MASSACHUSETTS
Office of the Child Advocate

Office of the Child Advocate Annual Report

FISCAL YEAR 2024

MARCH 2025
THE COMMONWEALTH OF MASSACHUSETTS
MARIA Z. MOSSAIDES, DIRECTOR

Table of Contents

Letter from the Child Advocate

I am pleased to present the Fiscal Year 2024 (FY24) report of the activities of the Office of the Child Advocate (OCA). The OCA is committed to ensuring that children and their families receive high-quality, effective, and timely state services while also identifying gaps in services and recommending improvements to systems, policies, and practices. This past year was marked by significant challenges and accomplishments. The OCA remains steadfast in our belief that through collaboration and targeted action, we can create a future where every child in the Commonwealth is safe, supported, and thriving. You will see in this report steady growth at the OCA in the number of staff, our ombuds function capacity, the range of research topics we conduct, and the number and size of the projects we pursued.

This year we incorporated the Center on Child Wellbeing & Trauma into the OCA. The OCA is dedicated to ensuring that state service agencies and their contracted providers are trauma responsive. This work includes trainings and technical assistance on how trauma impacts behavior, emotions, and the development of children and the adults who care for them. This knowledge and related skills can prevent re-traumatization and promote resilience. The Center was created through the work of the Childhood Trauma Taskforce, which the OCA chairs, and was originally launched as a project housed at the ForHealth Consulting Division of UMass Chan Medical School. The Center's goal is to provide support and training to child-serving organizations and state agencies across the Commonwealth. To better serve state agencies, the Center shifted to become a fully incorporated division of the OCA during FY24. Incorporating the Center as a new division within the OCA has provided us with the unique opportunity to apply the OCA's approach to systemic change in the field of trauma and resilience training. The incorporation of the Center also contributed to our growth in staff, as the OCA has increased from a staff of 20 in FY23 to a staff of 30 at the end of FY24, with further growth planned for FY25.

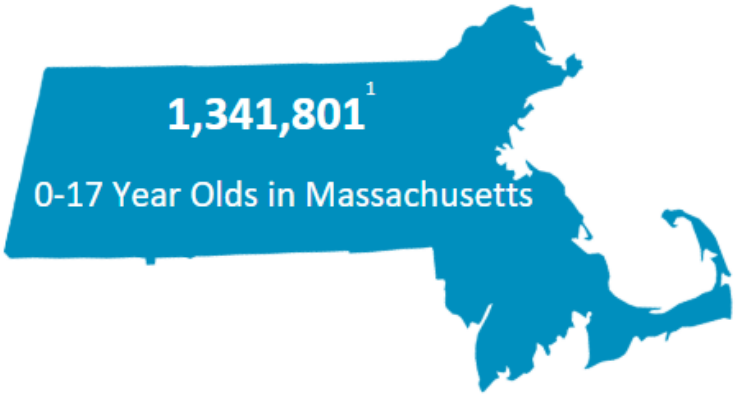
In addition to the growth of the OCA staff, we are expanding our reach and depth. This includes direct outreach to youth in group-care settings to enhance awareness of our Complaint Line, which is available to help youth understand their rights and get the resources they need. It also includes translating the OCA's mandated reporter training into Spanish. Nearly 8,000 individuals completed the training from its launch in August 2023 to the end of the fiscal year. In FY24, we also partnered with the Department of Youth Services to expand the Massachusetts Youth Diversion Program to more counties throughout the Commonwealth. We also issued a number of policy reports with recommendations for improvements in the quality and availability of state services, most notably a report with recommendations for expansion of the Family Resource Center network.

I want to extend my sincere and heartfelt thanks to the OCA staff for their dedication to improving the lives of the Commonwealth's children. I also wish to express my gratitude to the Legislature, the Governor, our many partners in the public sector, advocacy organizations, and families who support and collaborate with us daily. Without your continued partnership and support, the OCA would not be able to achieve its mission.

Sincerely,

Maria Z. Mossaides

Data Shapshot of Children in Massachusetts



Gender [1]

49% Female, 51% Male

Identify as Trans [4]

5.3%

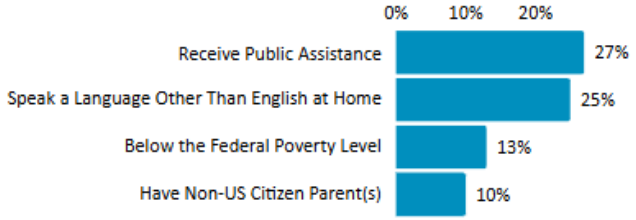
LGBTQ+ [4]

22%

Living with Two or More ACEs [1]

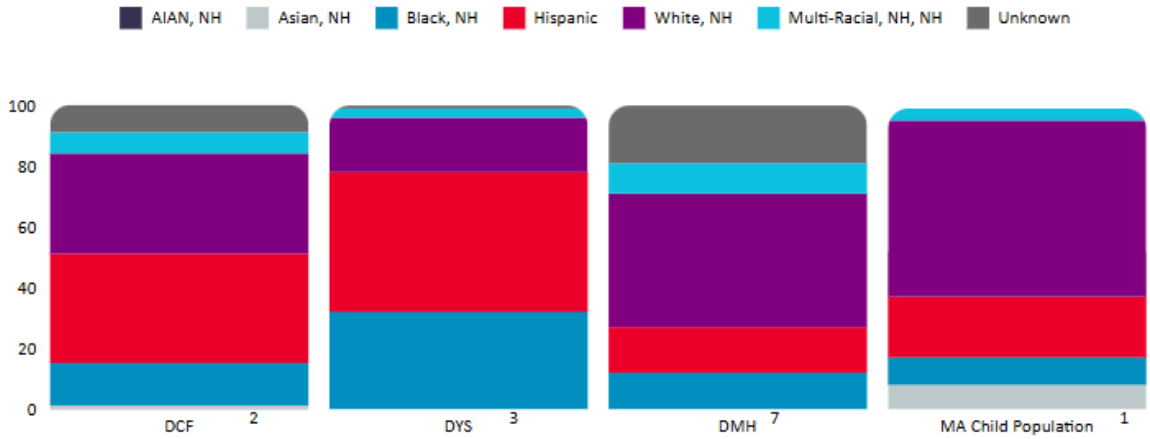
13%

Relevant Demographic Information [1]



Received State Services From...

Race & Ethnicity of State Service Recipients Compared to General Population



References:

1. Kids Count Data Center, accessed 11/4/2024. Note: ACEs = Adverse Childhood Experiences
2. FY24 DCF "Consumer Child" count for 0-17 open at **any time** while R&E breakdown is for open at **end of year**
3. Number of MYDP participants, Overnight Arrest Admissions, Pretrial Detentions, First-Time Commitments, and YES Transitions, JJPAD FY24 Annual Report
4. MCLGBTQY Annual Recommendations FY 2024
5. DDS Active/Eligible children under the age of 18 as of 6/30/2024. Race ethnicity breakdown is not currently available.
6. DPH Title V Service Numbers, FY23 Race ethnicity breakdown is not currently available.
7. DMH Full, limited and community services JJPAD FY24 Annual Report

Executive Summary

This OCA Annual Report provides a high-level description of the actions and activities undertaken in FY24 to advance our strategic goals and reach a future where all children—and specifically children in the care and/or custody of the Commonwealth—can thrive.

Through its oversight functions, the OCA:

- Responded to 532 inquiries on the **Complaint Line.**
- Received and reviewed 278 **critical incident reports** involving 380 children.
- Received and reviewed 465 Department of Children and Families (DCF) reports of **supported allegations of abuse and/or neglect of children in out-of-home settings** involving 676 children.
- Received and reviewed 15 DCF **Foster Care Review safety alerts** involving 17 children.

