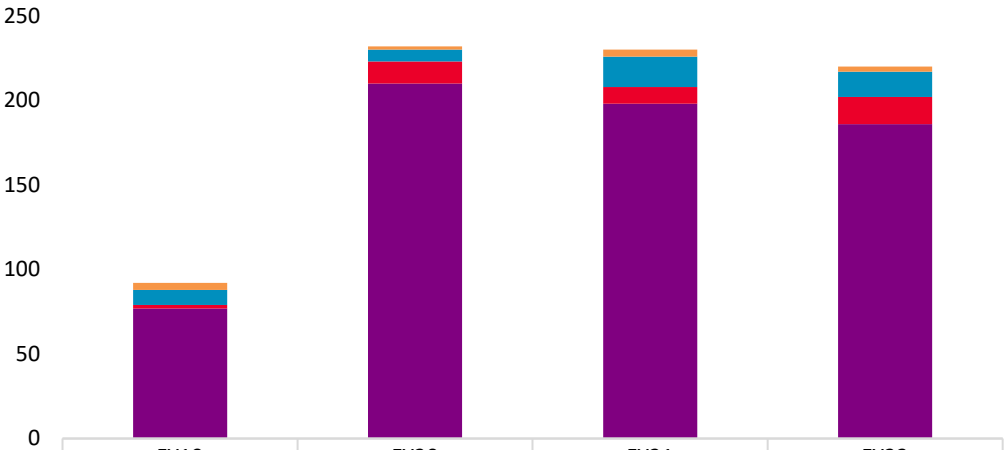
Nationally in 2021, almost 51,000 people died from drug overdoses, making it a leading cause of injury-related death in the United States. Approximately 2,500 Massachusetts residents died of an overdose that year.[38] Illicitly manufactured fentanyl and cocaine comprised 61% of drugs involved in overdose deaths nationally. According to the Center for Disease Control, 118 youth between the ages of 15-24 died of an overdose in 2021, with an additional 521 25–34-year-olds, and 706 35–44-year old's dying the same year in Massachusetts. Men consistently die of overdoses more than women.

When considering the effect that drugs and drug use has on the experience of children receiving state services, the OCA looks at both the direct experience of the child, and children

[38] Center for Disease Control. (n.d.) Drug Overdose

witnessing overdose. Combining these two categories, it is clear how deeply impacted children who receive state services are by the opioid epidemic.

Figure 13:
Overdose Events in CIRs By Outcome (FY19-FY22)



	FY19	FY20	FY21	FY22
Fatality	4	2	4	3
Near Fatality	9	7	18	15
Serious Bodily Injury	2	13	10	16
Emotional Injury	77	210	198	186

Overdose related critical incidents account for 16% of the overall critical incident events reported to the OCA in in FY21 and FY22. The number of reported critical incidents in which a child experienced an overdose[39] more than doubled from FY19 to FY22, from 15 to 34.

Fatalities due to overdose remained relatively stable from FY19 to FY22, with between two and four reported each year (note: while four reports were received in FY21, three children died)**.** Of the fatal overdoses reported, all overdosed of suspected opiates at their homes or the home of a friend. The children were 13 (one), 16 (two) and 17 (three). Two thirds of the decedents were girls, which differs from national and Massachusetts-specific public health data where men and boys are more likely to die from overdoses.

Near fatal overdoses decreased from FY21 to FY22 from 18 to 15 respectively. The circumstances of the overdoses are as follows:

[39] When the OCA receives a critical incident report about the overdose of a child or young adult, the OCA staff use the information provided in the report and from internal review of the incident to determine if the overdose was accidental or the result of a suicide attempt. If there is information that the overdose was the result of a suicide attempt, the OCA will categorize the event as a suicide attempt. If there is no information the overdose was the result of a suicide attempt, the OCA will categorize the event as an overdose.

- Twelve children ingested their parent or caregiver's illegal substances (fentanyl, clonidine, cocaine) in their respective homes. One child was in the care of their parents but in DCF legal custody at the time of the overdose; one child was in a residential substance use treatment facility with their parent; the remaining children were in the sole care and custody of their parents when they overdosed. Eleven of the children were younger than three and one was between four and seven years old.
- One youth between 12 to 15 years-old and in the care and custody of their parents accidently overdosed in the community on marijuana that unknowingly contained opiates.
- Nineteen youth between 15 to 22 years-old overdosed on opiates. One youth was in the custody of DCF and missing from their foster home placement at the time of their overdose, two youth were in the custody of DYS at the time of their overdose, and another eight youth were in the sole care and custody of their parents. The overdoses occurred in the community setting (seven), the youth's home (10), and in one instance the location of the overdose was unclear.

Serious bodily injury overdoses remained relatively stable from FY20 through FY22. In FY20, 13 serious bodily injury reports were received, compared to 10 in FY21 and 16 in FY22. The circumstances of the overdoses are as follows:

- Eight children between zero to three years-old and one child between four to seven years-old accidently overdosed on their caregivers' illicit substances which included marijuana (three), prescribed sleep aid medication (one), cocaine (one), and opiates (two; Fentanyl, one suboxone). One child was at home and in the care of their parents but the legal custody of DCF at the time of their overdose. The remaining children were in the sole care and custody of their parents and the incidents occurred within their respective homes.
- In two separate incidents in FY21, two youth between 12 to 15 years-old accidently overdosed on illicit substances which included acid, alcohol, and benzodiazepines. One youth was in the care and custody of their parents when they overdosed. One youth was in the care and custody of DCF and in a foster care placement when they overdosed.
- In three separate incidents in FY21, three youth between 16 to 22 years-old accidently overdosed on illicit substances. One youth in the care and custody of their parents overdosed on opiates. One youth in the care of their parents but legal custody of DCF overdosed on alcohol and benzodiazepines and the other youth in the care of their parents but legal custody of DCF overdosed on cocaine and marijuana.
- In two separate incidents in FY22, three 15 and 16-year-olds obtained opiates from a driver. In one case the driver was from "Hood Uber" and in the other the driver was affiliated with the residential facility at which the youth lived.

- In FY22, nine youth overdosed after obtaining substances for themselves. In two cases the medications were taken from a parent. One youth was 11 years old; the others were between 14 and 17 years old.

Emotional Injury: Witness to Overdose

Experts point to overdose exposure as an Adverse Childhood Experience. The negative impact of witnessing an overdose is compounded by the fact that children exposed to overdoses are often also victims of maltreatment which puts them at increased risk of complex trauma.[40]

Critical incidents involving children who witness an overdose comprised two thirds (or more) of all emotional injury events from FY20 through FY22. The OCA received 210 critical incident reports involving a child witnessing an overdose in FY20, 198 in FY21 and 186 in FY22. One third of those reports involved a child between one and six-years-old. In FY21, of the 198 involving a witness to overdose, 72% resulted in near fatalities compared to 28% resulting in fatalities. In FY22, of the 187 witnesses to overdose, 84% resulted in near fatalities while 16% resulted in fatalities.

Five-year-old Quinn came home to his unresponsive mother. She had fatally overdosed. With parents chronically using cocaine, heroin, and prescription medication, Quinn reported being used to seeing them put a shot of "yucky stuff" in their arms and falling asleep afterwards. He recalled his mother had been "dead" (i.e., overdosed) a month prior to her passing—highlighting his repeated exposure to this type of emotional injury and painful interpretation of these events.*

Critical Incident Report received by the OCA *Name has been changed to preserve anonymity*

Physical Abuse

Physical abuse is the non-accidental commission of any act by a caregiver which causes or creates substantial risk of physical injury to a child.[41] In FY22 DCF received 19,256 allegations of physical abuse of children and supported 1,649 of those allegations, which involved 1,853 unique children.

While the number of reported physical abuse critical incident events reported to the OCA increased sharply between FY19 (six) to FY20 (21), they decreased slightly in FY21 (19) and

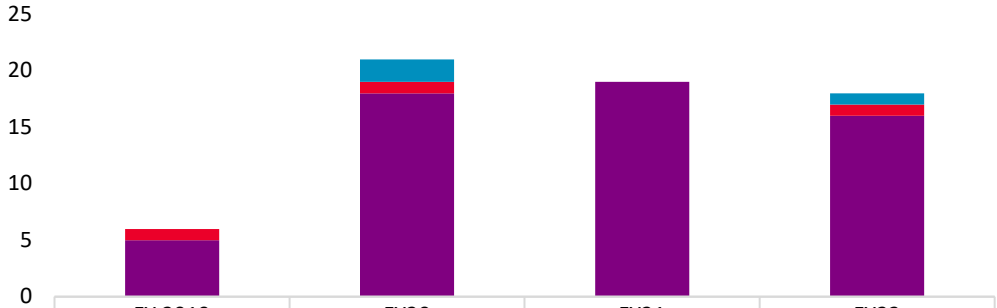
[40] Michell, K., Nolte, K., Turner, H., Hamby, S., Jones, L. (2018, January). Exposure to medication overdose as an adversity in childhood. Journal of Pediatric Nursing, 38, 127-132.
[41] For information about DCF's intake and response to allegations of abuse and neglect, refer to the DCF Protective Intake Policy.

again in FY22 (18). All the reports of physical abuse in FY21 resulted in serious bodily injury and 18 of the 19 children involved were under the age of six.

There were no reported critical incident fatalities or near fatalities of children due to physical abuse in FY21. DCF's investigations of each incident determined that the child's parent(s) were the perpetrator in 11 incidents. In three of these 11 incidents, it was determined that there were multiple perpetrators in addition to the child's parent, such as the parent's partner or a relative. The perpetrator was not identified in the remaining eight incidents of physical abuse.

In FY22, one of the 18 physical abuse incidents resulted in a fatality, one resulted in a near fatality, and the remainder (16) resulted in serious bodily injury. Of the 16 unique children involved, 15 were under four years old and one was 17. The children who suffered serious bodily injury were in the care and custody of their parents. The child's parent(s) were determined by DCF to be the perpetrator in nine incidents. Multiple perpetrators in addition to the child's parent were identified in one case. The perpetrator was not identified in the remaining 10 incidents.

Figure 14:
Physical Abuse Events in CIRs (FY19-FY22)



	FY 2019	FY20	FY21	FY22
Fatality	0	2	0	1
Near Fatality	1	1	0	1
Serious Bodily Injury	5	18	19	16

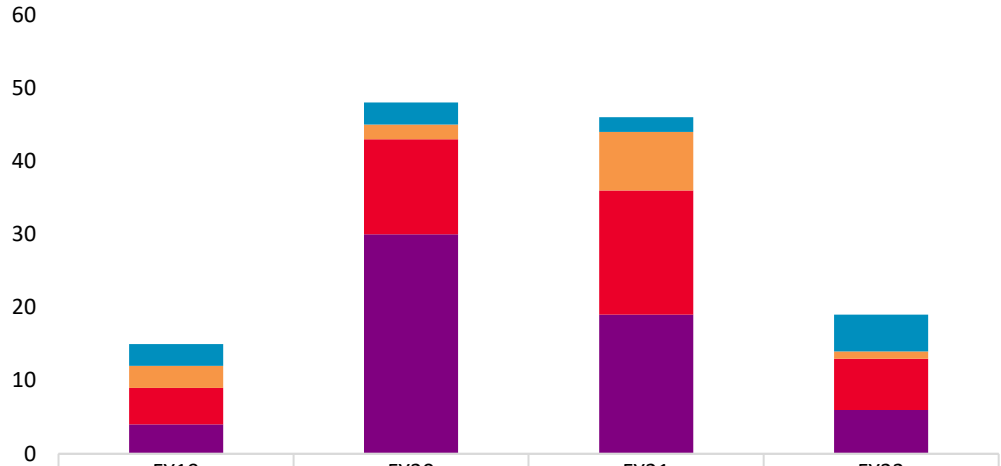
Suicide and Suicide Attempts

According to the Massachusetts Department of Public Health, "suicides are a significant yet largely preventable public health problem."[42] While emergency department visits for suicide attempts decreased in the early part of the COVID -19 pandemic, they began to increase in April 2020. Suicide and suicide attempt critical incidents reported to the OCA increased in FY20 and FY21 and decreased in FY22.

[42] DPH COVID-19 Data Brief 2020 Suicides, Suicide Attempts, and Suicidal Ideation in Massachusetts (2021)

Between FY19 and FY22 the OCA received a total of 13 critical incidents concerning the suicide death of a youth. During that same time frame, the OCA received 14 reports of a near fatality and 42 reports of serious bodily injury due to a suicide attempt. The proportion of fatalities to attempts was higher in FY22 compared to prior years, though the overall number of suicide reports was lower. From FY19 through FY22, all suicide attempts resulting in death or bodily injury involved youth aged 11-19.[43]

Figure 15:
Suicide and Suicide Attempt Events in CIRs By Outcome (FY19-FY22)



	FY19	FY20	FY21	FY22
Fatality	3	3	2	5
Near Fatality	3	2	8	1
Serious Bodily Injury	5	13	17	7
Emotional Injury	4	30	19	6

Emotional Injury: Witness to Suicide or Suicide Attempt

Children bereaved by parental suicide are at increased risk for anxiety, anger, and shame than children grieving a different death.[44] Additionally, children who lose family to suicide are more likely to struggle academically and to suffer from social maladjustment.[45] The "contagious" nature of suicide/suicidal behavior noted in research has implications for children impacted by

[43] The critical incident report trend data should not be interpreted as a complete representation of youth suicidality in Massachusetts, but it is important to reflect on these trends in the context of the identifying both current and potential youth suicide prevention efforts among state agencies.

[44] Cerel, J., Fristad, M. A., Weller, E. B., Weller, R. A. (1999, June). Suicide-bereaved children and adolescents: A controlled longitudinal examination. Journal of the American Academy of Child & Adolescent Psychiatry, 38(6), 672-679. https://www.sciencedirect.com/science/article/abs/pii/S0890856709631762

[45] Pfeffer, C., Martins, P., Mann, J., Sunkenberg, M., Ice, A., Damore, J., Gallo, C., Karpenos, I., Jiang, H. (1997, January). Child Survivors of Suicide: Psychosocial Characteristics. Journal of the American Academy of Child & Adolescent Psychiatry, 36(1), 65-74. https://www.sciencedirect.com/science/article/abs/pii/S0890856709637011

suicide: increased risk of ideation, attempts, and, in some cases, suicide. One study found children of depressed parents with suicidal behaviors were four times more likely to report a suicide attempt compared to children of depressed parents who did not have suicidal behaviors[46]. Another study found children grieving a parental suicide are likelier to die by suicide as adults than peers whose parent died by other causes[47].