The OCA also conducted research on a variety of issues, including problematic sexual behaviors in children, prevention of drowning for children with autism spectrum disorder, and barriers and opportunities to increase language access in child-serving systems. OCA staff conducted a landscape assessment of state-sponsored direct services for children, released additional data on juvenile justice involvement, and issued a notice and request for public comment about the revised DCF annual report. That research resulted in the release of the following reports:

- The Massachusetts Youth Diversion Program: Impact Report, Year One of Implementation, October 2023
- Childhood Trauma Task Force 2023 Annual Report, December 2023
- Massachusetts Juvenile Justice System 2023 JJPAD Annual Report, January 2024
- Family Resource Centers: Recommendations for Increasing Access and Improving Service Delivery, April 2024
- The Massachusetts Youth Diversion Program: Year Two Program Data, May 2024
- Evaluation of a Housing Stabilization and Support Program for Transition Age Youth Involved with the Department of Children & Families, June 2024
- Public Comment Summary and Response: Department of Children and Families Annual Report, August 2024

Nearly 8,000 individuals successfully completed the OCA's mandated reporter training; the Center on Child Wellbeing & Trauma (CCWT) conducted trainings about trauma-informed and responsive practices for a variety of professionals and organizations at state agencies and their providers; the Quality Assurance Team worked to raise awareness of the Complaint Line, especially with young people living in congregate care; and the OCA provided funding for diversion services in seven counties through the Massachusetts Youth Diversion Program, for play spaces for newcomer families living in shelters, and for young mothers through Roca Inc.'s. Young Mothers program.

The OCA led boards and task forces that advance conversations and create critical connections between key partners:

- The Juvenile Justice Policy and Data Board
- The Childhood Trauma Task Force
- Child Fatality Review in partnership with the Office of the Chief Medical Examiner and Department of Public Health (DPH)
- Child Sexual Abuse Prevention Task Force in partnership with the Children's Trust

Legislatively, the OCA advocated for initiatives that will improve the well-being of children and families and service delivery for children involved in the child protective and juvenile justice systems, including but not limited to:

- Advancing a foster children's bill of rights.
- Improving the Child Requiring Assistance system.
- Making key juvenile justice data available.
- Transferring authority of the Child Fatality Review program to a joint chairmanship between the OCA and DPH.
- Addressing the needs of substance-exposed newborns.

Finally, the OCA underwent substantial growth in FY24 with the incorporation of the Center on Child Wellbeing & Trauma. This growth was coupled with increased administrative capacity, attention to the development of standard operating procedures, and a revision of the data collection system that supports the OCA's core functions. Ten new employees joined the OCA to support these functions, with more hiring anticipated in FY25.

The OCA stands ready as a partner and collaborator to provide system navigation to individuals, identify gaps in state services, and work toward continuous improvement of policy, practice, regulations, and laws.

To report suspected child abuse and/or neglect

Call the DCF Area Office that serves the city or town where the child lives.

On nights, weekends, and holidays, call the Child-At-Risk Hotline at 1-800-792-5200.

For more information, visit: https://www.mass.gov/how-to/report-child-abuse-or-neglect.

Introduction

In FY24 the Office of the Child Advocate released our FY24-FY26 strategic framework. The framework is the result of a strategic planning process that started with the question, "What is the OCA's vision for the Commonwealth's children and their families, and what will it take to get there?" The framework identifies eight key goals that must be achieved by the Commonwealth to reach a future where all our children—and specifically our children in the care and/or custody of the Commonwealth—can thrive. These goals guide decisions about OCA projects and initiatives:

- **Safety, High-Quality Services & Continuous Quality Improvement (CQI):** Children in the care and/or custody of the Commonwealth are safe and receiving the services they need, and the state agencies serving them are continuously improving with well-functioning quality assurance mechanisms in place**.**
- **Prevention and Breaking the Cycle:** There is a comprehensive, coordinated statewide approach to supporting families with the aim of reducing child protective service and juvenile justice system involvement, particularly for those families for whom persistent disparities in supports exist and for families with multi-generational involvement.
- **Transition into Adulthood:** Youth receiving state services transition into adulthood with the support they need to succeed.
- **Addressing the Needs of Diverse Populations:** Our state child-serving systems are addressing the needs of traditionally underserved populations, including racially and ethnically diverse populations, LGBTQ+ youth, and newcomer families.
- **High/Complex Behavioral Health Needs:** The needs of children and youth with high and/or complex behavioral health needs are met, including their needs for timely delivery of and navigation to appropriate support.
- **Awareness of Services:** Families and youth, and those who serve them, are aware of available supports and services.
- **High-Quality Data:** Our state agencies serving children and families use high-quality data to inform decision making and continuous quality improvement.
- **OCA Capacity:** The OCA has the expertise, reputation, relationships, capacity, and operational infrastructure to execute its mission.

The following report provides a high-level description of the actions and activities undertaken by the OCA in FY24. The first section provides a description of all major projects organized by oversight functions, including descriptions of and actions taken in response to the reports and inquiries received by the OCA.

Strategic Priorities & Initiatives

The following section describes the major projects the OCA worked toward in FY24, organized by the OCA's eight strategic goals. While projects are described under specific priorities to help organize communication about our efforts, many projects address multiple goals.

Goal 1: Safety, High-Quality Services, and Continuous Quality Improvement

Children in the care and/or custody of the Commonwealth are safe and receiving the services they need, and the state agencies serving them are continuously improving with well-functioning quality assurance mechanisms in place.

OCA's Quality Assurance Oversight

The OCA quality assurance function is grounded in the OCA statute, which requires the OCA to ensure that children who are involved with an executive agency receive timely, safe, and effective services. The OCA statute establishes several pathways for information about state services to come to the OCA's attention. These are the operation of an OCA Complaint Line, receipt of critical incident reports, and receipt of DCF supported allegations of abuse and/or neglect of children in out-of-home settings. Although not statutorily required, as part of the OCA's long-term efforts to strengthen the Foster Care Review process, in FY22 the OCA also began to receive Foster Care Review safety alerts[1] from DCF.

As a result of these established pathways, in FY24 the OCA received 532 Complaint Line inquiries, 278 critical incident reports, 465 DCF supported reports of abuse and/or neglect in out-of-home settings, and 15 Foster Care Review safety alerts. OCA quality assurance staff provided advice and systems navigation to the 379 individuals who contacted the Complaint Line and reviewed each concern brought to the OCA's attention. OCA quality assurance staff also reviewed every critical incident report, DCF supported report of abuse and/or neglect in an out-of-home setting, and Foster Care Review safety alert. As a result of this work, OCA staff followed up with external state agencies and/or service providers regarding 426 reports/inquiries, filed four allegations of abuse and/or neglect (51As) with DCF, and conducted one non-public investigation. The OCA may initiate a formal investigation when we determine 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. Formal investigations may be non-public or public. Formal investigations include recommendations for implementation, which the OCA monitors through our ongoing oversight.

The OCA's engagement with external agencies because of our quality assurance oversight work can take several forms and has multiple goals. The primary goal is to ensure that children are safe, that they are receiving the services they need, and that barriers to those services are

[1] See Appendix E: Glossary of Terms for a definition.

resolved. The engagement can also provide additional information and context through discussion of agency policies and practices. This informs the OCA's individual case review work as well as our overall mission of ensuring that children and their families receive effective services.

Our work in this area also informs our day-to-day oversight of state agencies, our participation in the Child Fatality Review (CFR) program, as well as our work on various other boards and commissions and related research projects. 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, this information helps us:

- Determine policy and/or practice changes that could be instituted or refined to increase the safety of 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.

For more function-specific information and data, see the Oversight Functions of this report.

Improving Trauma-Responsive Practices in Congregate Care Programs

Beginning in FY22 and continuing through FY24, the Center on Child Wellbeing & Trauma worked with community-based congregate care service providers to improve the adoption of trauma-informed and responsive practices. The goal of this work is to enhance services to children placed in congregate care. Over this multi-year period, CCWT—through partnerships with DCF and the Children's League of Massachusetts—engaged with 26 congregate care organizations to provide in-depth assessment, training, and technical assistance.

CCWT administered an evidence-based assessment known as the Trauma-Informed Organizational Assessment (TIOA). This tool, developed by the National Child Traumatic Stress Network, assesses whether an organization is trauma responsive across eight key metrics, and identifies training and technical assistance needs. By the end of FY24, a total of 1,748 child-serving professionals across the 26 organizations completed the TIOA through CCWT.