In FY20 and FY21, witnessing a suicide or attempt was the third most common emotional injury event reported to the OCA. Witnessing a suicide or attempt dropped to the fifth or least frequently occurring type of emotional injury event reported to the OCA in FY22. The number of emotional injuries events related to a child witnessing a suicide or attempt decreased year over year from 30 in FY20 to 19 in FY21 and six in FY22. Of the 19 suicide-related emotional injuries events reported in FY21, 58% were children who witnessed a non-fatal attempt and 42% were children who witnessed a suicide. Of the six suicide-related emotional injuries reported in FY22, 17% were children who witnessed a non-fatal attempt and 83% were children who witnessed a suicide. While witnessing a suicide or suicide attempt decreased in FY22 compared to FY21, the suicide attempts witnessed in FY22 were more lethal compared to prior years.

Emotional Injury Outcome	FY21	FY22
Near Fatality	58%	17%
Fatality	42%	83%
Total	*100%*	*100%*

Unexpected Medical Events

Critical incidents reported to the OCA about the fatality or near fatality of a child due to medical causes are most often the result of life-limiting medical conditions or other complex health needs.

In FY21, DCF reported the fatality of nine children and near fatality of two children due to medical causes. DDS reported the fatality of six children due to medical causes. While in prior fiscal years most critical incidents submitted by DPH concerned the fatality of a child due to medical causes, DPH reported one in FY21.

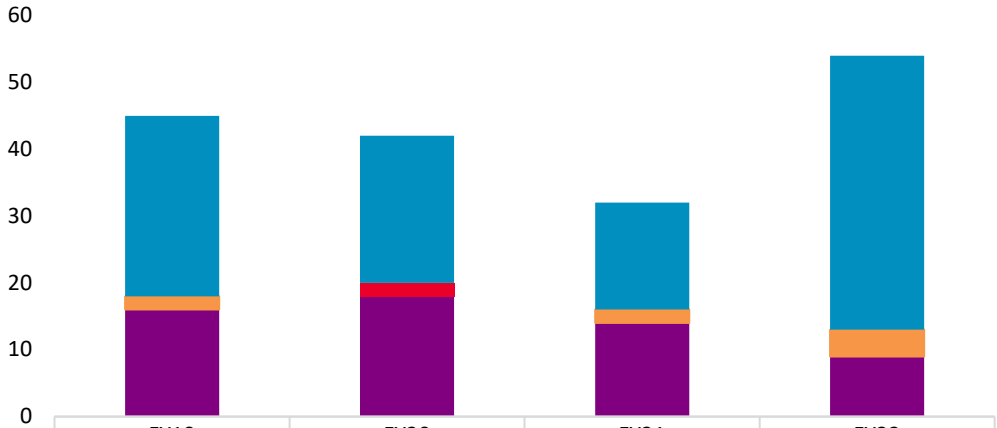
[46] Burke, AK, et al. (2010). Effect of exposure to suicidal behavior on suicide attempt in a high-risk sample of offspring of depressed parents. Am Acad Child Adolesc Psychiatry. 2010 Feb;49(2):114-21. doi: 10.1097/00004583-201002000-00005. PMID: 20215933; PMCID: PMC2915586.

[47] Wilcox, H. et al. (2010). Psychiatric Morbidity, Violent Crime, and Suicide Among Children and Adolescents Exposed to Parental Death Journal of the American Academy of Child & Adolescent Psychiatry, Volume 49, Issue 5,2010, Pages 514-523,ISSN 0890-8567,https://doi.org/10.1016/j.jaac.2010.01.020

In FY22, DCF reported the fatality of 12 children and near fatality of four children due to medical causes. DDS reported the fatality of nine children, and DPH reported the fatality of 20 children due to medical causes.

The number of fatalities due to medical events was substantially higher in FY22 compared to prior years, and primarily driven by reports from DPH which increased from one in FY21 to 20 in FY22. Fatalities reported by DPH frequently involve a child receiving care coordination services provided by DPH's Bureau of Family Health and Nutrition. Care coordination services are for families with a child or youth (up to age 23) who have special health care and/or complex coordination needs and is having trouble in obtaining or maintaining services.

Figure 16:
Medical Events in CIRs (FY19-FY22)



	FY19	FY20	FY21	FY22
Fatality	27	22	16	41
Near Fatality	2	0	2	4
Serious Bodily Injury	0	2	0	0
Emotional Injury	16	18	14	9

Emotional Injury: Witness to an Unexpected Medical Event

Children who witness an unexpected or untimely death experience more difficulty in the initial acceptance and in long-term adjustment than children who witness anticipated/natural deaths.[48] It's estimated about 10% of bereaved youth experience grief reactions of sufficient severity to produce clinically significant impairment.[49]

[48] Lehman, D. R., Lang, E. L., Wortman, C. B., & Sorenson, S. B. (1989). Long-term effects of sudden bereavement: Marital and parent-child relationships and children's reactions. Journal of Family Psychology, 2(3), 344–367.
[49] Kaplow, J. B., Howell, K. H., & Layne, C. M. (2014, January). Do circumstances of the death matter? Identifying socioenvironmental risks for grief-related psychopathology in bereaved youth. Journal of Traumatic Stress 27: 42–49.

Of the 14 critical incidents of a child witnessing an unexpected medical event in FY21, 79% related to fatalities and 21% were near fatalities. Of the nine critical incidents of a child witnessing an unexpected medical event in FY22, 100% were fatalities. Most of the incidents were a child witnessing a parent, sibling, or extended family member's death because of complications from pre-existing medical conditions as well as incidents of cardiac arrest and heart attacks.

Victims of Community Violence

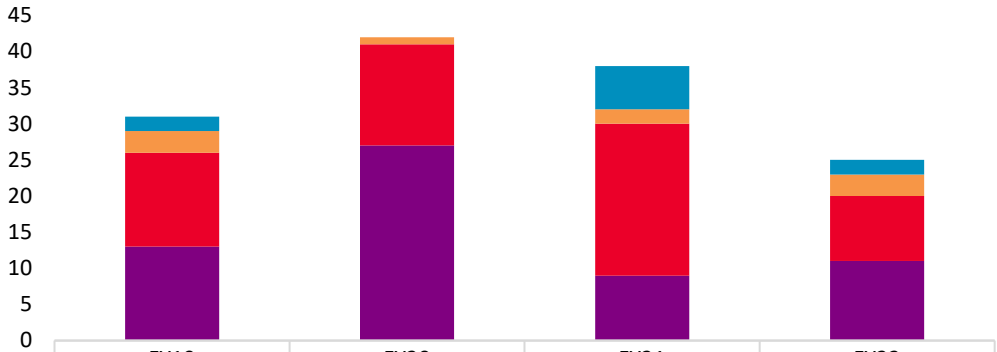
Events in which a child was a victim of community violence increased substantially in FY21 compared to prior years but decreased back to relatively normal reporting rates in FY22. These events made up 9% of all critical incident events reported to the OCA in FY20 and 14% of events in FY21.

In FY21 there were 28 youth[50] who were victims of community violence. All these youth were between the age of 15-20, seven were female and the remaining 12 were male. Gun violence was the most common cause of victim of community violence with five youth, two female and three males, suffering a fatality and two male youth suffering a near fatality. Of the remaining 21 youth, all experienced serious bodily injuries due to community violence: 16 experienced serious bodily injury due to gun violence, four experienced serious bodily injury due to stabbings, and the remaining one experienced serious bodily injury categorized by the OCA as "other." In FY21, 18 youth were involved with DYS. Nine youth were involved with DCF, and one youth was involved with both DCF and DMH.

Of the 13 youth[51] who were victims of community violence in FY22, all were between the age of 14-21, two were female and the remaining 11 were male. Gun violence was the most common cause of victim of violence with 10 youth, all males, suffering gunshot wounds. One died from his injuries, three experienced near fatalities, and seven experienced serious bodily injuries. Two youth, one female and one male, sustained serious bodily injuries due to a stabbing. In FY22, 11 youth were involved with DCF, two with DYS, and one was involved with both DYS and DCF.

[50] One youth was dually involved at the time of his death and each involved agency submitted a CIR.
[51] One youth was dually involved at the time of his death and each involved agency submitted a CIR.

Figure 17:
Community Violence Events in CIRs (FY19-FY22)



	FY19	FY20	FY21	FY22
Fatality	2	0	6	2
Near Fatality	3	1	2	3
Serious Bodily Injury	13	14	21	9
Emotional Injury	13	27	9	11

Emotional Injury: Witness to Violence

There is no statewide data on the prevalence of childhood indirect exposure to violence, but national data indicate 26% of children are exposed to domestic violence in their lifetime. In fact, the most prevalent exposure to domestic violence is Intimate Partner Violence (IPV) (90%).[52] From FY19 to FY22 60 critical incidents regarding a child witnessing violence were reported to the OCA. In FY21, six of these events involved the witnessing of a fatality, while three involved the witnessing of a near fatality. Child witnesses ranged from two years old to 18 years old. In FY22, nine of these events involved the witnessing of a fatality, while two involved the witnessing of a near fatality. Child witnesses ranged from three years old to 18 years old. Many of these cases involved a youth witnessing an event another youth was experiencing (such as witnessing a youth who was the victim of gun violence).

OCA Action Related to Critical Incidents

The OCA uses the information reported to our office to inform our work across the state child-serving system. This work not only addresses situations that have already occurred, but also identifies preventative ways that the state can reduce the incidences of harm to all children and young adults. We analyze and use the information from the critical incidents reported to our office to determine policy and practice changes to prevent future risks to children. We also identify trends where the Commonwealth would benefit from greater data gathering and analysis. Our work in this area informs our day-to-day oversight of state agencies, our

[52] National Survey of Children's Exposure to Violence

participation on the Child Fatality Review Program and Interagency Safe Sleep Task Force, as week as our various other boards and commissions and related research projects such as youth suicide prevention.

When a critical incident report is received the OCA quality assurance staff conducts an immediate review to learn more about the circumstance of the incident and the reporting agency's involvement with the child and family. When the OCA determines the actions or inactions of a reporting agency may have contributed to the incident, or that the child, young adult, or family is not receiving quality services to meet their needs, we may request additional reports from the agency, speak with staff, and further review case records to learn more about the family history and involvement with the agency. When the OCA identifies an individual case practice concern or system-wide pattern or trend, we contact the agency involved and take necessary steps to resolve the matter thereby improving state services to children and families.

While the OCA reviews critical incident reports from all child-serving state agencies, the OCA's mandate is to focus particularly on critical incidents involving children in the care or custody of DCF and DYS. Critical incident reports from DCF undergo a thorough review of the family's DCF electronic record. The purpose of this review is to understand the family and their needs, to substantively review DCF's understanding of the family and their needs, and to evaluate DCF's efforts to assist and engage the family and protect the child from harm. In this context, the OCA will identify what worked well and where there are opportunities for improvement in policy and case practice across the system or with the specific family.

The OCA communicates identified case practice concerns to a designated liaison within DCF senior leadership on an immediate and ongoing basis. This liaison shares the information with the Regional and Area Office management where the family receives services as well as ensures that the senior leadership team is aware of the OCA concerns. The Regional and Area Office responds to the OCA's concerns by providing the OCA with details about the steps they have taken or will take to address the OCA's identified concerns. **The OCA confirms that all the case practice concerns identified through the OCA's review are resolved appropriately and in a timely manner to ensure the safety and well-being of the children involved and/or improve services to the family.**

In FY21, the OCA identified case practice concerns in 140 of the 302 DCF critical incident reports received. Of these 140 cases, 94 were open cases, meaning DCF was actively providing services to the child and family when the incident occurred. In FY22, the OCA identified case practice concerns in 127 of the 267 DCF critical incident reports received. Of these 127 cases, 88 were open cases. In both fiscal years, approximately 68% of the cases requiring further action based on the OCA's review were open cases.

The OCA categorizes concerns into those identified with the DCF intake[53] and response[54] case practice, and those with the ongoing[55] case practice. These concerns are identified through an evaluation of DCF's work on the case in relation to the requirements of DCF's policy and protocols. The OCA may identify multiple case practice concerns within one case. While the identified case practice concerns do not always contribute to the critical incident, all the concerns identified warrant the attention of DCF.

The following Intake and Response Case Practice concerns were identified in FY21 and FY22:

Intake/Response Practice Concerns	FY21	FY22
Outcome Decision	25	16
Care and Custody of Child	12	8
Other Concern	11	5
Safety Planning	9	5
Collateral Contact	7	4
Record Review	5	1
Interviewing/Engaging Children	4	2
DCF Specialist Consultation	1	1

Care and Custody of Child: A concern that DCF left the child in the care and/or custody of a parent or caregiver or removed the children from the care and/or custody of a parent or caregiver. In both FY21 and FY22 the OCA's concerns included both disagreement with decisions to remove and decisions not to remove.

Collateral Contact: A determination that the risk posed to the child was not fully assessed because the response worker did not contact professionals and/or natural supports or did not ask questions that elicited information necessary to inform the clinical practice. Cases are not identified for this concern if the barrier to obtaining information is the result of parent/caregiver refusal to provide releases of information.

[53] When DCF receives a report of abuse and/or neglect (51A), DCF gathers information to determine whether the allegations meet DCF criteria for suspected abuse and/or neglect, if there is immediate danger to the safety of a child, whether DCF involvement is warranted and how to best respond. DCF begins its screening process (intake) immediately upon receipt of a 51A report. If a 51A is "screened in," it is assigned for a child protective response to determine whether there is reasonable cause to believe that a child has been abused and/or neglected. "Screened-in" are categorized as requiring either an immediate emergency response or a non-emergency response. For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.

[54] "Screened-in" 51A reports are assigned to a DCF response social worker for completion of an investigation in accordance with MGL c. 119 § 51B. The response worker, in consultation with the supervisor, determines a finding on the reported allegation(s), including a finding on person(s) responsible and whether DCF involvement is necessary to safeguard safety and well-being. These findings are based on the facts gathered during the investigation, the assessment of parental capacities, the results of the risk assessment tool and DCF's clinical judgement.

[55] Ongoing social workers provide the necessary services to help children who are abused and/or neglected. In many situations, social workers interact with children and family members including siblings, parents, extended relatives, and guardians to assess the needs of each child and determine the best course of action for improving the child family environment. For more information about DCF's ongoing case management refer to the DCF Ongoing Casework Policy.

DCF Specialist Consultation: A determination that a DCF specialist consultation was not completed during the response although there were identified complex or high-risk factors that warranted one.

Interviewing/Engaging Children: A determination that the response worker did not perform a full, protective, developmentally appropriate interview with the child as part of the response and/or interviewed the child in the presence of the alleged perpetrator without making attempts to meet with the child alone.

Other concerns: The OCA identifies errors in the electronic record and/or poor-quality case activity notes including electronic records that should have been, but were not uploaded (i.e. education records, medical records).

Outcome Decision: OCA disagreement with an intake or response decision either regarding the critical incident or a prior DCF intake and response involving the same family. This could mean a disagreement with a screening decision, with a finding of abuse or neglect, with a finding on the alleged perpetrator, or with a categorization of a case as either emergency or non-emergency.

Record Review: There is no documentation in the case record that the response worker reviewed the family's prior DCF history, if any, as part of their response.

Safety Planning: A concern that DCF approved an individual(s) responsible for ensuring a child's safety and that individual was not an appropriate caregiver and/or was not aware of the safety plan and DCF's concern for the child.

The following Ongoing Case Practice Concerns were identified in FY21 and FY22:

Ongoing Case Practice Concerns	FY21	FY22
Clinical Formulation	69	47
Collateral Contact	50	50
Lack of Father Engagement	32	25
DCF Specialist Consultation	29	36
Other Concern	28	46
Care and Custody of Child	23	14
Inconsistent Home Visits	23	16
Interviewing/Engaging Children	22	5
Premature Case Closing	21	7
Safety Planning	14	17
Permanency Planning	4	2
Inconsistent Placement Visits	3	6
Interagency Collaboration	1	0

Care and Custody of Child: A concern that DCF left the child in the care and/or custody of a parent or caregiver or removed the children from the care and/or custody of a parent or caregiver. In both FY21 and FY22 the OCA's concerns included both disagreement with decisions to remove and decisions not to remove.

Clinical Formulation:[56] DCF did not holistically assess the family based on all information available to them to create a realistic plan of required changes to promote a child's safety, permanency, and wellbeing within their family. Clinical formulation requires a thorough review of DCF's history with the family.

Collateral Contact: A determination that the risk posed to the child was not fully assessed because the response worker did not contact professionals and/or natural supports or did not ask questions that elicited information necessary to inform the clinical practice. Cases are not identified for this concern if the barrier to obtaining information is the result of parent/caregiver refusal to provide releases of information.

DCF Specialist Consultation: A determination that a DCF specialist consultation was not completed during the response although there were identified complex or high-risk factors that warranted one.

Inconsistent Home Visits: A determination that family participants in an open DCF case have not been visited by the DCF social worker monthly and there is a lack of documentation regarding attempts to visit the family if such attempts were made.

Inconsistent Placement Visits: There is no documentation in the record that a child in DCF custody is being visited monthly in their placement, such as foster care or congregate care.

Interagency Collaboration: A child has additional agency involvement (DDS, DMH, DYS) and there is no documentation in the record that DCF is collaborating on an ongoing basis with the agency.

Interviewing/Engaging Children: A determination that the social worker is not performing full, protective, developmentally appropriate interviews with the child as part of their ongoing case management responsibilities.

Lack of Father Engagement: A determination that one or more of the following occurred: the father was not assessed as part of a family assessment and action plan; not contacted as part of ongoing case management; or not visited or contacted monthly and a reasonable explanation is not documented in the case record to support why these actions did not occur.

[56] **Clinical formulation** is defined as a holistic way of putting everything learned about a family together, incorporating the goals of both the family and DCF, to create a realistic plan that sets forth the hopes and vision for what needs to change to promote a child's safety, permanency, and well-being within their family. The formulation is dynamic, and changes based on new information that is divulged or gathered.

Other Concern: The OCA identifies errors in the electronic record and/or poor-quality case activity notes including electronic records that should have been, but were not uploaded (i.e. education records, medical records).

Permanency Planning: At least one of the following areas applies: there was not a permanency planning conference for a child in DCF custody in conjunction with DCF's Permanency Planning Policy and/or when it was clinically appropriate; a child in DCF custody was not progressing toward their permanency goal; the current permanency goal for the child was not appropriate.

Premature Case Closing: A determination that a DCF case was closed without one or more of the following occurring: the protective concerns that led to the family's involvement being addressed; the case closed with protective concerns due to lack of family cooperation; collateral contacts were not performed prior to case closure; the case closed post critical incident without appropriate services/supports in place.

Safety Planning: A concern that DCF approved an individual(s) responsible for ensuring a child's safety and that individual was not an appropriate caregiver and/or was not aware of the safety plan and DCF's concern for the child.

The OCA monitors the effect of the OCA's case practice concern identification as part of the OCA's ongoing oversight of DCF and internal quality assurance practices. The OCA does not cease communication with DCF regarding the OCA's concerns until our concerns are fully addressed. In most cases, DCF addresses the OCA concerns by bringing those concerns directly to appropriate DCF staff at all levels (caseworker, supervisor, area management etc.). Often DCF reports that the identified concerns were previously also identified by DCF's own internal quality assurance mechanisms and though they were addressed, the information was not documented in the family's DCF electronic record. In some instances, DCF Regional and/or Area Office management use the OCA's case practice concerns to retrain staff, convene a higher-level management review to discuss case direction, or elevate the concern to the DCF senior leadership team who then addresses the OCA feedback. When the OCA identifies trends in the case practice concerns the OCA brings those trends to the DCF senior leadership team as part of broader discussions about DCF policy and practice. Additionally, when OCA staff determine through our review that DCF has done exemplary work with a family or has gone above and beyond their policy and practice requirements, the OCA provides this feedback to DCF. The OCA recognizes that positive feedback helps to support a culture of productive and fair engagement with families.

OCA-Led Commissions

The OCA chairs a variety of legislatively created Commissions, Boards, Task Forces and Working Groups. The mission and membership of these groups is established by statute; the OCA is charged with executing the mission, convening the membership, and producing any mandated reports to the Legislature.

Juvenile Justice Policy and Data Board

The OCA chairs the Juvenile Justice Policy and Data (JJPAD) Board, which was created as part of *An Act Relative to Criminal Justice Reform* (Chapter 69 of the Acts of 2018). The Board is a permanent entity that is chaired by the Child Advocate and comprised of members representing a broad spectrum of stakeholders involved in the juvenile justice system.

The Legislature charged the JJPAD Board with evaluating juvenile justice system policies and procedures, making recommendations to improve outcomes based on that analysis, and reporting annually to the Governor, the Chief Justice of the Trial Court, and the Legislature. The statute creating the JJPAD Board also placed a special emphasis on improving the quality and availability of juvenile justice system data, including data on racial and ethnic disproportionality, and assessing the quality and accessibility of community-based services, including diversion programming. The JJPAD Board is also tasked with monitoring the implementation and impact of statutory changes to the juvenile justice system and making recommendations to the Legislature for further improvements.

The JJPAD Board has two subcommittees – a Data Subcommittee and a Community-Based Interventions Subcommittee – both of which are chaired by the OCA. The Childhood Trauma Task Force, described in more detail below, also operates under the umbrella of the JJPAD Board.

FY22 Activities and Accomplishments

- **Studying the Impact of Recent Statutory Changes:** The Board released its 2021 annual report in March 2022, which detailed the impact of the 2018 Criminal Justice Reform Act (CJRA) and 2020 Policing Act on the juvenile justice system.

    - Impact of the CJRA: Based on the available data, it is clear the CJRA is having its intended effect of limiting the number of youths coming into contact with the juvenile justice system. Since FY18, there has been a decrease in use of the juvenile justice system ranging from 44% to a 70%, depending on the process point, with most of this decline stemming from fewer youth coming into contact

with the juvenile justice system who are accused of lower-level offenses. The Board's 2019 report includes specific recommendations for additional statutory changes needed to address implementation challenges identified by the JJPAD Board.[57]

- Implementation of the 2020 Policing Act: In December 2020, the Legislature passed *An Act relative to justice, equity and accountability in law enforcement in the Commonwealth* (referred to in this report as the "2020 Policing Act"), which included four provisions specific to the juvenile justice system. At the time of the JJPAD Board's FY21 report, three out of the four provisions were in the process of being implemented. The JJPAD Board provided an update on the implementation of these provisions in its 2022 Annual Report.

- **Studying Racial and Ethnic Disparities:** Throughout the winter and spring of FY22, the Data Subcommittee reviewed an in-depth OCA analysis of the data on racial and ethnic disparities in the juvenile justice system, a project that was launched after the JJPAD Board identified substantial racial and ethnic disparities in each of its Annual Reports to the Legislature. The Subcommittee identified the largest disparities at the "front door" of the state's juvenile justice system (i.e., at the applications for delinquency complaint stage). The Subcommittee decided to focus the data brief on disparities in *how* youth first came to the juvenile court—whether that was through a custodial arrest (i.e., a physical arrest), or through a court issued summons, which is the preferred method of bringing a youth to court.[58]

  The OCA's analysis revealed that:

  - Compared to white youth in Massachusetts, Black youth were over three times more likely to be the subject of an application for complaint, which is the beginning of the Juvenile Court process, and Latino youth were almost twice as likely.

  - Black youth in Massachusetts were over four times more likely to experience a custodial arrest than white youth in Massachusetts. Latino youth were almost three times more likely to experience a custodial arrest than their white counterparts.

  The JJPAD Board took a deeper dive into the issue by examining common hypotheses, including those pointing to both individual (e.g., seriousness of the alleged offense) and systemic (e.g., police department policies/practices) factors, that are often posed as

[57] Massachusetts Juvenile Justice Policy and Data Board. (2019). Early Impacts of "An Act Relative to Criminal Justice Reform". https://www.mass.gov/doc/early-impacts-of-an-act-relative-to-criminal-justice-reform-november-2019/download

[58] M.G.L. c. 119C § 54

explanations for these disparities. The JJPAD Board's analysis indicates there is no single reason for racial and ethnic disparities in the juvenile justice system in Massachusetts, but rather, disparities result from a combination of factors stemming from both differences in individual behaviors influenced by societal factors *and* differences in how police departments and/or individual officers respond to Black and Latino youth compared to white youth.

The report (issued in FY23) makes seven recommendations for both the state and individual police departments.[59]

- **Reviewing Annual Juvenile Justice Data Trends:** In March 2022, the Board released its third annual report that detailed FY21 data, including trends over time since the passage of the CJRA and the impact of COVID-19 as seen in the data.[60] Some of the key findings of this report include the fact that Massachusetts continues to use the juvenile justice system less, and while some of the decrease in use seen in FY21 was due to COVID-19, a portion of the decrease can also be attributed to the ongoing impact of the CJRA. Still, there is room for improvement, including opportunities to divert more youth away from the juvenile justice system (which research shows can negatively impact a youth's life), especially Black and Latino youth who continue to be overrepresented in our state's juvenile justice system. The report also details the Board's 2021 activities.

- **Analyzing the Impact of the Pandemic on the Juvenile Justice System:** In the fall of 2021, the JJPAD Board released a report with recommendations for supporting youth and preventing further delinquency. [61] These recommendations were the result of an analysis of how the COVID-19 pandemic has affected youth's current—as well as possible future—involvement with the Massachusetts juvenile justice system. The report's analysis draws from research on risk factors of juvenile justice involvement, delinquency prevention, and positive youth development. The report outlines numerous concrete actions state government actors – from legislators who allocate funding to individual practitioners who work with youth on a day-to-day basis – can take to mitigate the impact the pandemic has had on youth and support their positive development.

[59] Massachusetts Juvenile Justice Policy and Data Board. (2022). Racial and Ethnic Disparities at the Front Door of Massachusetts' Juvenile Justice System: Understanding the Factors Leading to Overrepresentation of Black and Latino Youth Entering the System. https://www.mass.gov/doc/racial-ethnic-disparities-at-the-front-door-of-massachusetts-juvenile-justice-system-understanding-the-factors-leading-to-overrepresentation-of-black-and-latino-youth-entering-the-system/download
[60] Massachusetts Juvenile Justice Policy and Data Board. (2022). Massachusetts Juvenile Justice System: 2021 Annual Report. https://www.mass.gov/doc/jjpad-2021-annual-report/download
[61] Massachusetts Juvenile Justice Policy and Data Board (2021). COVID-19 and the Massachusetts Juvenile Justice System Recommendations for Supporting Youth and Preventing Future Delinquency. https://www.mass.gov/doc/covid-19-and-the-massachusetts-juvenile-justice-system-jjpad-report-october-2021/download

- **Updated Report on Juvenile Justice Data Availability:** In March 2022, the JJPAD Board, through the work of the Data Subcommittee, issued a report to the Legislature on the state of Massachusetts' juvenile justice system data. [62] This was the second iteration of this report, as the Legislature charged the JJPAD Board with reporting initial findings in 2019. About three years later, the 2022 report documents the significant progress made in the amount of data publicly reported and documents the challenges that remain.

  The report makes four recommendations to continue to improve the amount and quality of data publicly reported regarding the juvenile justice system, including steps the Legislature can take to improve data availability in the short term.

- **Juvenile Justice Data Website:** As recommended in the JJPAD Board's June 2019 report on juvenile justice system data, and as envisioned by the Legislature in the CJRA, the OCA, in partnership with the Executive Office of Technology Services and Security and with the Data Subcommittee as advisors, launched a juvenile justice system data website. This interactive website, which makes aggregate juvenile justice system data publicly accessible, went live in November 2020. In FY22, the website was viewed 8,318 times, with 6,226 unique views.