After the assessment, CCWT staff provided participating organizations with 9-12 months of individualized training and technical assistance. This included training; regular coaching sessions focused on practices, policies, and program implementation; and drafting and implementing best practice materials. The process engaged every organizational level from leadership to direct care staff. Based on this work, organizations modified their intake practices to be more trauma responsive, implementing secondary traumatic stress interventions to increase staff retention, and creating reflective supervision training and practices.

After that, organizations were reassessed using the TIOA to determine areas of improvement or ongoing challenges. Overall, sites reported significant improvement across all nine domains of the TIOA.

The OCA in Action: Meeting the Needs of Children

Dr. John contacted the OCA regarding Ashley*, a youth in DCF care who was a frequent visitor to Dr. John's emergency department. Dr. John reported concerns regarding Ashley's frequent running away from her congregate care program and the program's ability to meet Ashley's needs. Upon review of Ashley's record, the OCA learned that Ashley experienced extensive abuse at a young age resulting in some complex physical and emotional needs with long-lasting effects. Through communication with the DCF area office, Ashley was moved to another program that could meet her needs. Ashley then contacted the OCA directly about not feeling safe at the new program and inconsistent visits with her clinician. Through her own advocacy and advocacy of the OCA, Ashley was moved to a more appropriate placement. The OCA continues to monitor Ashley's case to ensure that she is receiving the services she needs.*

Goal 2: Prevention and Breaking the Cycle

There is a comprehensive, coordinated statewide approach to supporting families with the aim of reducing child protective service and juvenile justice system involvement, particularly for those families for whom persistent disparities in supports exist and for families with multi-generational involvement.

Training for Mandated Reporters

The OCA chaired the Mandated Reporter Commission (MRC), established by the Childhood Wellness Bill of 2019, from 2020-21. In 2021, the MRC published a report that, among other things, identified the importance of providing profession-specific training to educate mandated reporters on their responsibilities to identify and report child maltreatment to DCF. This includes exploring correct identification of abuse and/or neglect, differentiating neglect from poverty, considering the roles bias and cultural considerations play in evaluating whether to make a report, and structured decision-making skills that will prevent potential overreporting of families to the DCF system.

In response to the MRC's findings, the OCA created and launched a free, online and on-demand general training designed for all mandated reporters, as well as a module specifically designed for school personnel that delves deeper into issues particularly relevant to Massachusetts K-12 educators. The training (both the general module and the profession-specific module) launched in August of 2023. The OCA prioritized the creation of the educator-specific module because schools are where children are most frequently seen outside the home and educators generate the highest number of mandated reports submitted to DCF each year, making educators a particularly important group to reach.

The trainings are accompanied by an extensive resource library, available online at any time and without the prerequisite of taking the training. The resource library provides mandated reporters with Massachusetts-specific resources to learn more about relevant topics and services. The resource library also provides valuable tools to assist mandated reporters with connecting families to services when concerns don't rise to the level of abuse and/or neglect, as well as an optional structured worksheet to help mandated reporters think through whether a situation requires a report to DCF.

From August 21, 2023-June 30, 2024, a total of 7,897 individuals successfully completed the training. A total of 341 organizations—including schools, childcare providers, religious groups, medical and dental providers, and sports and recreation organizations—registered to assign the training to their staff. A report describing the OCA mandated reporter training curriculum, additional outcome data, lessons learned, and future evaluation and expansion plans will be issued in FY25.

Massachusetts Youth Diversion Program

The OCA has prioritized expanding statewide diversion opportunities for youth and improving community-based interventions as part of our focus on reducing juvenile justice system involvement for the children in Massachusetts. In FY24, that work included an ongoing partnership with The Department of Youth Services (DYS) to improve and expand the Massachusetts Youth Diversion Program (MYDP), a 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. There is a strong body of research showing that diverting youth away from the juvenile justice system can be an effective strategy for improving life outcomes for youth, while preserving and protecting public safety and reducing court processing costs.[2]

The OCA chairs the Juvenile Justice Policy and Data (JJPAD) Board. Based on the recommendations made in the JJPAD Board's 2019 report on diversion, and modeled after JJPAD's Model Program Guide, DYS and the OCA partnered to launch the MYDP as a pilot program in December of 2021 in three counties. In FY23, the pilot phase of the program concluded, and the program expanded to serve two additional counties. In FY24, two more counties were added, resulting in juvenile diversion services available in Essex, Middlesex, Worcester, Plymouth, Hampden, Bristol, and Barnstable (Cape and the Islands) counties.

The diversion services at each site include a diversion coordinator dedicated to accepting referrals of youth to the program, conducting necessary assessments, developing a diversion agreement, matching services, and providing ongoing case management. There is also a DYS-funded diversion manager, who acts as a central coordinator across all sites.

The OCA works closely with our partners at DYS to monitor implementation. In FY24, this included:

[2] Wilson, H. & Hoge, R. (2013). The Effect of Youth Diversion Programs on Recidivism: A Meta-Analytic Review. *Criminal Justice and Behavior*. Vol. 40, No. 5, May 2013, 497- 518. http://users.soc.umn.edu/~uggen/Wilson_CJB_13.pdf

- Monthly reviews of program data, highlights of which were presented to the JJPAD Board.
- Publishing two impact reports discussing data from Year 1 (published October 2023) and Year 2 (published May 2024) of implementation.
- Partnering with ForHealth Consulting at UMass Chan Medical School to conduct an extensive evaluation of the program, the results of which were published in August 2024.

As part of the FY24 Massachusetts state budget, with the full support of the OCA, funding and full operational responsibility shifted to DYS for FY25 through the creation of a line item. The OCA will continue to partner with DYS on the MYPD, with the ultimate goal of expanding the program statewide to ensure youth across the Commonwealth have access to high-quality diversion services.

Pretrial Detention & Dually Involved Youth

A wide body of research makes clear that even a short stay in pretrial detention[3] can have a significant negative impact on youth, including increasing their chances of re-offending and deepening their systems involvement. It is therefore imperative that pretrial detention be used as infrequently as possible. Massachusetts made a concerted effort to decrease the use of pretrial detention for youth through initiatives, policy changes, and practice shifts, and was largely successful: From FY15 to FY24, pretrial detention admissions for youth dropped by 57%. However, use of pretrial detention has increased in recent years, including a 33% increase in pretrial detention admissions from FY22 to FY24 and a 68% increase in youth supervised/monitored pretrial by probation in FY23 compared to FY22.

The majority of youth who are detained are held as a result of bail or personal recognizance being revoked after an alleged violation of pretrial or probation condition. Just under half (47%, n=420) of all pretrial detention admissions in FY24 were for youth who were involved with DCF, including some who were in the care and/or custody of the Commonwealth.[4]

This intersection between pretrial detention and other state service (primarily DCF) involvement has not previously been publicly studied or reported in Massachusetts. The JJPAD Board determined it was worth further examining and launched two initiatives: one focused on the pretrial phase and one focused on dually involved youth who cross over from the child protection system to DYS.

In FY24, OCA staff conducted stakeholder interviews, carried out a literature review of national research, and requested and analyzed relevant state data for both projects. OCA staff also led numerous JJPAD and subcommittee meetings that convened members from across child-serving state agencies, the judiciary, and advocacy and provider communities to discuss these issues. In

[3] See Appendix E: Glossary of Terms for a definition of pretrial detention.
[4] "Youth who were involved with DCF" refers to a youth who already either was in the care/custody of DCF or had an open case with DCF at the time of pretrial detention.

FY25, the JJPAD Board will publish a report on the pretrial phase and complete its research for the dually involved youth project.