The JJPAD Board was also charged by the Legislature with studying the quality and accessibility of community-based services, including diversion programming, with the goal of connecting youth with needed services and reducing the number of youths entering and moving through the juvenile justice system. In FY22, that work included monitoring the launch of the Massachusetts Youth Diversion Program (more details on this below), as well as studying the state's Child Requiring Assistance system:

- **CRA System Study:** In FY21, the CBI Subcommittee of the JJPAD Board launched a new study of Massachusetts' Child Requiring Assistance (CRA) System. Since the Board's inception, juvenile justice system stakeholders have expressed concern that the youth in the CRA system were not having their needs met, and as a result were more likely to end up in either the state's child welfare system, juvenile delinquency system, or both. Based on information gathered from over 100 people interviewed by the OCA, dozens of Subcommittee discussions and presentations, a case file review, four focus groups with caregivers, a review of Massachusetts' and other states' policies, and an analysis of available data, the Subcommittee crafted Findings in FY22 and spent the beginning of FY23

[62] Massachusetts Juvenile Justice Policy and Data Board. (2022). Improving Access to Massachusetts Juvenile Justice System Data: An Update of the 2019 Report. https://www.mass.gov/doc/improving-access-to-massachusetts-juvenile-justice-system-data-2022-update/download

crafting recommendations for improvement to the state's system. The report, which was released in December 2023, is available on the JJPAD Board's website.[63]

Childhood Trauma Task Force

The OCA chairs the Childhood Trauma Task Force (CTTF), which was created by *An Act Relative to Criminal Justice Reform* (Chapter 69 of the Acts of 2018). The CTTF is charged with determining how the Commonwealth can better identify and provide services to youth who have experienced trauma, with the goal of preventing future juvenile justice system involvement.

The membership of the CTTF is statutorily derived from the membership of the JJPAD Board, and so in practice the CTTF operates as a JJPAD subcommittee.

Childhood trauma is widespread and has important short- and long-term impacts on the lives of children. Not only does trauma negatively affect children's behavioral and physical health, it can also impact children's functioning at home, in school, and in their communities. Recognizing the complexity and scale of the group's assignment, the Legislature created the CTTF as a permanent entity. Learn more about the CTTF here: https://www.mass.gov/lists/childhood-trauma-task-force-cttf

FY22 Activities and Accomplishments

- In December 2021, the CTTF issued *Identifying Childhood Trauma: An Interim Report on Trauma Screening and Referral Practices*. The report provided general background on trauma screening and screening processes and detailed important topics to consider when implementing screening procedures. Additionally, the report described the ways in which child-serving organizations across the United States use trauma screening instruments to identify children who might have experienced a traumatic experience and highlighted many successful screening initiatives. At the same time, the report also presented cautions and arguments against this method of trauma identification in some contexts.

- In Spring of 2022, the Task Force began developing recommendations on different approaches child-serving organizations can take to trauma identification, which include screening as well as other methods. Building upon its findings from the above-

[63] Massachusetts Juvenile Justice Policy and Data Board. (2022). Improving Massachusetts' Child Requiring Assistance System: An Assessment of the Current System and Recommendations for Improvement 10 Years Post "CHINS" Reform. https://www.mass.gov/doc/improving-massachusetts-child-requiring-assistance-system-an-assessment-of-the-current-system-and-recommendations-for-improvement-10-years-post-chins-reform/download

mentioned *Interim Report*, the CTTF began developing general recommendations on trauma identification practices as well as recommendations for specific child-serving sectors, namely education, pediatric primary care, early childhood settings, child welfare and juvenile justice systems, and first responder settings. The CTTF issued its annual report on the topic in December 2022, which is available on our website.[64]

Child Welfare Data Work Group

The OCA has co-chaired the Child Welfare Data Work Group in partnership with DCF since it was established by the Legislation in Section 128 of Chapter 47 of the Acts of 2017. This group became known as the "Data Work Group" (DWG).

The DWG was tasked with reviewing the current list of DCF's legislatively mandated reports, and making recommendations on ways in which duplicative or unnecessary reports could be eliminated or streamlined, and what new reporting was needed to, as described in statute, "*inform the legislature and the public about the status and demographics of the caseload of the department of children and families, the department's progress in achieving child welfare goals, including safety, permanency and well-being, the status of proceedings in the juvenile court department that involve children in the department's caseload and the status of children who are or have been involved in both the child welfare and juvenile justice systems."*

The membership of the DWG was set by statute, and included representatives from the Executive, Legislative and Judicial Branches as well as advocacy organizations and an individual with expertise in child welfare data.

The DWG group sunset in 2022, in alignment with statute. The group's final Legislative report[65] described the groups' accomplishments over the four-and-a-half-year period it was in existence, including:

- A review of federal child welfare reporting
- A review of current state reporting requirements
- The redesign of DCF's Quarterly Profile, Fair Hearing, and Foster Care Review reports
- The creation of DCF's Annual Report
- A review of data provided by DCF regarding the impact of the COVID-19 pandemic on its work

[64] Massachusetts Childhood Trauma Task Force. (2022). Identifying Childhood Trauma: Recommendations Trauma Identification Practices in Child-Serving Organizations. https://www.mass.gov/doc/childhood-trauma-task-force-cttf-2022-report-identifying-childhood-trauma-recommendations-on-trauma-identification-practices-in-child-serving-organizations/download

[65] Massachusetts Child Welfare Data Work Group. (2022). Final Report. https://www.mass.gov/doc/data-work-group-2022-legislative-report/download

- a review of data provided by DCF on racial and ethnic disparities, sexual orientation, and gender identity (SOGI), and outcome measures.

The DWG made the following recommendations for future work in this area:

1. The Legislature should repeal certain reporting requirements, and revise others, currently contained in Massachusetts General Laws (M.G.L.s) and General Appropriations Act (GAA) to reflect the newly designed report created by the DWG.
2. DCF should continue to produce the annual and quarterly reports as outlined throughout the final report.
3. DCF and the OCA should continue their work to further improve data collection and reporting on newly designed reports and special topics, including 18+ Youth Services, Racial Disproportionality, SOGI, and Education.
4. DCF should continue work to implement a data visualization tool for internal and public reporting.

The DWG's meeting materials can be found at: Data Work Group Meetings

Reviews of State Service Systems

In addition to the functions the OCA is explicitly required by statute to perform, as described above, the OCA's enabling statute more generally authorizes us to: "periodically review, report and make recommendations, as appropriate, with respect to system-wide improvements that may increase the effectiveness of the care and services provided to children and their families and suggested legislative and regulatory changes."[66]

In addition to the work described above in the sections on Core Functions and OCA-Led Commissions, the OCA also conducts independent research projects. OCA staff and consultants employ a variety of research methods, which can include observation of state service systems, qualitative interviews with stakeholders, focus groups, data analysis, case file reviews, statutory review, examinations into models employed in other jurisdiction, and review of academic and grey literature. The OCA regularly uses the results of our research and investigations to make recommendations to our partners in the Executive and Legislative branches.

This section details major research projects in FY22.

[66] M.G.L. c. 18C § 5

Investigations

The OCA may choose to initiate a formal investigation while completing our statutory "core work" if the OCA determines the actions or inactions of a reporting agency were egregious and significantly contributed to the harm of a child. Although an investigation is typically spurred by a critical incident report, the OCA has discretion to investigate any matter that aligns with our statutory oversight obligations. Formal investigations may be made public or may be kept confidential.

The purpose of a formal investigation, in accordance with M.G.L. c. 18C § 5 , is to determine: "(1) the factual circumstances surrounding the critical incident; (2) whether an agency's activities or services provided to a child and his family were adequate and appropriate and in accordance with agency polices and state and federal law; and (3) whether agency policies, regulations, training or delivery of services or state law can be improved." The scope of an OCA investigation is different from a criminal investigation as a criminal investigation will address any individual responsibility related to the harm of a child.

Every OCA investigation is designed and executed in an independent manner relying solely on the discretion of the Child Advocate for the scope and approach necessary. No other state agency or state entity's counsel is sought when determining whether a formal investigation will be initiated, how an investigation will be conducted, and whether the OCA will make public the results of that formal investigation. OCA investigations include a review of relevant facts, records, and policy. Most investigations involve months of study, research, and direct contact with relevant agencies and stakeholders including interviews with personnel. All formal investigations result in recommendations for improvement to state services to children and families.

During FY21 and FY22, the OCA conducted two publicly released investigations, one on the death of David Almond and one on the case of Harmony Montgomery. In FY22, the OCA released a follow-up report on the status of the implementation of the Almond report recommendations.

David Almond Investigative and Status Update Report

On March 31, 2021 the OCA publicly released our formal investigation into the death of 14-year-old David Almond via starvation and neglect and the serious bodily injury and emotional injury to 14-year-old Michael Almond as well as information regarding the other children in the Almond-Coleman family. Additional information about that report can be found in the OCA's FY21 Annual Report.

The investigative report determined that these children suffered extraordinary harm at the hands of their caregivers and that the gaps in our state system of care played a key role in making that harm possible and allowing that harm to continue. Many of the gaps were created by the lack of understanding of how a child's disability may affect that child, how evaluation of risks and warning signs of abuse and neglect should take a child's disabilities into account, and how caregiver capacity should be evaluated considering the individualized strengths and needs of children. These systemic gaps were compounded by the unprecedented strain the COVID-19 pandemic had on the Commonwealth's children and families and on the public and private entities that provide support to them.

The OCA made 26 recommendations for policy, procedure, and practice improvements within and across DCF, DESE, the Fall River Public Schools, the Massachusetts Juvenile Court, and the Massachusetts Probation Service (MPS). After the publication of the formal investigation, the OCA turned its attention to overseeing the implementation of these recommendations. Governor Baker committed to expeditiously implement all the OCA's recommendations for the executive branch state agencies involved and his administration fulfilled that commitment. The OCA consulted on draft policy and practice changes for DCF and DESE and maintained open and collaborative conversations with the Juvenile Court and Probation Service as they pursued policy and practice changes.

On March 22, 2022 the OCA released a status report, Investigation Status Report Regarding the Multi-System Investigation into the Death of David Almond, detailing the timely and concerted actions the state entities took to implement the OCA's recommendations, including:

- **Department of Children and Families** developed new and revised policies including but not limited to: a revised Supervision Policy, a revised Protective Case Practice Policy, a revised Family Assessment and Action Planning Policy, a revised Education Policy, a new interim Reunification Policy, a new Disability Policy, and the hire of the agency's first Director of Disability Services.

- **Department of Elementary and Secondary Education** developed new and updated guidance including but not limited to: an updated Promoting Student Engagement, Learning, Wellbeing and Safety Guidance, new Guidance for Attendance Policies and additional resources, updated Joint DESE/DCF Advisory Regarding Mandated Reporting Responsibilities of School Personnel in Cases of Suspected Child Abuse and Neglect, a guidance document regarding DCF's Access to Students' Education Records, and significant work in improving the dissemination of information and guidance to educators.

- The School Committee of **Fall River Public Schools** established the "Almond Commission" which engaged in a process of examination and reflection resulting in a set of their own recommendations focused on strengthening the implementation of existing policies and procedures across the district. Fall River Public Schools also adopted a new student information system providing greater real-time communication to families and alerting the schools of negative attendance trends, has provided clearer guidance, and provided training on mandated reporting, and strengthened community partnerships – particularly between the Student Services department and DCF.

- **The Juvenile Court** addressed many of the recommendations through their Pathways Initiative which began in 2019 and which provides for a differentiated case flow management to improve legal permanency for children, as well as through a series of bench cards that facilitate judicial inquiry into issues such as promotion of permanency, educational stability, and assessing danger, risk, and safety. The Juvenile Court also issued a Standing Order addressing the return of custody in Care and Protection proceedings which significantly and substantially addressed the OCA's recommendations.

- **The Massachusetts Probation Service** worked with DCF to develop a detailed MOU regarding information sharing. The Juvenile Court Standing Order addressing the return of custody in Care and Protection proceedings specifically addresses situations in which MPS must advance a case, and MPS worked with the Juvenile Court to finalize a case advancement form.

The OCA also continues to monitor the state services provided to David's brothers, Michael, Noah, and Aiden.[67] The OCA has ensured the three remaining children have been provided safe and stable living environments to support the process of grieving the loss of David and healing from the abuse and neglect they endured.

The publication of the OCA's formal investigation into the death of David Almond and the lives of his siblings resulted in widespread change in Massachusetts which improved the services the state provides.

Harmony Montgomery Investigative Report

On May 4, 2022 the OCA publicly released a formal investigation into the case of Harmony Montgomery who would have been seven-years-old at the time of the release. At the time the OCA completed its formal investigation, Harmony Montgomery was widely considered to be a

[67] The names "Noah" and "Aiden" are pseudonyms.

missing child. Harmony was determined by law enforcement to be a deceased child after the OCA released our report.[68]

Harmony Montgomery was born in Massachusetts to Crystal Sorey and Adam Montgomery in 2014, an unmarried couple who were not together at the time of her birth. Harmony was solely in Ms. Sorey's care after her birth as Mr. Montgomery was incarcerated. At two months old, Harmony was removed from the care and custody of Ms. Sorey and placed in foster care by DCF. Harmony remained in the custody of DCF until February 2019, when Mr. Montgomery, who had very limited contact with Harmony throughout her life, was awarded custody of Harmony pursuant to a Care and Protection case in Juvenile Court. Mr. Montgomery obtained custody over DCF's objection but with the consent of Harmony's attorney. Mr. Montgomery was living in New Hampshire when he was awarded custody of Harmony.

On December 31, 2021, the Manchester, New Hampshire police publicly announced Harmony's disappearance and their search for her. Mr. Montgomery has since been criminally charged with second-degree murder in connection with the death of Harmony; these developments were not part of the OCA's report as they occurred after the release of the OCA's report.

The key and central finding in the OCA's investigation and report were that Harmony's individual needs, wellbeing, and safety were not prioritized or considered on an equal footing with the assertion of her parents' rights to care for her in any aspect of the decision making by any Massachusetts state entity. This includes the work that DCF did with the family. Harmony was also not prioritized in the legal case regarding her own care and protection. The Judge and the attorneys in the case did not put Harmony's needs, safety, or wellbeing at the center of the discussion of custody nor was there a discussion on how Harmony could safely transition to Mr. Montgomery's care. The court awarded cross-border custody without compliance with the requirements of the Interstate Compact on the Placement of Children.

When children are not at the center of every aspect of the child protective system, when their unique individuality is not used to inform an understanding of parental capacity to care for them, then the system cannot truly protect them. The OCA's Harmony Montgomery report describes the ripple effect of miscalculations of risk and an unequal weight placed on parents' rights versus a child's wellbeing.

The OCA's report details 11 recommendations for changes to the Massachusetts state system of services provided to children and families beyond the recommendations made in the investigative report on the death of David Almond. As many of the recommendations in the report regarding Harmony Montgomery involve the state's judicial system and the Committee

[68] The determination that Harmony was deceased or what criminal activity occurred in New Hampshire was in no way influenced by the OCA's report.

for Public Counsel Services, there has not been the same across-the-board commitment to expeditiously implementing the recommendations in the report as there was for the recommendations made in the report on the death of David Almond. In particular, the OCA is concerned that the welfare and best interest of the child is not adequately presented in care and protection cases and that without some rebalancing of interests' children will be put in unsafe situations.

Family Support and Stabilization Services Redesign

In FY22, DCF announced it would be launching a redesigned Family Support & Stabilization program through a re-procurement process.[69]

Family Support & Stabilization Services (S&S) are family-centered, home-based services designed to assist families by improving parenting and family functioning while keeping children safe. DCF contracts with community-based service providers to offer these services, with the goal of preventing out-of-home placement and supporting family reunification when out-of-home placement has already occurred.

To supplement DCF's ongoing efforts to gain input on the program design and help ensure that the program design meets the needs of families, in early 2022, the OCA hosted a series of focus groups with individuals who have lived and/or professional experience with the child welfare system more generally, and family support & stabilization services more specifically. The goal of the focus groups was to better understand the experience of families receiving these services, including what is working for them, what isn't, and what they would like to see change in the future. Over 80 individuals participated in 10 different focus groups, which were conducted in numerous languages and with individuals from across the state.

Key themes from the focus groups included:

- Focus group participants feel that DCF typically determines needs and puts services into place without consulting families and providers, and without considering family schedules and needs, including linguistic capacity.
- In general, family plans are not individualized, can be overly complicated, and often do not address root causes, such as mental health and substance use.
- Fathers do not receive the same level of attention and support as mothers.
- Not all families who are eligible for S&S services receive them; more can be done to increase equitable access to these services.

[69] Procurement is the process by which the Commonwealth contracts with vendors to provide goods or services.

- The duration of the program services is too short, particularly given long waitlists for some services, and cases often close without a warm handoff to continuing services if needed.
- S&S services should be put in place earlier more often, with the goal of preventing home removal.

Services and supports families would like to see more of include:

- Increased access to family partners and peer support
- Providers that speak their language and understand their family's culture, particularly for immigrant families
- Support for basic needs (help with housing, food, transportation, and childcare)
- Trauma-informed services
- Services for youth
- Services targeted toward fathers
- Increased access to mental health and substance use services

The OCA is deeply grateful to the parent/caregivers, family partners, and other professionals who participated in focus groups as well as to the community service providers and advocacy organizations who helped us connect with focus group participants and provided a variety of other logistical support. We are using the information gained from the focus groups to inform our ongoing work with DCF regarding the redesign of the Family Support & Stabilization program in particular, and on system reforms to support child wellbeing and family preservation more generally.

Foster Care Review Improvement

In December 2018, at the request of the Joint Committee on Children, Families and Persons with Disabilities, DCF and the OCA agreed to collaborate to improve the Foster Care Review (FCR) program. Three main areas of concern were identified: adequate and timely notice for all required attendees; ensuring that all foster care reviews have the three-member panel of reviewers with a special need for volunteer reviewers and second party (i.e., DCF Area Office) reviewers; and improvements to the substance and quality of the review. The OCA continues to meet with DCF monthly to monitor the progress on improvements to address these concerns.

When the OCA became involved, DCF already planned for needed changes which included:

- Application updates to their case management system, i-FamilyNet. The i-FamilyNet application changes were designed to improve the capacity for more extensive information gathering and reporting, as well as to address the problem of meeting notices. The new i-FamilyNet application piloted in January 2019 and the full implementation of the first round of changes was completed by the end of FY19.
- Improvements to notice and scheduling processes.
- Policy requirements that FCR panel members comply with a new series of questions that are required to be answered in accordance with federal law.

While the policy and i-FamilyNet application changes were underway, the FCR unit focused on recruiting and training additional volunteer panel members. The number of FCRs with a volunteer reviewer increased from 47.5% in the quarter ending Mar-2017 to 94.7% in the quarter ending Mar-2022. Due to the pandemic, FCRs are now conducted virtually, which has led to an increased level of participation across all required participant cohorts.

The OCA also conducted surveys of participants and sat in on a sampling of FCRs once the changes were implemented to confirm the desired outcomes of improved reviews was achieved. Between March and April of 2022, OCA staff attended a random sampling of 51 FCRs selected to include all DCF Area Offices and FCR Unit case reviewers who convene and facilitate the review meetings. The OCA concluded that the foster care reviews were thorough, and the facilitator case reviewer was well-prepared and took steps to ensure that all participants, including the volunteer reviewer, were included in the discussion.

The OCA believes that the issues that were raised originally in discussions between the Joint Committee, DCF, and the OCA that led to the OCA's active monitoring have been satisfactorily addressed.
Due to new data and information that can be produced by DCF following the changes to i-FamilyNet, DCF (in collaboration with the OCA and the Data Work Group) was able to issue a re-designed and significantly more informative Foster Care Review report. The new public facing reports provide a tool to monitor the FCR process.

The OCA has agreed to maintain an increased level of monitoring in FY23 to address the continued concerns about the effectiveness of the FCR process. The OCA also continues to encourage that individual concerns be brought to our attention through the OCA Complaint Line.

What is a Foster Care Review?

DCF is mandated by federal and state law to have an independent Foster Care Review Unit that operates outside of DCF's daily delivery of casework services and provides quality oversight of case decisions.

The purpose of a Foster Care Review meeting is to determine the progress a family is making to resolve the reasons for DCF involvement and to make recommendations for a child to safely achieve permanency.

Foster Care Reviews are chaired by a three-person panel whose members are not responsible for case management, oversight or service delivery of the case being reviewed. They are held every six months for the duration a child is in out-of-home placement and compliments the oversight role of the juvenile court.
DCF Foster Care Review Policy, 2019

Youth Suicide

Youth suicide is a highly preventable and serious public health concern. Suicide is a leading cause of death among youth and young adults ages 10-24 both nationally and in the Commonwealth. Nationally, suicide is prevalent in a young person's developing years as it is the third leading cause of death for youth 10–14 years of age and the second leading cause of death among people 15–24.[70] Childhood, adolescence, and young adulthood are important social, emotional and brain development periods; as such, suicide prevention efforts for youth vary from those aimed at adults. Youth anxiety and depression are sharply on the rise and experts fear there will be an increase in suicide, especially among vulnerable populations of youth.[71]

The OCA's focus on preventable childhood injury and death coupled with a review of over ten years' worth of OCA critical incident report trend data has led to the agency's priority for addressing youth suicide. In September 2020, the OCA released the Youth Suicides in Massachusetts: A Cohort Perspective in National Context report, which is supported by the OCA's mission to ensure all children receive appropriate, timely, and quality services. This report highlights vulnerable groups of children and young adults who are at particularly high risk of dying by suicide.

To better understand youth suicide prevention efforts throughout Massachusetts, the OCA launched the Massachusetts Youth Suicide Prevention Initiatives Survey in May 2021. The survey was widely distributed via email to Massachusetts child-serving state entities and organizations that serve youth. This survey reached individuals across the state who work in varying capacities among a range of organization types. At the close of the survey in June 2021, the OCA received a sample size of 303 responses that yielded the following findings:[72]

- Almost half (49%) of the respondents' organizations participate in youth suicide prevention.
- Most youth suicide prevention efforts do not focus on specific cohorts of vulnerable youth.
- Most youth suicide prevention efforts focus on general youth suicide education for families, targeted suicide education for youth, and employee training about youth suicide.

[70] Centers for Disease Control and Prevention. (2021, August 31). Disparities in Suicide. https://www.cdc.gov/suicide/facts/disparities-in-suicide.html

[71] Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

[72] While responses were collected from a variety of respondents, the OCA acknowledges that this survey is not a complete representation of all state agencies and youth serving organizations who participate in youth suicide prevention initiatives in the Commonwealth.

- Educational and training opportunities are available but could be more robust across the state.
- Insufficient staffing, limited funding and limited time are the primary barriers to youth suicide prevention initiatives.

The survey findings examine Massachusetts child-serving state agencies and organizations in prevention initiatives, training processes to ensure staff are prepared to serve youth with suicidal thoughts or behaviors, cohort-specific initiatives, and challenges faced by organizations and agencies in developing prevention initiatives. The OCA envisions that the survey findings will be the first of many steps towards resolving a largely preventable public health issue—one that has unfortunately been exacerbated by the pandemic and its impact on children and families' mental health, economic security, and sense of safety.

The DPH Bureau of Community and Health Prevention oversees a wide range of prevention programs that advocate for the health and safety of all residents in Massachusetts. The Suicide Prevention Program website has information about suicide, suicide prevention data, suicide prevention resources, trainings including their annual 2-day Suicide Prevention Conference and information aimed at special populations at risk of suicide. This includes communities of color, Youth, LGBTQ individuals, and service members, veterans, and families.

Partnerships with State Agencies to Improve Service Quality

The OCA works, in partnership with state agencies, to ensure children and youth – particularly those served by the child welfare or juvenile justice systems – are provided with the highest quality of services and supports.[73] State agencies regularly seek our review and feedback on draft regulations, policy or guidance, as well as major service procurement requests for responses (RFRs). We have also, at the invitation of the Executive Branch, from time to time participated in agency or cross-agency working groups on topics where our expertise can be of value.

We also incubate innovative new programs and services designed to improve the quality of state services. These new programs and services are designed with other state entities and are often operated in partnership with those state entities. When choosing incubation projects, we prioritize projects that cut across state agencies or branches of government, and that require multiple voices at the table to design, launch, monitor, evaluate, and continuously improve. Many of these projects have come at the direct request (through funding appropriation) from the Legislature.

We focus on projects that are innovative - grounded in research and designed to test new approaches to long-standing challenges – and ones where the OCA's unique position in state government as a convener of multiple voices, research hub, and independent advocate for the needs of the Commonwealth's children can help contribute to the overall success of the initiative.

Major projects in this category of work include:

Center on Child Wellbeing and Trauma

The Center on Child Wellbeing and Trauma (CCWT) was established in October 2021 as a partnership between the Office of the Child Advocate and UMass Chan Medical School. The creation of the CCWT was a recommendation made by the Childhood Trauma Task Force in 2020. With funding included in the annual state budget, the CCWT supports child-serving organizations and systems in becoming trauma-informed and responsive through training, technical assistance, professional learning opportunities, and other practice advancement support.

[73] M.G.L. c. 18C § 2

FY22 Activities and Accomplishments

- In its first nine months, the CCWT onboarded a team of six staff and held over 100 stakeholder meetings to understand the specific needs of child-serving organizations in the Commonwealth. Additionally, the Center hosted extensive informational sessions to explain how it planned on helping professionals working with children and families become more trauma-informed and responsive.

- Equipped with an understanding of what is needed on the ground, the Center created a website and developed resources on childhood trauma and resilience, trauma-informed and responsive practices, as well as organizational toolkits based on local initiatives focused on racial equity and resilience. These resources include articles and reference documents, video trainings on both adverse and positive childhood experiences, and a full framework on trauma and resilience.

- The Center established partnerships with the Department of Children and Families, the Department of Transitional Assistance, the Department of Early Education and Care, and the Department of Housing and Community Development in its first year of operations. This led to the Center:
    - Providing assessment and coaching to organizations wanting to strengthen their trauma-informed and responsive policies and practices, including Family Resource Centers (FRCs) and DCF funded-congregate care facilities.
    - Developing and implementing professional learning communities on trauma, resilience, and trauma-responsive care with providers working in transitional assistance and services for families who are homeless.

- These partnerships also led to the development of a variety of projects, planned to launch in FY23, with state agencies designed to support agency staff and/or contracted providers in implementation of trauma-responsive practices.

- In partnership with Thriving Minds, the Center also supported assessment and coaching work with 12 schools/districts across the Commonwealth seeking to implement more trauma-responsive practices in their schools. Through this partnership, the Center also trained 200+ school professionals across the state.

- Finally, the CCWT funded a pilot program focused on building community resilience and addressing racial trauma and equity in Worcester through a training (and train the trainer) process involving over 60 service providers.

Child Fatality Review Program

The OCA is an active participant in the Massachusetts Child Fatality Review (CFR) program. The CFR program was established in 2000 following the passage of M.G.L. c. 38, § 2A and fulfills a federal requirement for Title IVE funding SEC. 470. [42 U.S.C. 670] . The purpose of child fatality review is to decrease the incidence of preventable child fatalities and near fatalities. The law requires Massachusetts to have two types of CFR teams: local child fatality review teams (CFRTs) and a state child fatality review team (SCFRT).

Eleven local child fatality review teams meet under the leadership of their respective District Attorneys' offices to conduct multidisciplinary reviews of individual child deaths. The local teams formulate recommendations for the state team to consider, including changes to statewide policy, practice, and/or regulations. The OCA is a member of the state team and OCA staff attend the state and many local CFRT meetings.

Beginning in FY19, the OCA has annually recommended and secured funding from the Legislature to support a Child Fatality Review Program Coordinator and Epidemiologist at the Department of Public Health. The Child Fatality Review Program Coordinator supports the ongoing work of the CFR program, including the implementation of recommendations outlined in the OCA state and local child fatality review team assessments completed in FY17 and FY18.[74]

In FY21 and FY22, OCA staff attended local CFR and state team meetings. The office also advised DPH in the development of a draft fatality review guidelines for local teams, and the design of a community of practice aimed at streamlining improving review practices across local teams.