Roca, Inc.'s Young Mothers Program

Mothers younger than 20 are at higher risk for mental health challenges and may find parenting very difficult, due to their age as well as the impact of any trauma on their parenting skills.[5] Young mothers are more likely to be the victim/survivor of abuse and to have experienced high levels of trauma. They also experience higher levels of PTSD and a higher incidence of substance use disorder.[6] Studies indicate those experiences may lead to higher risk of multi-generational trauma and systems involvement.[7] Their children are at higher risk of negative outcomes, such as poor physical and mental health, lower academic achievement, and lower lifetime earnings in adulthood.[8]

Roca, Inc.'s Young Mothers Program aims to prevent or end multigenerational systems involvement.[9] In FY24, the Legislature added an earmark to the OCA's budget to partially fund this program. In FY24, the Roca Young Mothers program provided intensive case management, trauma-informed supports, systems navigation, and programming (life skills, education, employment) to 300 young mothers ages 14-24 and their children in Roca's five Massachusetts sites: Boston, Chelsea, Lynn, Holyoke, and Springfield.

> Roca, Inc.'s Young Mothers Program supports women, most of whom are mothers, who are traumatized victims of abuse and neglect. To break the cycle for their children, Roca supports the stabilization of program participants and, over a four-year intervention, teaches them the skills they and their children need to succeed.

The program also worked with Tufts University Interdisciplinary Evaluation Research in FY24 on an implementation and outcome evaluation, including identification of key outcomes to track, risk and needs assessment, assessment of the program's impact on young children, dosage of programming, model intensity, and length of programming. This evaluation is ongoing.

Review of Family Resource Network

Massachusetts Family Resource Centers (FRCs), overseen by DCF, are community-based centers that provide a wide array of family support services. FRC services are meant to help reduce family involvement with DCF and the Child Requiring Assistance (CRA) system in the juvenile

[5] Hodgkinson, S., Beers, L., Southammakosane, C., & Lewin, A. (2014). Addressing the Mental Health Needs of Pregnant and Parenting Adolescents. Pediatrics, 133(1), 114–122. https://pmc.ncbi.nlm.nih.gov/articles/PMC3876179/

[6] Jenkins, T. (2022, October 11). *Parenting Teens: Their Unique Struggles and How to Support Them*. Comprehensive Behavioral Health Center. https://cbhc1.org/how-to-support-parenting-teens/

[7] Cox, J. E., Harris, S. K., Conroy, K., Engelhart, T., Vyavaharkar, A., Federico, A., & Woods, E. R. (2019). A Parenting and Life Skills Intervention for Teen Mothers: A Randomized Controlled Trial. Pediatrics, 143(3). https://publications.aap.org/pediatrics/article-abstract/143/3/e20182303/76780/A-Parenting-and-Life-Skills-Intervention-for-Teen?redirectedFrom=fulltext

[8] Aizer, A., Devereux, P. J., & Salvanes, K. G. (2020). Grandparents, Moms, or Dads? Why Children of Teen Mothers Do Worse in Life. *SSRN Electronic Journal*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3708643

[9] *Young Women - Roca*. Roca. (n.d.). https://rocainc.org/how-we-do-it/outcomes/young-mothers/

court. In FY24, the OCA conducted a review of FRCs and issued an April 2024 report making recommendations for improvements to the FRC structure and operations.

Findings and recommendations in the FRC report are based on information gathered from interviews and focus groups with a wide variety of executive branch, legislative, and judicial stakeholders, community and advocacy organizations, FRC staff, and FRC consumers, as well as an analysis of a large amount of data on FRC operations and children involved in other state systems, including DCF and the CRA system. The findings from the report indicate that while FRCs provide valuable support to families across the Commonwealth, there is considerable variation from one FRC to another. Further, the recent expansion of the role and scope of FRCs without staffing or budget expansions has led to staff stress and reduced focus on preventing systems involvement. Similarly, the landscape of human services has changed in critical ways since FRCs were first procured, resulting in duplication of services and/or lack of alignment in key areas. Many more families across the Commonwealth could likely benefit from FRC services. Increased alignment with, and support from, other state and local entities would help improve FRC effectiveness.

The report also issued recommendations for improvement in the following categories:

- Focus FRCs on a priority goal of preventing entry (or re-entry) to the child protective services and Child Requiring Assistance systems.
- Expand funding for FRCs, which should be funneled toward increasing staff and expanding sites.
- Enhance support from, and integration with, other state systems and services.

In FY25, the OCA will continue to advocate for these recommendations with the Legislature and key state agencies. The OCA will also offer continued technical assistance to support the advancement of these vital changes.

The OCA in Action: Ensuring a Safer Future

Megan contacted the OCA on behalf of her son Albert*, who was physically assaulted by a counselor at an after-school program. Megan reported that the incident was significant in nature and resulted in the counselor's termination from the program as well as Albert needing therapy to process the incident. Megan's concerns included poor communication from the program about the incident and poor communication from DCF regarding the investigation. The OCA discovered that several reports of abuse and neglect were filed with DCF on behalf of Albert regarding the assault, and both were screened out, with the rationale that the child is no longer at risk from the counselor as a result of the counselor's termination. The OCA reached out to the DCF area office about the need to investigate the incident to ensure there is no future risk to other children. The area office filed a new report which was supported so that the abusive counselor is now listed in DCF's central registry of abusers.*

Child Sexual Abuse Prevention Task Force

The OCA has served as the co-chair of the Child Sexual Abuse Prevention (CSAP) Task Force in partnership with the Children's Trust since 2014. Although the Task Force's legislative authorization expired in November 2022, the work of the Task Force continues through the commitment of the OCA and the Children's Trust and continued funding from the General Court. The OCA and Children's Trust chose to transition the Task Force into an advisory council following the end of the group's statutory authorization. The advisory council continues to convene experts in the field to discuss CSAP strategies and to implement the Safe Kids Thrive website, which provides modules for youth-serving organizations to conduct a self-assessment to evaluate child safety and then adopt the sexual abuse prevention framework.

In FY25, the OCA and Children's Trust will complete development and begin implementation of a new three-year strategic plan focused on the following six goals:

- Increase youth-serving organizations' awareness of, access to, and utilization of CSAP training and technical assistance.
- Develop a comprehensive approach to the response and prevention of problematic sexual behaviors in children and adolescents.
- Build awareness of CSAP and improve access and utilization of CSAP resources for parents and caregivers.
- Enhance state policies and programs to promote CSAP and reduce systemic barriers to implementation.
- Increase the availability of CSAP research and data critical to meeting CSAP goals.
- Refocus CSAP partnerships to successfully implement the previously listed goals.

The OCA will lead projects related to policy development, legislative advocacy, and research to advance these goals.

Goal 3: Transition Into Adulthood

> Youth receiving state services transition into adulthood with the support they need to succeed.

Supporting High-Risk Young Mothers

Transitioning into adulthood comes sooner and is fraught with additional challenges for young parents, especially young mothers. The Department of Transitional Assistance (DTA) and the Department of Public Health oversee programs focused on supporting young mothers, including a service provider network of close to 100 providers. CCWT partnered with DTA and DPH to increase trauma responsive resources training and technical assistance to that provider network. In FY24, the team developed an eight-module toolkit for young parent providers and implemented a five-session training series for the provider network on the toolkit, covering topics such as the developmental needs of adolescents, trauma resilience and healing-centered engagement, and best practices in working with parents under 25. The toolkit was successfully piloted and fully launched in October 2024 and can be found at Supporting Parents Under 25: A toolkit for, and by, Young Parent Program—Child Trauma and Wellbeing. Assuring that services

for young parents are trauma-informed and responsive improves service delivery and can support successful transition into adulthood.

Transition Aged Youth Housing Stabilization & Support Program

For youth transitioning to adulthood from childhood involvement with state systems such as DCF, it is vital they have access to safe and stable housing once they turn 18 years old. Youth can opt in for additional DCF services after they turn 18, although some youth choose not to do so. Youth who do not opt in for additional services are at high risk of homelessness, disrupted education, unemployment, and behavioral health challenges.

In early 2021, the OCA partnered with the Executive Office of Health and Human Services (EOHHS) to launch a Transition Aged Youth (TAY) Housing Stabilization and Support Program (HSSP) pilot project. The goal of this project was to better connect youth in DCF custody with supports to help their transition to adulthood when those youth choose not to sign a Voluntary Placement Agreement post-age 18.