Collaboration with the Office of the Inspector General

The Office of the Inspector General (OIG) has been working with DCF for several years to improve the administration of the agency's contract with the Baker Center, formerly the Judge Baker Children's Center, to run DCF's after-hours hotline. In 2020 the OCA was invited to collaborate with the OIG in this effort and the OCA has continued this work through FY21 and FY22. The OCA can leverage our clinical expertise, knowledge of DCF and child protection, and policy and oversight work to assist in this collaboration. This work focuses on improving the substantive and procedural work of the hotline by focusing on hotline staff trainings, staff performance metrics, call metrics, and consistency in decision-making between hotline staff and area office screening decisions. The OCA is grateful for the opportunity to collaborate with the OIG in this manner.

[74] Massachusetts Office of the Child Advocate. (n.d.) OCA Project Reports. https://www.mass.gov/service-details/oca-project-reports

Massachusetts Youth Diversion Program

Based on the recommendations in the Juvenile Justice Policy and Data (JJPAD) Board's 2019 report on diversion, and modeled after the Board's Model Program Guide, the OCA partnered with the Department of Youth Services to launch the Massachusetts Youth Diversion Program (MYDP), beginning with a Diversion Learning Lab, in FY22. The MYDP is a state-level youth diversion initiative that provides high-quality, evidence-based youth programming that can serve as an alternative to arresting youth or prosecuting them through the Juvenile Court.

With funding from the OCA, DYS issued a Request for Responses (RFR) that led to the selection of three community-based providers to pilot the state model in three counties:

- Worcester (with diversion services provided by Family Continuity)
- Middlesex (with diversion services provided by NFI)
- Essex (with diversion services provided by Family Services of the Merrimack Valley)

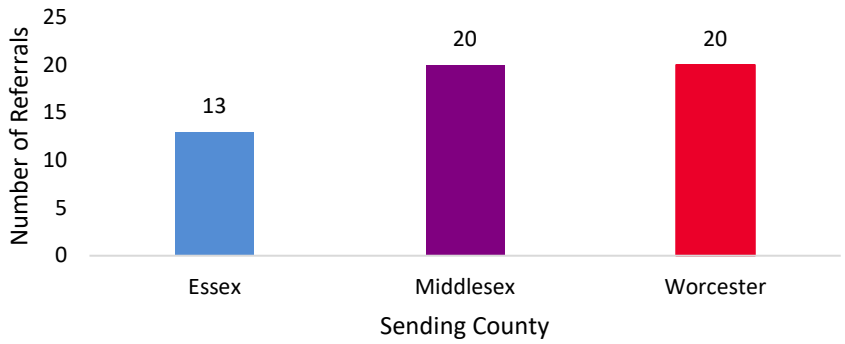
Each provider has a Diversion Coordinator dedicated to accepting referred youth to the program, conducting necessary assessments and intake, developing a diversion agreement, matching services, and providing case management. Additionally, DYS hired a Diversion Manager to act as the central coordinator across all three sites.

To prepare for the program's launch, the diversion coordinators and provider staff were trained on the fundamentals of the model program guide, including:

- How to properly administer the Youth Level of Service (YLS) assessment needed to determine risk level for delinquent behaviors and match youth to any services needed (e.g. therapy, mentor programming, educational supports) and the mental health screening tool used to identify any behavioral health concerns that should be addressed as part of case management
- Data tracking requirements
- Racial and ethnic disparities in the juvenile justice system
- Victim's rights in the diversion process

The program began accepting referrals in January of 2022. As of June 30, 2022, the program had accepted 53 referred youth, with the majority of referrals related to person offenses.[75] Referrals can come from those legally permitted to divert youth away from the traditional juvenile justice system: police, court magistrates, district attorneys, and judges. Between January and June, most of the referrals came from judges and police departments (22 and 18 referrals respectively). The age of youth referred to the program ranged from 12 to 18.

Figure 18:
Referrals by Sending County
(as of 6/30/2022)



The majority of youth who began programming in FY22 identified as Latino (52%), with 30% identifying as white, 11% identifying as Black or African American, and 6% identifying as Asian. 65% identified as male, with the remaining 35% identifying as female. Of the youth screened with the YLS, the majority were reported as being "low or moderate" risk of delinquent behavior, with the two most common identified needs being an increase in structured leisure/recreation time and support in gaining employment.[76]

The OCA works closely with our partners at DYS to monitor implementation. This includes monthly reviews of program data. Additionally, the DYS Diversion Team regularly reports program data to the JJPAD Board's Community-Based Interventions (CBI) Subcommittee, which acts in an advisory role to the program. In FY23, the Diversion Learning Lab will be expanding to two new sites, serving an additional two counties. Ultimately, the OCA hopes this model can expand statewide to ensure youth across the Commonwealth have access to high quality diversion services.

[75] Examples of a person offense includes assault and battery or robbery
[76] Office of the Child Advocate. (2022). *Juvenile Justice Policy and Data Board: CBI Subcommittee [PowerPoint Slides].* https://www.mass.gov/doc/jjpad-cbi-subcommittee-june-16-2022-meeting-presentation/download

Mandated Reporting Survey and Training Pilot for Educators

The OCA has identified the improvement of mandated reporting of child abuse and neglect in the Commonwealth as a priority for the past several years.[77] The OCA chaired the Mandated Reporter Commission from 2020 to 2021. One common theme that arose during the Commission's deliberations and the public comments was that teachers, who represent 85% of the reports filed with DCF, were allegedly identifying circumstances and making 51A reports that did not meet the statutory definitions of abuse and neglect.[78]

In response to these concerns, the OCA launched a project to design an evidence-based online training on mandated reporting of child abuse and neglect specifically for kindergarten through 12th grade educators. This online training is intended to cover aspects of mandated reporting of child abuse and neglect relevant to all mandated reporters in the Commonwealth, but also have information that is specifically designed to address common issues regarding educators' responsibilities and experiences with reporting.

To further the OCA's understanding of this issue, we launched a Mandated Reporter Survey for Educators in November 2021. The survey, which closed in mid-January 2022, was completed by 913 educators including teachers, administrators, school-based social workers, school athletic coaches, school nurses. The survey obtained information about recent mandated reporter trainings that the educator had taken, the educator's confidence level in reporting cases of abuse and neglect, the educator's motivation for reporting cases of abuse and neglect, and the topics that the educator would most want to learn about in a profession specific training. The OCA is using the results of this training to help guide the Commonwealth-specific curriculum design of the mandated reporter training.

In February 2022 the OCA engaged a consultant to assist our efforts to scope the pilot project and write the Request for Response (RFR) for a vendor who could create the online training program technology and work with the OCA to create the curriculum. The OCA posted the RFR to select a vendor in May 2022 and closed the bidding in July 2022. The OCA convened a bid-evaluation team of highly qualified professionals from DESE, DCF, and EEC and selected a vendor in mid-August 2022.

The OCA will work throughout FY23 to adapt available baseline mandated reporter training material to the specific needs of Commonwealth educators based on the expertise we have in this topic. The training will include a focus on implicit and confirmation bias in its curriculum.

[77] Mandated reporting is a legal requirement that certain identified people and/or professionals have an obligation to report child maltreatment (abuse or neglect) to the child protective services system. The Federal Child Abuse Prevention Treatment Act (CAPTA) requires that states have mandatory reporting laws (42 U.S.C. § 5106a(b)(2)(B)(i)).
[78] The mandated reporting statute in Massachusetts is largely contained in MGL c. 119 §§ 21, 51A, and 51B.

We will work with content partners at DESE, DCF, and other relevant partners with expertise to refine the curriculum to be as responsive to the profession-specific questions and concerns as is reasonably possible.

The OCA is confident that the integrity of this pilot design, including the experienced vendor the OCA has chosen via the bidding process, will translate into a deliverable that will meet the needs, and hopefully exceed the expectations, of educators in the Commonwealth by providing them with actionable tools and knowledge to keep students safe and supported.

Residential School Program Project

Residential special education schools play a vital role in the life of children with autism, behavioral, and developmental challenges. The Approved Special Education Residential Schools Programs (ASERPS) serve some of the most vulnerable youth on behalf of the Commonwealth, and without them, these youth would be unable to receive educational services.[79]

The Commonwealth has not historically viewed the ASERPs as one holistic program that provides both education and residential services. Instead, the functions of managing and regulating ASERPs falls cross multiple state agencies under two Secretariats, with the EEC, DESE, DCF and DMH all having various roles to play in the licensing, approval, placement of children, and investigation of any complaints at these programs.[80] This can cause a lack of communication that can lead to confusion for the ASERPS and potentially places the programs and youth at risk. This is particularly true when information about safety concerns at a school are not shared across agencies, preventing the Commonwealth from identifying troubling patterns.

Since 2016 the OCA has been working in partnership with the Executive Branch on a variety of projects designed to improve collaboration and sharing of information across Commonwealth agencies involved with ASERPs, with the goal of improving the safety and well-being of youth receiving services in residential schools.

In FY22, OCA's efforts have included working EEC, DESE, DCF, and DMH to increase communication and collaboration with regards to oversight over ASERPS by:

- **Convening Regular Interagency Meetings**
- **Sharing and Analyzing Incident Reports, which the OCA uses to** review agency responses and cross-agency communication, identify trends (e.g., identifying a need for

[79] There are 34 Approved Special Education Residential School Programs (ASERPs) in Massachusetts. These schools have 150 dedicated residential homes serving approximately 2,300 youth.
[80] See **Appendix A** for a description of the roles and responsibilities of each agency with regards to ASERPs

training or support at a particular program), set the agenda for interagency meetings, and make recommendations for changes in practice or policy as necessary.

- **Leading cross-agency conversation and planning** toward the goal of creating a single incident report form and reporting portal that will meet the needs of all the agencies and simplify the reporting processes for the ASERPS.

Transition Age Youth

For the last several years, the OCA has participated in efforts to examine how the Commonwealth can better support the needs of youth and young adults who are receiving state services and embarking on a path into adulthood. This population of young people is commonly referred to as "Transition Age Youth" or "TAY."

At the beginning of the COVID-19 pandemic in the spring of 2021, the OCA partnered with EOHHS to convene an inter-secretariat work group focused on the urgent needs of transition-aged youth at-risk of experiencing homelessness, disrupted education, unemployment, behavioral health challenges, and more because of the pandemic. This led, in January 2021, to the OCA, EOHHS, and the Unaccompanied Homeless Youth Commission successfully launching the first phase of a Housing Stability and Support Program (HSSP) pilot that serves young people aged 18-21 who opted-out of DCF care after turning 18. These young adults were connected to housing, education, employment, transitional assistance programs, and other on-going supports as needed.

In FY22, this program was expanded to 11 organizations providing services statewide.

Young adults participating in this program are typically referred by DCF outreach unit or DCF social workers but may also be referred by other organizations or self-refer. Once a referral is made, HSSP providers engage the young adults and assess their need for housing and additional supports. Providers then offer judgment-free cases management services and connect young adults to resources as needed. To ensure effective programming, providers track program engagement, services provided, and outcomes of young adults.

An OCA-funded program evaluation conducted by the Commonwealth Medicine Diversion of UMass Medical School in 2022 found that youth who participated in the HSSP saw positive changes in housing, employment, and income:[81]

[81] Office of the Child Advocate. (2022). *Juvenile Justice Policy and Data Board: CBI Subcommittee [PowerPoint Slides].*Evaluation of a Housing Stabilization and Support Program for DCF-Involved Youth and Young Adults: FY22 Update *[PowerPoint Slides].* https://www.mass.gov/doc/a-housing-stabilization-and-support-program-for-young-adults-opting-out-of-dcf-care-interim-evaluation-august-2022-update-on-hssp-pilot/download

- The percentage of youth in secure housing increased from 25% at intake to 69% at discharge
- The percent employed increased from 45% to 56%
- The percent with a source of income increased from 79% to 89%

86% of youth referred to HSPP had at least one engagement with a provider. Many young adults reported finding the process of connecting with HSSP providers to be quick and easy. Additionally, young adults reported finding the program helpful in creating balance, organization, and comfort in their lives.

This program is supported by a $300,000 earmark in the OCA's budget as well as additional funding provided by EOHHS.

Legislative Affairs

As an independent agency, the OCA communicates regularly with the Massachusetts Legislature on many policy issues relevant to our statutory mandate and expertise. The OCA routinely provides testimony for bills that may impact the delivery of state services to children. The OCA also serves as a resource to the Legislature in designing and analyzing proposed legislation or budget items. The OCA takes seriously the task set before us by the Massachusetts Legislature in our statute and view our agency as a unique neutral convener for bringing together stakeholders to address issues and make policy recommendations based on data and research.

As part of our legislative affairs work, the OCA meets frequently with the Chairs of the Joint Committee on Children, Families, and Persons with Disabilities, and communicates regularly with House and Senate leadership on a range of topics under our purview. We use these conversations as opportunities to raise concerns about trends the OCA has identified, share information regarding any public investigations that the OCA may be conducting, and make recommendations about proposed or pending legislation and/or budgetary matters.

While the OCA supports and testifies on a wide variety of legislation and budget priorities that would impact children and families, we also work with members of the legislature to draft and introduce bills, budget items, and amendments every year that are directly related to the work of the OCA and/or are the result of recommendations of the various Commissions we lead. In FY22, these included:

Center on Child Wellbeing and Trauma

In 2020, the Childhood Trauma Task Force recommended the creation of a Center on Child Wellbeing and Trauma (CCWT), supported with state funding, that would ensure all child-serving systems in Massachusetts are trauma-informed and responsive by providing child-serving systems with training, technical assistance, coordination, and practice advancement support. The OCA advocated for funding to support the creation of the Center in FY21 and FY22.

The Massachusetts Legislature generously appropriated $1 million in the FY22 state budget to support the creation and initial operation of the Center, which launched in October 2021. The FY23 budget significantly expanded the Center's appropriation, to $3.5 million.

Details about the implementation of the Center are described above.

Child Fatality Review Program

The OCA is an active participant in the Massachusetts Child Fatality Review (CFR) program and a member of the State Child Fatality Review Team. The CFR program's charge is to decrease the incidence of preventable child fatalities and near fatalities in the Commonwealth. The program is comprised of local child fatality teams and a state child fatality team.

The State CFR Team is currently chaired by the Office of the Chief Medical Examiner (OCME). In FY17-FY18, at the request of the State CFR Team, the OCA conducted a needs assessment of the CFR program, in which we recommended transferring oversight of the CFR program to a joint chairmanship between the Department of Public Health (DPH) and the OCA. The proposal had the support of the Secretaries of EOHHS and EOPSS in the Baker Administration, and the State Child Fatality Team itself. The OCA is currently funding positions at DPH to facilitate the continued work of the CFR program. The OCA is seeking legislation effectuating a transfer of the chairmanship from the Office of the Chief Medical Examiner to a joint chairmanship between the OCA and DPH.

This transfer would adequately reflect the role that DPH currently plays in facilitating the program as well as the funding and the policy-setting specialization provided by the OCA. The proposed legislation would also add the Department of Early Education and Care (EEC) to the state CFR team. Legislation to this effect has advanced through the legislative process several times, and was most recently included in H.88, *An Act relative to accountability for vulnerable children and families*, which passed the Massachusetts House of Representatives in March 2021. The OCA looks forward to continuing to work with the legislation to enact this proposal into law.

Child Marriage Ban

On July 28, 2022, Governor Charlie Baker signed a law that raises the legal age of marriage to 18 with no exceptions.[82] Well-documented harms that come from child marriage, including the lack of legal protections and services available to minors in such situations. The OCA was an active participant in the movement to end the practice of child marriage in Massachusetts, which prior to the passage of this new law was allowed with consent from a parent and judicial approval from the Massachusetts Probate and Family Court.

The OCA was proud to support this effort and applauds the Massachusetts Legislature and Governor Baker for acting to protect vulnerable minors from this harmful practice.

[82] Language to end child marriage in Massachusetts was included in the FY23 state budget: https://malegislature.gov/Budget/FY2023/FinalBudget

Department of Children and Families' Data

Beginning in December 2018, the OCA participated in a subgroup of the Data Work Group that also included DCF and staff from the Joint Committee on Children, Families, and Persons with Disabilities, to discuss statutory and budgetary language that mandates reports from DCF. This subgroup was tasked with creating a new structure for DCF's reporting requirements that could stand the test of time. As a result, the subgroup drafted a legislative proposal that would codify the new data reporting structure that the DWG had developed that included provisions for future improvements and continuity. The subgroup presented its draft to the DWG in February and March of 2019 and incorporated feedback from additional members of the group. The legislative proposal was then agreed upon by the full DWG.

This proposal codified the new Quarterly and Annual Reports, while providing flexibility in the language for future improvements and additions to the report without legislative changes. It also codified changes to the Fair Hearing report, added a report on DCF Youth (age 18+), streamlined notifications on changes to DCF policy and regulations, and eliminated current reporting requirements no longer needed in the GAA and MGLs. It also required the Department to set targets for various safety, permanency, and well-being measures.

Several bills introduced at the beginning of the 192nd session was informed by the DWG proposal and priorities of House and Senate leadership.[83] The OCA appreciates the Legislature's consideration of these proposals and is committed to supporting efforts to promote public accountability of the Commonwealth's child welfare agency.

Access to Juvenile Court Records

The OCA currently has statutory authority to access court records as well as criminal offender record information (CORI) reviews. Although the courts have permitted the OCA access to individual files on a case-by-case basis for the purposes of investigations, we have been denied access to data on juvenile court records held by the state Department of Criminal Justice Information Services (DCJIS) because the OCA's statute does not explicitly authorize access to juvenile records from DCJIS. The OCA believes that such access is critical to our work in the field of juvenile justice. Having access to this data would also allow us to better-fulfill requests for information we have received from the Legislature. During the 192nd session, H.1558/S.922, ***An Act clarifying the child advocate's authority to access juvenile records***, was filed to resolve this issue.[84]

[83] For the legislative history and full text of these bills, please see: H.239/S.32, *An Act relative to accountability for vulnerable children and families,* H.88, *An Act relative to accountability for vulnerable children and families,* and H.4787, *An Act Enhancing Child Welfare Protections*

[84] For the full text and legislative history of these bills, please see: H.1558 and S.922

This legislation received a favorable report from the Joint Committee on the Judiciary and was referred to the House Committee on Ways and Mean. For the bill's text and legislative history, please see: https://malegislature.gov/Bills/192/H1558

The OCA also supported **H.1579, *An Act relative to juvenile court reporting requirements***, which would require the Juvenile Court to provide the OCA with information regarding key court performance measures in child abuse and neglect cases.[85] Currently, the OCA has statutory authority to access to "relevant records held by the clerk of the juvenile court and the clerk of the probate and family court records."[86] The Trial Court has interpreted this to mean that the OCA has a right to access to individual case files for the purpose of investigations, but does not have a right to access to what they deem to be "bulk" data under Trial Court rules. While the OCA can request the court file for any individual child, this information does not tell us about the common barriers to safety and timely permanency that trend data would provide to us. Specific data reporting from the courts, as proposed in H.1579, is the bird's eye view that is critical to our unique ability to advocate on behalf of the Commonwealth's most vulnerable children.

This bill received a favorable report from the Joint Committee on the Judiciary and was referred to the House Committee on Ways and Means. For the bill's text and legislative history, please see: https://malegislature.gov/Bills/192/H1579

Bail Procedures for Justice Involved Youth

In 2019, the JJPAD Board, which is chaired by the OCA, recommended eliminating the $40 administrative bail fee imposed on justice-involved youth and amending juvenile arrest procedures to require the Bail Magistrate, rather than the Officer in Charge, to make the decision about whether an arrested youth should be released or held on bail. Under current law, the Officer in Charge at the police station is given the authority to release a youth or call the Bail Magistrate to make a bail determination. This has led to confusion and inconsistent practices across the state.

S.923/H.1557, ***An Act updating bail procedures for justice-involved youth,*** proposes codifying this JJPAD recommendation into law.[87] This legislation also codifies the standing order issued by the Executive Office of the Trial Court during the COVID-19 pandemic, giving Bail Magistrates the authority to administer any oath or required affirmations while taking bail through telephone or virtual options, in addition to the traditional in-person measures. It would also permit bail to be paid through a virtual or mobile payment option.

[85] For full text and legislative history, please see: H.1579
[86] M.G.L. c. 18C § 6
[87] For full text and legislative history, please see: S.923 and H.1557

This legislation was passed by the Massachusetts Senate in June of 2022. For the full legislative history of the bill, please see: https://malegislature.gov/Bills/192/S923

Initiatives and Committees

In addition to the OCA's statutorily required work and leadership of various commissions, Director Mossaides and OCA staff participate as a member on many diverse boards, councils, and initiatives across the state that work toward improving the lives of children and young adults in the Commonwealth. 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.

For the purposes of this report, the OCA has broken down this work into two general categories: **Child and Family Safety and Wellbeing** and **Children's Mental and Behavioral Health**.

Child and Family Safety and Wellbeing

Name	Target Population	Program Type	OCA's Role
Children's Trust The Massachusetts Children's Trust is a leader in efforts to stop child abuse in Massachusetts. https://www.childrenstrustma.org/	Children and families at risk of child welfare system involvement	Community based programs focused on strengthening families and preventing child abuse	The OCA is a statutory member of the Children's Trust Board
Child Fatality Review Program The Massachusetts CFR program was established in 2000. The purpose of child fatality review is to "decrease the incidence of preventable child fatalities and near fatalities" in the Commonwealth." Eleven local teams meet under the leadership of the District Attorneys' Offices to conduct multidisciplinary reviews	Children and youth under age 18 who have suffered a fatality or near fatality	Multidisciplinary collaboration to increase awareness and develop or improve policy and practice at the state and local level	The OCA is a statutory member of the State Team and OCA staff attend local CFRT meetings. The OCA provides financial support to the

of individual deaths. The local teams provide recommendations to the State Team based on the individual cases they review. The State Team reviews those recommendations and gathers information from outside experts to determine whether those recommendations for statewide changes should be sent to the Governor and Legislature for consideration.			program to facilitate its work
Family and Child 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 have serious problems at home or in school, who repeatedly run away from home, who are habitually truant from school, or who are the victims of commercial sexual exploitation. 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. Family Resource Centers: https://www.frcma.org/	Youth who are involved in a Child Requiring Assistance (CRA)	Oversight and monitoring of the Family Resource Centers	The OCA is a statutory member of the Advisory Board
Governor's Council to Address Sexual and Domestic Violence – High Risk and Assessment Work Group The GCSDV charge is to advise the Governor on how to help residents	Children and youth who are victims of sexual or domestic violence	Multidisciplinary collaboration to ensure victims and their children are identified and	Though not a member of the Governor's Council, the OCA's Director of Quality

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.		receive the support and services they need	Assurance participates in the High Risk and Assessment Work Group
Interagency Safe Sleep Task Force The Interagency Safe Sleep Task Force is a multidisciplinary group of state and provider agencies who aim to reduce the incidents of sudden unexpected infant death through public awareness and creating systems that reduce SUID related risk factors. www.mass.gov/safesleep	All newborns and infants, birth to 12 months	Multidisciplinary collaboration to increase community awareness and develop or improve state agency policy and practice about safe sleep messaging	The OCA attends meetings to participate and contribute expertise to policy and practice improvements
Leadership Advisory Board of the Massachusetts Child Welfare Trafficking Grant Five 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.	Children and youth either experiencing or at-risk of human trafficking and commercial sexual exploitation	Increase the capacity of the child welfare system to address child trafficking	The OCA is a member of the Advisory Board and OCA staff attend the quarterly meetings
The Children's League of Massachusetts	Children and youth	Advocate for policies and	The OCA is a special

CLM is a non-profit association of private organizations and individuals who collectively advocate for policies and quality services in the best interests of the Commonwealth's children and youth and their families. http://www.childrensleague.org/		quality services in the best interests of the children, youth and families	member and staff attend the monthly meetings to stay informed of emerging issues and contribute to the collaboration
Model School Resource Officer MOU Commission The Model School Resource Officer Memorandum of Understanding (SRO-MOU) Review Commission is tasked with designing a Memorandum of Understanding for the Commonwealth's School Resource Officer Program with the goal of creating a publicly engaged and responsible framework. This Commission was created by the Legislature in 2020 by *An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth*	School-aged children and youth	Developing a Model MOU to be used by school districts and police departments that have a School Resource Officer program	The OCA is a statutory member of the Commission. The group's work concluded in FY22. For more details on the group's work, see the Commission website.
Encompass: Community and Collaboration for Foster Families Encompass serves foster families in the Central MA area. Each family is matched with a Peer Trauma Coach who works with the foster parents to understand how trauma affects a child and to make sense of a child's behaviors and feelings. With insight as to why children behave the way they do, foster parents are more effective in helping a child cope with trauma. Caregivers also have the	Foster Parents	Deploys trained staff to coach foster parents in trauma informed parenting and to engage community volunteers to provide meaningful, tangible supports to foster families	The OCA attends meetings to contribute to this effort to support foster parents

opportunity to network with other foster parents as part of a virtual group designed to further enhance trauma informed parenting skills and encourage peer-to-peer discussions.			
Restraint and Seclusion Initiative The Interagency Restraint and Seclusion Prevention Initiative was formed in 2009. The interagency initiative brought together DDS, DCF, DMH, DYS, DESE and EEC to work in partnership with providers, advocates, educators, schools, families and youth to focus on advancing trauma informed practices and prevent the use of coercive practices that traumatize/retraumatize youth, including restraint and seclusion use.	Children and youth	Advancing trauma informed practices and prevent the use of coercive practices that traumatize/ retraumatize youth	The OCA is an active participant in this initiative and serves as a member of both the Executive and Advisory Committees

Children's Mental and Behavioral Health

Name	Target Population	Program Type	OCA's Role
Children's Behavioral Health Initiative The CBHI Council works to ensure that children's behavioral health issues are brought to the forefront in policy discussions on healthcare reform by advising the Governor, the Legislature, and the secretary of EOHHS. https://www.mass.gov/childrens-behavioralhealth-initiative-cbhiv	Children and youth under age 21 with mental and behavioral health needs	Problem solving across areas of expertise to improve and streamline services and identify areas for improved state action	The OCA is a statutory member of the CBHI Advisory Council
Infant and Early Childhood Mental Health Policy Workgroup	Ages birth to five	Coordination of policy and practice	The OCA attends meetings to understand

The purpose of IECMH Policy Workgroup, which is coordinated by DMH, is to provide a forum where both state and private stakeholders who touch the life of families with young children can gather to coordinate efforts, discuss most up-to-date information regarding IECMH both in Massachusetts and successful examples from other states that can be used by all stakeholders to educate and inform best practices, policies, and activities.		developmen t	emerging issues and initiatives and to participate in policy and practice recommendatio ns
Psychotropic Medication Task Force The Psychotropic Steering Committee is a multidisciplinary, interagency team led by DCF that meets regularly to ensure appropriate oversight of psychotropic medication use for youth in state custody.	Children and youth in DCF custody	Legally standardize requirement s across all settings	The OCA is a participant in this initiative
The Children's Mental Health Campaign The CMCH is a coalition of families, advocates, health care providers, educators, and consumers from across Massachusetts dedicated to ensuring all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health in a timely, effective and compassionate way. http://www.childrensmentalhealthcampaign.o rg/	Children at risk of and/or who have mental health issues	Ensuring all children have access to resources to prevent, diagnose, and treat mental health in a timely and effective way	OCA staff sit on the School Based Behavioral Health Advisory Board, which is part of the CMHC

Appendix A: Data and Definitions Regarding Out-of-Home Settings

The supplemental statistics, data visuals, and definitions presented throughout Appendix A provides complementary data to the information outlined in the **Abuse and Neglect in Out-of-Home Settings** section of this report.