The HSSP program provides youth (17 and over) who have decided not to opt in to DCF services after turning 18, or are unlikely to opt in, with access to a dedicated young adult housing stability specialist employed by a community-based organization, who can help them connect to housing, education, employment, income, and other supports.

For the first several years of the program the OCA and EOHHS partnered with UMass Chan Medical School to conduct an evaluation of the program. Data from the program shows that the HSSP has yielded a consistently positive impact on its participants, as youth were significantly more likely to have secure housing and employment after participation.

The FY24 evaluation concluded the pilot and evaluation phases of this successful program. From FY25 onward, data collection and analysis will be conducted by EOHHS. The OCA supports the transition to a solely EOHHS program. This is consistent with the OCA's strategy of partnering with state entities to design, implement, and evaluate innovative pilot programs and then step back once that phase is complete and the program is established.

Goal 4: Addressing the Needs of Diverse Populations

Our state child-serving systems are addressing the needs of traditionally underserved populations, including racially and ethnically diverse populations, LGBTQ+ youth, and newcomer families.

Trauma-Informed and Responsive Services for Newcomers

The number of migrant families coming to Massachusetts has significantly increased in recent years and includes many children and families who experienced significant trauma.[10] In response to this increase in newcomers, the Commonwealth created Welcome Centers and

[10] "...the administration has logged more than 11,000 migrants from October 2022 through September 2023, the federal fiscal year. That represents an increase of more than 152 percent over the previous fiscal year." Gross, S. J. (2024, April 1). How Many Migrants Have Arrived in Massachusetts? It's Hard to Know for Sure, but They Keep Coming. - The Boston Globe. BostonGlobe.com. https://www.bostonglobe.com/2024/04/01/metro/how-many-migrants-in-massachusetts/

placed families with children in need of housing in hotels and other non-traditional locations. Due to the exigency of the situation, some shelters were set up quite rapidly. Shelter staff quickly recognized the acuity of the needs of the newcomer families and how deeply affected many of them are by trauma.

CCWT partnered with the Executive Office of Housing and Living Communities (EOHLC), EOHHS, and the Department of Early Education and Care (EEC) to support shelter staff providers and other staff working to support newcomers. CCWT immediately responded, creating and executing training to providers on trauma-responsive interventions and tools. Over 1,000 attendees across the Commonwealth, including providers working with children in shelters, participated in the three-part training series. Sessions focused on understanding trauma and its impact on newcomers; promising practices for working with newcomers, with a focus on reducing or preventing re-traumatization; and addressing the secondary traumatic stress experienced by staff providing support to these children and families. While initially focused on the EOHLC and EEC's Coordinated Family and Community Engagement (CFCE) contracted partners, the training series expanded to include staff from various child-serving systems statewide, such as DTA, DCF, DPH, and public schools from multiple districts. Representatives from Catholic Charities, Boys and Girls Clubs, YMCAs, and other agencies across the Commonwealth also participated. Over 90% of participants indicated that they found the sessions provided valuable information that improved the quality of how they interacted with newcomer families and children.

Beyond training support, the OCA also provided concrete material resources. Shelters at hotels and other nontraditional shelter sites had limited places for young children to play. The OCA provided funding to EEC to create play spaces in larger hotel and emergency shelter locations. The play spaces were designed to be trauma-informed, using a soothing color palate and natural woods and incorporating toys that encourage creativity, allowing children to develop their own play, rather than pre-scripted materials or toys with batteries.

The OCA also provided funding for EEC to expand services for families with young children. The funds allowed 22 CFCE grantees to increase the provision of multi-generational and related child development activities for 7,435 children in 37 emergency assistance shelters. In addition to running a large number of playgroups, the funding allowed for the purchase of supplies and materials given to families to extend learning, such as books in Haitian Creole, Spanish, Portuguese, and English. Over 5,580 educational materials (e.g. culturally and developmentally relevant items, such as counting blocks, puzzles, and spatial awareness toys) and over 8,690 books were distributed.

Assessing Opportunities for Improving Language Access to Services

One in four Massachusetts residents speaks a language other than English at home.[11] Language access is critical to ensuring individuals are aware of, able to access, and benefit from supports available to them. However, sufficient language access supports are inconsistently available in

[11] Census Bureau Profile—Massachusetts. https://data.census.gov/profile/Massachusetts?g=040XX00US25

many government services, creating a major barrier for individuals accessing government-provided services, resources, and information.

On September 13, 2023, Massachusetts Governor Maura Healey signed Executive Order #615, Promoting Access to Government Services and Information by Identifying and Minimizing Language Access Barriers. The purpose of this Executive Order is to ensure equitable delivery of services and resources for residents with limited English proficiency (LEP) by requiring Massachusetts executive department agencies to develop language access plans. This is a welcome development demonstrating the Commonwealth's commitment to addressing this challenge.

Providing sufficient language access can be a particular challenge for state-contracted child and family service providers, which in many cases are smaller community-based organizations. The OCA is working in partnership with service providers to identify gaps and opportunities for improvement as well as creative solutions, including those that could be deployed more efficiently at scale, with the goal of making recommendations to state agencies that fund these services.

Throughout FY24, the OCA interviewed individuals at state-contracted child and family service organizations to better understand the challenges service providers face in serving families for whom English is not a primary language. These interviews informed the development of a language access needs-assessment survey covering the following domains:

- Understanding how LEP individuals interact with state-contracted service providers.
- Identification and assessment of LEP communities that are served by service providers.
- Provision of language assistance services.
- Organizational policies and contracted staff training.

The OCA's research and work in this area will continue in FY25.

Toolkits for Providers Working with LGBTQ+ Youth

LGBTQ+ youth experience higher levels of trauma, bullying, harassment, violence, physical and sexual abuse, and bias compared to their heterosexual and cisgender peers.[12] They also experience higher levels of suicide and mental health complexities. Ensuring that human services providers can recognize and address the needs of LGBTQ+ youth, which can help them better support these youth who may be dealing with challenging situations, is a critical goal of the OCA.

In FY24, CCWT partnered with experts, including an LGBTQ+ youth advisory group, to develop a series of trainings and toolkits to support providers working with the LGBTQ+ youth population. This process included determining local and national best practices, working with experts who identify as LGBTQ+, completing interviews and focus groups with LGBTQ+ youth, and developing a series of trainings for community providers, educators, and healthcare workers.

[12] Tran, N. M., Henkhaus, L. E., & Gonzales, G. (2022). Adverse Childhood Experiences and Mental Distress among US Adults by Sexual Orientation. *JAMA Psychiatry*, 79(4), 377. https://pubmed.ncbi.nlm.nih.gov/35195677/

CCWT developed three online toolkits geared to specific provider populations. By tailoring the information to each setting, providers can obtain concrete solutions and approaches to reducing trauma, healing, and promoting resilience for LGBTQ+ youth.

Goal 5: High/Complex Behavioral Health Needs

> The needs of children and youth with high and/or complex behavioral health needs—including the need for timely delivery of and navigation to appropriate support—are met.

Addressing Problematic Sexual Behavior

Children who exhibit problematic sexual behaviors (PSB)[13] can face complex behavioral health and educational challenges that greatly impact their lives at home and in their communities. Although they may at some point and in some circumstances become involved with the child protection and/or juvenile justice systems, there is no one state agency statutorily responsible for ensuring that children with PSB receive the appropriate interventions and services. Instead, there is a patchwork system for identifying and serving children in need of support in this area. And despite the efforts of many, critical service gaps exist.

As co-chair of the Massachusetts Legislative Task Force for the Prevention of Child Sexual Abuse, the OCA received concerns from professionals across sectors regarding these gaps in services for children who engage in PSB. Research shows that most sexual assaults of children are committed by other children; it also shows that with the right therapeutic supports, children who exhibit PSB are highly unlikely to recidivate.[14,15] This means that addressing the needs of children with PSB is vital both for the children themselves and for child sexual abuse prevention in general.

OCA staff conducted interviews with over 60 providers and stakeholders across child-serving sectors about PSB, including members of the CSAP PSB working group, followed by quantitative data analysis of the findings and an extensive review of evidence-based research on this topic. Through that work the OCA found that in Massachusetts:

- Many of the identification and referral pathways for PSB do not lead to services for children.
- There are gaps in services to prevent and effectively respond to PSB.
- There are inequitable and, at times, overly punitive responses to PSB incidents.
- There is a lack of data to inform needs and system response.

[13] Problematic sexual behaviors involve sexual body parts, happen outside of children's expected developmental trajectory, cause harm to the child who is exhibiting the behaviors or to others, and do not respond to typical caregiving strategies.
[14] Finkelhor, D., Ormrod, R., and Chaffin, M. (2009, December). Juveniles Who Commit Sex Offenses Against Minors. *Juvenile Justice Bulletin*. https://www.ojp.gov/pdffiles1/ojjdp/227763.pdf.; Gewirtz-Meydan, A. and Finkelhor, D. (2019). Sexual Abuse and Assault in a Large National Sample of Children and Adolescents. *Child Maltreatment, 1*(12). https://doi.org/10.1177/1077559519873975
[15] Kelley, A., Shawler, P., Shields, J. and Silovski, J. (2019, April). A Qualitative Investigation of Policy for Youth with Problematic Sexual Behavior. Journal of Community Psychology, 47(6), 1347–1363. https://doi.org/10.1002/jcop.22187 ; Caldwell M. F. (2010). Study Characteristics and Recidivism Base Rates in Juvenile Sex Offender Recidivism. International Journal of Offender Therapy and Comparative Criminology, 54(2), 197–212. https://doi.org/10.1177/0306624X08330016

In FY25, the OCA will release a report detailing the above-mentioned findings and making recommendations for Massachusetts to have a more effective and trauma-responsive system of supports for children who engage in PSB and their families.

Supporting Children with Trauma-Related Behavioral Needs in Early Education & Care Settings

Trauma can have significant impacts on a child's physical and emotional well-being. When children experience trauma, it can affect their ability to form relationships, regulate their emotions, and learn. Early education and care settings offer unique opportunities to promote safety and well-being for children with trauma histories. Trauma-informed and responsive approaches in early learning settings can reduce stress, anxiety, and depression in children. They can also reduce educators' stress and feelings of helplessness when they are responding to children with trauma histories. Creating a trauma-informed and responsive early education and care environment is critical for supporting the needs of children who have experienced trauma and ensuring their success in learning and development.

Educators may struggle to support children with trauma-related behavioral needs. Early education and care programs often struggle to prevent exclusionary practices in response to challenging behaviors. To address this challenge, CCWT is partnering with EEC to design and implement a multi-pronged approach to developing and sustaining a trauma-responsive early education system.

This work includes:

- **Learning Management System Training:** Developing an online foundational training in trauma, race, resilience, and the Guiding Principles of Trauma-Informed and Responsive Care for all EEC providers. This asynchronous training was completed in December 2024 and will be provided to all early childhood educators starting in February 2025.
- **Professional Development Core Champions Training:** To continue supporting educators to develop their trauma-responsive skills, this series will offer additional training and technical assistance to support educators and program staff and prepare them to cope with the challenging work of serving young children impacted by trauma and their families. The series will launch in February 2025.
- **Trauma-Responsive Training for Frontline EEC Staff**: To support EEC licensors and investigators, CCWT is offering full-day trainings on trauma, race, and resilience. This work will launch in January 2025.

Autism Spectrum Disorder (ASD) and Unintentional Fatalities Due to Wandering

Since 2018, the OCA has collaborated with the chair of the Child Fatality Review (CFR) program in the Office of the Chief Medical Examiner (OCME) and DPH to implement and continuously improve the CFR program.[16] As part of that effort, the CFR program began exploring demographic inequities in child fatalities in 2020. In FY24, the program focused on exploring inequities in fatality rates associated with autism spectrum disorder. While ASD is not a life-limiting diagnosis, specific behaviors and an affinity for water sometimes seen in children with ASD can contribute to an increased risk of unintentional fatality.[17,18] A 2017 study of National Vital Statistics data from 2010-16 reported that drowning was the leading cause of death for children with ASD, many instances of which occurred within the context of unsupervised elopement from the child's home (also known as wandering).[19] In FY24, CFR staff conducted a literature review and more than 40 key informant interviews to gather information on best practices in wandering prevention and the accessibility of those best practices in Massachusetts.

The OCA in Action: A Door to Children's Rights

Gabrielle is a 17-year-old youth in the custody of DCF who resides out of state in a congregate care setting. Gabrielle contacted the OCA reporting that the door to her bedroom was taken off the hinges. Gabrielle stated this was a concern for her because she was unable to use her coping skills privately when she became dysregulated. The OCA contacted both Massachusetts DCF and the out-of-state agency advocating for Gabrielle's door to be returned, as removal of the door is a violation of her rights. The OCA learned that the program has a 'no-closed-door' policy and will remove doors from youth to ensure their safety. The out-of-state licensing agency noted that there are no restrictions in their regulations about removing a youth's door. As a result, updates are being made to the licensing agency's rules and regulations, making it a violation of a child's rights to remove their bedroom door.*

Promoting Trauma-Responsive Practices in Schools

Since 2021, there has been an increase in mental health disorders in youth, including depression, anxiety, and suicidal ideation.[20] This increased prevalence of mental health challenges is concerning, especially because mental health challenges were already the number one cause of disability and poor life outcomes in young people before the COVID-19 pandemic.[21] The OCA, through CCWT and in partnership with Thriving Minds, has supported

[16] See Appendix B: Boards and Commissions for additional information about Child Fatality Review.
[17] Catalá-López, F., Hutton, B., & Page, M. (2022). Mortality in Persons With Autism Spectrum Disorder or Attention-Deficit/Hyperactivity Disorder. JAMA Pediatrics. https://doi.org/10.1001/jamapediatrics.2021.6401
[18] Guan, J., & Li, G. (2017). Characteristics of Unintentional Drowning Deaths in Children with Autism Spectrum Disorder. *Injury Epidemiology*, *1*. https://doi.org/10.1186/s40621-017-0129-4
[19] Guan, J., & Li, G. (2017). Injury Mortality in Individuals with Autism. *American Journal of Public Health*, *5*, 791–793. https://doi.org/10.2105/ajph.2017.303696
[20] Office of the Surgeon General, Youth Mental Health (2025). Retrieved from https://www.hhs.gov/surgeongeneral/reports-and-publications/youth-mental-health/index.html
[21] Ibid.

youth in school settings through a training and technical assistance group focused on mental health in schools.

In FY24, Thriving Minds offered more than 25 professional learning community sessions in four different series, to share information with practitioners across schools and districts and to support the implementation of specific strategies for advancing mental health and trauma-responsive practices. Topics included Navigating the Effects of Vicarious Trauma; Trauma-Focused Therapeutic Supports: Practices and Techniques for School Mental Health Staff; Special Topics on Marginalized Populations; and Unpacking Tier I Trauma-informed Supports for Students. Thriving Minds also provided tailored coaching for over a dozen school districts working to implement trauma-responsive practices and strengthen students' social and emotional learning, behavioral and mental health, and wellness. Each district was paired with an experienced coach who provided ongoing support and guidance.

Goal 6: Awareness of Services

> Families and youth, and those who serve them, are aware of available supports and services.

Youth Engagement Initiative and Increased Complaint Line Outreach

The OCA Complaint Line is available for anyone to express concern or seek information and resources about a state service a child or young adult is receiving or is eligible to receive, and our statute prioritizes youth as a target group for the Complaint Line. Yet, consistent with prior years, in FY24 youth accounted for roughly 2% of the individuals who contacted the Complaint Line. The OCA recognizes this lack of contact from youth is likely due to a lack of awareness of our Complaint Line among this population.