Department of Children and Families

DCF is the child protective service agency for Massachusetts. DCF is the state agency responsible for receiving and responding to allegations of child maltreatment, for providing services to children and their families that enable caregivers to safely care for their children, and when that is not possible to assume custodial care as authorized by the Juvenile Court. DCF provides services to more children and families than any other Executive Office of Health and Human Services child-serving agency.

The data below reflects a snapshot in time. In total in FY21, DCF served 10,796 unique children through foster care, not including independent living. In FY22, DCF served a total of 10,515 unique children through foster care, not including independent living.

At the end of FY21, 26,307 families were being served by DCF. These cases involve 93,802 children and adults: 44,465 children (0-17), 2,271 young adults (18 & older), and 47,066 adults.

At the end of FY22, 24,593 families were being served by DCF. These cases involve 86,453 children and adults: 41,263 children (0-17), 2,194 young adults (18 & older), and 42,996 adults.

Table 1 shows the number of DCF involved children placed in each type of congregate care as of the end of FY21 and FY22.

Table 1: Children in DCF Custody Placed in Congregate Care as of June 30, 2021, and June 30, 2022		
Congregate Care Type	**Number of Children in Congregate Care as of June 30, 2021**	**Number of Children in Congregate Care as of June 30, 2022**
Medically Complex Residence	9	8
Treatment Residence	693	563
Residential School	364	331
Emergency Residence	281	255
Youth and Young Adult	7	20
Total	**1,354**	**1,177**

Table 2 shows the number of DCF involved children placed in each type of foster care as of the end of FY21 and FY22. Children were placed in kinship foster care more than any other type of care.

Table 2: Children Placed in Departmental or Comprehensive Foster Care as of June 30, 2021 and June 30, 2022		
Foster Care Type	**Total Number of Children birth-17 as of June 30, 2021**	**Total Number of Children birth - 17 as of June 30, 2022**
DFC Kinship	2,674	2,581
Comprehensive Foster Care (CFC)	1,190	1,081
Departmental Foster Care (DFC)	1,898	1,886
DFC Child Specific	558	588
DCF Pre-Adoptive	503	501
DCF Independent Living	2	2
Total	**6,825**	**6,639**

Department of Mental Health

The Department of Mental Health (DMH) Child, Youth and Family Services also provides services to children and youth through child/adolescent case management, individual and family support services, day services and out-of-home treatment services to children and youth with serious mental health needs. Most mental health services, including medication and therapy are provided through health insurance – MassHealth (Medicaid), the Massachusetts Health Connector (health insurance marketplace) or through private insurance (employer-based).

Table 3 shows *Children and Youth Placed in DMH Out-of-Home Treatment as of June 30, 2021 and June 30, 2022.*

Table 3: Children and Youth Placed in DMH Out-of-Home Treatment as of June 30, 2021 and June 30, 2022.

Congregate Care Service Type	Number of Children and Youth in DMH Out-of-Home Treatment (aged 18 and younger as of June 30, 2021)	Number of Children and Youth in DMH Out-of-Home Treatment (aged 18 and younger as of June 30, 2022)
Intensive Community Services		
Therapeutic Group Care		36
Young Adult Therapeutic Care-Staffed Apartments		8
Caring Together Services		
Intensive Group Home Services	18	6
Residential School Services	14	14
STARR Services	0	
Transitional Age Youth Services	26	1
Statewide Program Services		
Intensive Residential Treatment	63	49
Clinical Intensive Residential Treatment	5	6
Inpatient Continuing Care	23	22
Total in Out of Home Placements	149	142

Department of Youth Services

In addition to DCF foster care placements, youth in the custody of DYS pretrial can be placed in a *hardware secure facility*, a *staff secure facility*, or with a *foster family* in the community.[88] Because youth may have been admitted to various detention placements throughout the fiscal year, Table 4 reflects the number of youth detained at DYS as of June 30, 2021. Consistent with previous fiscal years, *hardware secure facility* placements were most common for youth detained at year-end FY21 and *foster family* placements were least common. No youth placed with DYS foster families were not reported to the OCA in for abuse or neglect in FY21. For more detailed information about the FY21 DYS detention population, please refer to the JJPAD 2021 Annual Report.

Table 4: DYS Detained Youth by Placement Type as of June 30, 2021 and June 30, 2022.

Placement Type	Number of Detained Youth as of June 30, 2021	Number of Detained Youth as of June 30, 2022
Foster Family	2	0[89]
Staff Secure Facility	23	37
Hardware Secure Facility	91	97
Total	**116**	**136**

In addition to DCF and DMH congregate care placements, a judge can *commit* the child to the physical custody of the Department of Youth Service (DYS) until their 18th birthday.[90] Because youth may have been committed to various placements over time, Table 5 reflects the number of committed youths in each placement type as of June 30, 2021. For more detailed information about the FY21 DYS commitment population, please refer to the JJPAD 2021 Annual Report.

[88] Placement type is determined by the youth's risk level and offense type.
[89] Cannot be reported due to cell suppression
[90] Commitments can be extended to ages 19, 20, or 21 years old depending on the time and type of disposition.

Table 5: DYS Committed Youth by Placement Type at Year-End FY21[91] and June 30, 2022		
Placement Type	**Number of Committed Youth as of June 30, 2021**	**Number of Committed Youth as of June 30, 2022**
Community[92]	127	100
Staff Secure Facility	49	42
Hardware Secure Facility	63	67
Total	**240**	**209**

Definitions of Out-of-Home Settings

Term	Definition
Congregate Care	Congregate care is a term for placement settings that consists of 24-hour supervision for children in a varying degree of highly structured settings such as group homes, residential childcare communities, childcare institutions, residential treatment facilities, or maternity homes.
DCF Emergency Residence	Two congregate care, out-of-home treatment service models designed to accept emergency intakes on a 24/7 basis to meet the needs for immediate placement for youth with behavioral needs (moderate to severe) that reflect a lack of self-regulation.
DCF Medically Complex Residence	Two congregate care, out-of-home treatment service models for youth with complex medical needs that cannot be managed in a home setting due to the need for 24/7 direct skilled nursing or medical equipment. Youth will have a range of other challenges, which may include sensory impairments, intellectual disabilities, or physical impairments. One of the

[91] One youth on June 30, 2021, was AWOL and thus, missing from the setting data provided. This data includes youth who have been adjudicated delinquent multiple times and re-committed to DYS.

[92] Youth committed to DYS who are living in the community do so on a "Grant of Conditional Liberty" or GCL. A GCL can be revoked based on a violation of a condition, and a youth can be brought back to a DYS facility at the discretion of DYS. This is roughly equivalent to "parole" in the adult justice system.

	models serves youth who also have behavioral health challenges
DCF Residential School	Congregate care, out-of-home treatment services that are integrated with an onsite special education school. Youth receiving residential school services need a self-contained, integrated treatment, and educational program due to severity of behavioral risk to self or others preventing them from safely attending school offsite
DCF Treatment Residence	Four congregate care, out-of-home treatment service models for youth with behavioral needs (moderate to severe) that reflect a lack of self-regulation. Specialized models address a specific need or group (e.g., CSEC (Commercial Sexual Exploitation of Children), intellectual disabilities, Autism Spectrum).
DCF Youth and Young Adult	Four congregate care, out-of-home treatment service models for older adolescents and young adults to increase their skill set towards independently navigating community living and increasing self-sufficiency. Youth and Young Adult includes a model specifically for pregnant and parenting youth.
DCF Comprehensive Foster Care	Foster homes that offer more intense therapeutic care and supports setting for children with more complex needs. This service is only provided by licensed foster care agencies in accordance with the licensing requirements of the Department of Early Education and Care (EEC) and DCF.
DCF Departmental Foster Care (DFC)	Foster care placements provide stability and safety for children/youth that have been brought into the protective care of the state. These foster care placements may be with family or extended family, or through unrelated caretakers who have completed training and are approved as licensed foster parents assigned to a DCF social worker.
DFC Child Specific Foster Care	Foster care placements where a non-kinship individual(s) is identified and licensed as a placement for a particular child (e.g., teacher or parent(s) of the placed child's friend). This is a person who the family or child has a strong bond with and is significant in their life.
DFC Kinship Foster Care	Foster care placements provided by persons related by either blood, marriage, or adoption (e.g., adult sibling, grandparent, aunt, uncle, first cousin) or other adult to whom the child and/or parent(s) ascribe the role of the family based on cultural and affectional ties or individual family values.
DFC Independent Living	Services may be provided at either scattered or centralized (e.g., apartment) sites with staff that provide outreach and care coordination to young adults and are available for face-to-

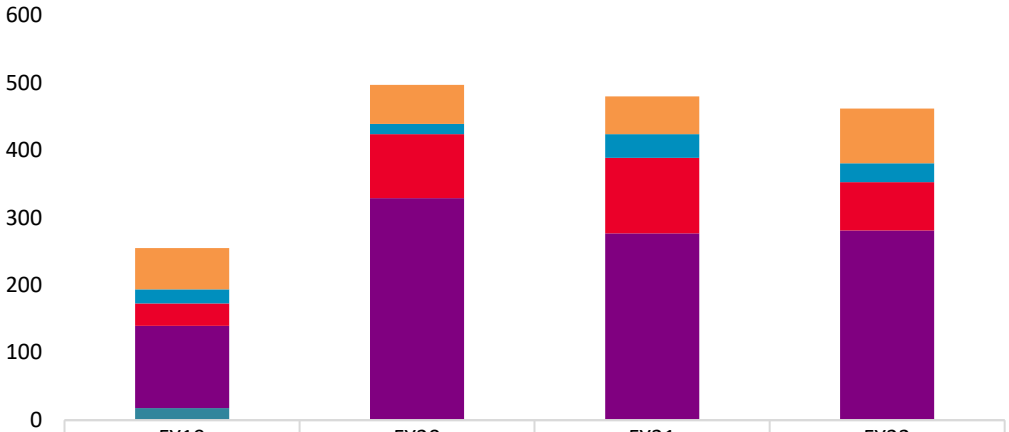
	face crisis intervention 24 hours a day, seven days a week. This model serves young adults 17.5 or older who are not able to be served in a family setting due to their clinical needs, but who are able to live on their own with support; independently manage community access; have attained a sufficient level of independent living skills to enable them to live without on-site staffing; require and are able to utilize staff support to strengthen these independent skills; exhibit a strong level of self-regulation; are enrolled in school or a GED program; or have completed the above and are working or involved in vocational training.
DFC Pre-Adoptive Foster Care	A resource that has been identified as the child's permanent family. The person(s) has been approved for adoption and is a licensed adoptive family. The child is required to be in that specific home for a minimum of six months before the adoption can be finalized.
DFC Unrestricted Foster Care	An individual(s) who has been licensed by the Department as a partnership resource to provide foster/pre-adoptive care for a child usually not previously known to the individual(s).
DMH Intensive Community Services – Therapeutic Group Care	Provides out-of-home treatment to youth and young adults with mental health needs whose behaviors have been difficult to maintain in family settings. It is a 24-hour staffed treatment environment where youth stay temporarily while receiving treatment services.
DMH Intensive Community Services – Young Adult Therapeutic Care-Staffed Apartments	Provides out-of-home treatment for young adults ages 18-25. The service has two levels of support: staffed apartments and supported apartments. Both levels provide therapeutic support to help young adults live, work, attend school and participate in their communities.
DMH Caring Together – Intensive Group Home Services	An out of home shared living environment located in the community. Youth attend a community-based school. Individual therapy is provided, and staff work with the family to develop and support the plan for the youth to return home
DMH Caring Together – Residential School Services	Out of home shared living environment that is typically campus based with a therapeutic school on campus and intensive services in residential housing.
DMH Caring Together - Stabilization Assessment and Rapid Reunification (STARR) Services	Out of home shared living environment available for up to 45 days. STARR programs provide a short-term intervention to help stabilize and assess youth and family needs.
DMH Caring Together - Transitional Age Youth Services	Specialized out of home shared living environment for youth ages 18 to 25 who need assistance living independently. These services provide support and skill building to youth so they can

	live in either shared living or independent living situations with ongoing access to clinical supports
DMH Statewide Program - Intensive Residential Treatment Programs (IRTP)	Locked settings that offer both therapeutic services and a DOE-contracted school on site for youth 13-18.
DMH Statewide Program - Clinical Intensive Residential Treatment (CIRT)	Unlocked setting for youth under 13 years old with intensive therapeutic services and DOE-contracted school on site
DMH Statewide Program - Inpatient Continuing Care	Locked setting for youth (13-18) who require the most intensive level of clinical treatment, specialized hospital care available and on-site DOE licensed school
DYS Hardware Secure Treatment Facilities	Characterized by physically restrictive construction and procedures that are intended to prevent youth from leaving without the approval of the Department. Hardware secure residential treatment programs are primarily long-term (6 months and longer). These programs typically provide treatment services to youth committed to DYS for Grid Level 4-6 offenses. Youth committed on Grid Level 3 offenses involving Firearms or Sex Offenses may also be considered for Secure Treatment. Initial time recommendations in these placements range from 6-18 months in duration
DYS Staff Secure Treatment Facilities	Characterized by a system of staff development and behavior control procedures designed to prevent youth from leaving without the approval of the Department. Staff secure residential treatment programs are primarily short-term (3-5 months typically). Examples include Group Homes and Chapter 766 Residential Programs. Staff secure programs emphasize accountability, pro-social skill development, and planning for community re-entry.

Appendix B: Critical Incident Reports

Figure 19 shows the distribution of critical incidents by type of incident from FY19 to FY22 and provides complementary data to the information outlined in the **Critical Incident Reports** section of this report.

Figure 19:
Critical Incident Reports by Fiscal Year, FY19-FY22



	FY19	FY20	FY21	FY22
Fatality	61	58	56	81
Near Fatality	21	15	35	28
Serious Bodily Injury	33	95	112	72
Emotional Injury	122	329	277	280
Other	18	0	0	1

Commonwealth of Massachusetts
Office of the Child Advocate

Phone
Main Office: (617) 979-8374
Complaint Line: (617) 979-8360

Address
One Ashburton Place, 11th Floor
Boston, MA 02108

Website
https://www.mass.gov/orgs/office-of-the-child-advocate

Contact
childadvocate@mass.gov