To better reach youth, the OCA designed a Complaint Line outreach campaign specifically to ensure that youth who may need information, guidance, or help are aware of the OCA Complaint Line and how to access it. This project is called the OCA Youth Engagement Initiative and is designed with an initial focus on youth in congregate care settings. The OCA drafted materials, including a poster, and engaged with providers and others for feedback as to the best ways to disseminate these materials. The OCA surveyed employees of DCF, DYS, the Department of Mental Health (DMH), the Commission on LGBTQ Youth, the Children's League of Massachusetts, and others to develop these materials. The poster will be displayed in EEC-licensed congregate care facilities aiming to increase awareness of the Complaint Line. See Appendix F: Complaint Line Poster for the poster.

In addition to outreach to youth, the OCA is continuously working to increase awareness about the Complaint Line more generally. In FY24 the OCA conducted three briefings for legislators and their staff about the Complaint Line. The OCA also hosted meet-and-greets with other state ombuds, including with DMH, the Department of Developmental Services (DDS), DCF, MassHealth, the Massachusetts Commission for the Blind, and the Massachusetts Commission for the Deaf and Hard of Hearing. We continue to update the resources listed on the OCA

website to streamline information and resources. The OCA plans to continue this outreach in the next fiscal year.

Service Mapping and System Navigation

Through the Complaint Line, OCA quality assurance staff provided support to 379 people as they navigated ombuds, legal, child protective services, and educational systems. Providing that navigation requires constant scanning of the service landscape in Massachusetts and staying abreast of new and changed agency policies and programs. To support that work, OCA staff undertook a service mapping project by compiling a list of procurements, contracted entities, and programs that provide direct services to children.[22]

The service mapping project led to a rudimentary overview of all state-provided child services in Massachusetts. According to the search, 21 state agencies provide direct service using well over 200 service models and with over 12,000 licensed, contracted, or regulated organizations. Findings from that landscape assessment were vetted with select agencies and shared with key partners on an as-needed basis. The project highlights the depth of programs and services available in Massachusetts, as well as the challenge facing people who are trying to navigate the service landscape and maintain up-do-date lists of services, providers, and eligibility. The OCA is exploring service and system navigation landscapes for opportunities to streamline access to, and information about, state-sponsored direct services.

Understanding Trauma Supports for Massachusetts Children and Families

As chair of the Childhood Trauma Task Force (CTTF), the OCA staffs the research, writing, and presentation of findings about how the Commonwealth can better identify and provide services to youth who have experienced trauma. In FY24, CTTF's research efforts focused on learning more about trauma supports in three key sectors: early education and care, K-12 schools, and juvenile justice. To better understand these supports, CTTF set up panel presentations from state agencies and community-based organizations about their efforts to support children and families who have experienced trauma as well as the staff that works with them. These presentations are discussed in CTTF's 2023 Annual Report. The report shares that there is no single repository of all available trauma services in Massachusetts. Organizations often develop their own provider directories for internal use, while others rely on various existing directories. Directories available to the public include:

- Massachusetts Behavioral Health Help Line, funded by DMH and operated by the Massachusetts Behavioral Health Partnership, connects individuals to a range of treatment services for mental health and substance use.
- LINK-KID, a referral system of UMass Chan Medical School, was created to streamline access to evidence-based trauma treatments.

[22] The OCA defines direct services as "any type of state-sponsored assistance or support that involves personal interaction between a provider and a recipient." In Massachusetts, some direct services are provided by Commonwealth employees, some are regulated or licensed by the Commonwealth, and some are delivered through contracts, which are governed by procurements and funding criteria.

- Network of Care Massachusetts, a directory of over 5,000 programs and organizations across the Commonwealth, is managed by the Massachusetts Association for Mental Health and privately funded.
- Massachusetts Behavioral Health Partnership's directory includes over 1,200 behavioral health providers from their network.
- William James College INTERFACE Referral Service is a toll-free line to help families find licensed mental health providers that match the caller's location, insurance, and specialty needs. This service is only open during the workday and is limited to 53 participating municipalities in Central Massachusetts, MetroWest, and the South Shore.

In FY25, the OCA will continue to focus on better understanding related training requirements of professionals working for child-serving state agencies.

The OCA in Action: Addressing Concerns and Ensuring Better Care

Annabelle contacted the OCA with concerns for their 16-year-old daughter, Genevieve*. Genevieve has been involved with DMH for years due to concerns around suicidal ideations and self-harming behaviors. Annabelle had concerns regarding Genevieve's treatment while in a DMH facility as Genevieve was making minimal-to-no improvements. The OCA reached out to DMH and was able to discuss Annabelle's concerns regarding Genevieve with DMH senior leadership. With this collaboration the OCA was able to learn more about Genevieve's needs. Genevieve was able to be transferred to another intensive DMH facility where some of Annabelle's concerns could be addressed.*

Goal 7: High-Quality Data

Our state agencies serving children and families use high-quality data to inform decision making and continuous quality improvement.

Juvenile Justice Policy and Data Board Annual Data Report

The JJPAD Board, which is chaired and staffed by the OCA, released its 2023 JJPAD Annual Report in January 2024. This report describes FY23 juvenile justice system data trends and key takeaways, including:

- **There was an increase in use of the juvenile justice system in Massachusetts** in FY23 compared to FY22, and, generally, there has been an increase in system use since pre-pandemic (FY19). This increase begins at the "front door" of the system with an increase in applications for complaint (driven in particular by an increase in arrests) and continues through all major court process points.
- **This increase is driven by increases in cases involving youth alleged of misdemeanor/lower-level offenses**. This is true even at process points that involve taking a youth into custody (e.g., arrests, detention), which generally involve more serious offenses.

- The number of cases of youth entering and moving through the juvenile justice system in FY23 was lower than it was prior to passage of the Criminal Justice Reform Act (CJRA) (FY18). However, **if the recent rates of increase over the past two years continue, system use will revert to pre-CJRA levels in the next one to two years.**
- Additionally, **racial and ethnic disparities worsened at the beginning stages of the system compared to the prior fiscal year,** particularly with regard to applications for complaint brought by arrest rather than by a court summons.
- Youth held at DYS have higher rates of behavioral health needs, educational challenges, and—in some cases—trauma than last fiscal year, including an increase in the percentage of youth detained who have current child welfare system involvement.

JJPAD encouraged the state to implement the numerous recommendations that it has made in prior reports within the following three themes:

- Increase opportunities to divert youth away from the system prior to court involvement.
- Address the policies and practices in the Commonwealth contributing to racial and ethnic disparities in the juvenile justice system.
- Improve the triaging of and access to supports for youth with unmet needs.

The OCA will publish the JJPAD's 2024 Annual Report in early 2025.

Juvenile Justice Data Website

To make informed policy recommendations, our state agencies and the public need access to high-quality data across all juvenile justice system process points. The OCA's Interactive Juvenile Justice System Data Website was created with that mission in mind, using data provided to the OCA by our partners in the judiciary and executive branches through the annual JJPAD data collection process.

The OCA partnered with our colleagues at the Executive Office of Technology Services and Security to launch the webpage in 2020, with significant input and collaboration with the entities contributing data to the website. The website was launched in 2020, and the OCA continues to build new pages as juvenile justice system partners have increased their data availability.

In FY24, OCA staff maintained the data website, updated the data to include FY23 trends, and (as discussed below) created a new page dedicated to measures of racial and ethnic disparities.

In FY25, the OCA plans to release new webpages dedicated to presenting data on how youth enter the juvenile justice system (i.e., arrests/summons) and how cases are resolved. The OCA will update data across the website to include FY24 updates.

Racial and Ethnic Disparities in our Juvenile Justice System

It is well documented that racial and ethnic disparities are persistent in our state's juvenile justice system. The OCA-chaired JJPAD Board has highlighted these disparities in the juvenile justice system in each of its annual reports as well as in its 2022 Racial and Ethnic Disparities at the Front Door of Massachusetts' Juvenile Justice System. To address racial and ethnic

disparities in a system as complex as the juvenile justice system, comprised of multiple state and local agencies, our state must rely on accurate data reporting and measures of disparity. This data must be accessible to the public. Toward this aim, in FY24, the OCA launched a new page on our Juvenile Justice System Interactive Data Website that reports specially on racial and ethnic disparities over time and across process points in the juvenile justice system.

This new racial and ethnic disparities page explains **how** we measure disparities in the juvenile justice system and gives users the ability to explore the racial and ethnic disparities that exist across juvenile justice process points and over time. The dashboards detail data reported by the Trial Court, Massachusetts Probation Services, and DYS as part of the JJPAD Board annual reporting process.

DCF Annual Report Public Comment Project

In December 2022, the Child Welfare Data Work Group (DWG), co-chaired by DCF and the OCA, released its final report based on a multi-year analysis of ways to streamline and improve public reporting by DCF. The DCF FY22 Annual Report reflects the changes recommended in DWG's final report.[23] To ensure the redesigned report accomplishes the goals set before the DWG, the OCA issued a request for public comment in June 2023. The public comment request guided members of the public to submit written comments about the utility of the FY22 Annual Report and the extent to which the redesign meets the needs of the public.

The OCA received seven responses to the call for public comments. Respondents acknowledged the improvements made in the DCF annual report and stated that more of the data they are looking for is now available. They also provided feedback and insight into additional data, context, and analysis that they believe would improve the utility of the DCF annual report. Those improvements most frequently related to reporting on education, neglect allegation subclassifications, consumer characteristics, budget revenue and expenditures, decision-making, placements, and service provision. In particular, respondents were looking for improvements and additions to stratifications by identity characteristics, such as race, ethnicity, and gender identity. In total, respondents requested an additional 152 metrics, submitted 20 research questions related to their work, and provided numerous examples of additional narratives, explanations, and definitions that, if addressed, would better serve their needs.

In collaboration with DCF, the OCA reviewed each response, organized the requests and feedback, then conducted a feasibility assessment. The assessment showed that several of the requests are now feasible using the new Child Protective Services Dashboard, which launched in July 2023, or through sources such as the Foster Care Review Annual Report and National Youth In Transition Data Set. It also found that many requests are currently being considered by DCF, while others need additional information or clarity, or pose data quality or privacy concerns. Overall, the assessment found that while the new annual report structure is more complete, there is still more that can and should be done to ensure child protective services data are as transparent, robust, and user-friendly as possible.

Based on the review, the OCA makes the following five priority recommendations:

[23] FY22 took place from July 1, 2021-June 30, 2022.

- DCF, the Department of Elementary and Secondary Education (DESE), and the OCA should develop a strategy for making information on educational outcomes for DCF-involved children more accessible and robust.
- DCF should define subcategories for neglect and work to build more nuanced neglect reporting into the DCF data structure.
- DCF should add additional data metrics to the annual report where feasible, especially related to mandated reporting and TAY.
- DCF should continue to conduct an annual review to determine if metrics with data quality concerns have improved enough to be considered for reporting.
- The Legislature should ensure DCF and the Executive Office of Health and Human Services Information Technology team that supports DCF are adequately staffed and funded to produce highly contextualized and robust data reports.

Respondents and the OCA acknowledge that addressing everything described in the comments would take time and that a staggered improvement approach would achieve more in the long run.

Goal 8: OCA Capacity

The Office of the Child Advocate has the expertise, reputation, relationships, capacity, and operational infrastructure to execute its mission.

Incorporation of the Center on Child Wellbeing & Trauma

The Center on Child Wellbeing & Trauma was incorporated into the OCA. This move provides the Commonwealth with an evidence-based state agency resource for training and technical assistance related to trauma-informed and responsive practices for children.[24]

Growth in Staff & Operations

The incorporation of CCWT required the OCA to create new positions to support both the work of CCWT as well as the operations of the OCA. In total, the OCA grew from 20 staff at the end of FY23 to 30 at the end of FY24. To support the growing team, the OCA revised the employee handbook and engaged all staff in strategic planning and updated policies. The senior leadership team created a plan for regular all-staff in-service training and professional development sessions geared toward intra-agency engagement, knowledge sharing, and collaboration.

Data Collection CQI

The OCA is committed to excellence and believes that continuous quality improvement, including regular reviews and updates to our data collection system and reporting structure, will enable us and the agencies we oversee to deliver timely, effective, and culturally responsive services. As such, substantial changes were made to the OCA data collection system in FY24. The OCA revised our data collection system to streamline reporting on areas that we have determined are of concern, to streamline findings from OCA case reviews, and to track the

[24] See About the Office of the Child Advocate, pg. 96.

OCA's follow-up and outreach to state agencies. Since 2018, the OCA has utilized Salesforce, a cloud-based database system, to record and track the work of the OCA quality assurance team. Salesforce allows the OCA to track quantitative and qualitative information about children, perpetrators, institutions, and other incident-specific information that comes to our attention. It also provides flexibility to customize data metrics and reports to identify emerging and ongoing trends across the child-serving system.

The revision to the data collection system resulted in improvement in the OCA's capacity to identify concerns with the provision of state services, regardless of how the information was brought to the OCA's attention. The revision also permitted the collection of additional information about the actions the OCA took to address issues it identified through a case review and an external agency's response to the OCA's feedback. Finally, the system revision streamlines data collection of identity characteristics such as race, ethnicity, sex, gender, sexual orientation, disabilities, and systems involvement.

Oversight Functions

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

- **Complaint Line**:[25] Respond to concerns about state services provided to individual children or families. Youth, 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 is receiving or eligible to receive.
- **Critical Incident Reports**:[26] Receive and review reports from state agencies regarding children or youth who die or experience a near fatality, serious bodily injury, or an emotional injury while receiving state services.
- **Foster Care Review Safety Alerts:**[27] Receive and review DCF Foster Care Review safety alerts (as of July 2022).
- **Supported Reports of Abuse and/or Neglect in Out-of-Home Settings**:[28] Receive and review DCF reports of supported allegations of abuse and/or neglect of children in out-of-home settings.
- **Investigations:** The OCA may initiate a formal investigation when we determine the actions or inactions of a reporting agency were egregious and significantly contributed to the harm of a child or young adult. Typically, a critical incident report brings cases to our attention for investigation, though the OCA has discretion to investigate any matter that aligns with our statutory oversight obligations. Formal investigations may be non-public or public. Formal investigations include recommendations for implementation which the OCA monitors through our ongoing oversight.[29]

[25] See Appendix E: Glossary of Terms for definitions.
[26] See Appendix E: Glossary of Terms.
[27] Foster Care Review Safety Alerts are not a statutory obligation of the OCA, however they are reviewed and analyzed in the same fashion as CIRs. For more information about Foster Care Review safety alerts, see the FY23 OCA Annual Report. https://www.mass.gov/doc/oca-annual-report-fiscal-year-2023/download
[28] See Appendix E: Glossary of Terms for definitions.
[29] The two most recent public investigations are Office of the Child Advocate Investigative Report: Harmony Montgomery, 2022 and Office of the Child Advocate Investigative Report: David Almond, 2021

Table 1: OCA By the Numbers, Fiscal Year 2024			
Statutory Mandate	**Reports or Inquiries**	**Children Involved**	**Resulting in OCA Follow Up**
Complaint Line[30]	532	528	109 (20%)
Critical Incident Reports	278	380	148 (53%)
Foster Care Review Safety Alerts	15	17	11 (73%)
DCF-Supported Reports of Abuse and/or Neglect in Out-of-Home Settings	465	676	158 (34%)

When a complaint, critical incident report, Foster Care Review safety alert, or DCF-supported report of abuse and/or neglect in an out-of-home setting is received, the OCA quality assurance staff conduct an immediate review to learn more about the circumstances that brought it to the attention of the OCA and any state agency involvement with the child and family. When the OCA determines that the actions or inactions of an agency may have contributed to the complaint or incident, or that the child, youth, or family is not receiving the services required to meet their needs, we may request additional reports from the agency, speak with agency senior leadership staff, and/or further review case records to learn more about the family's history and involvement with the agency. Through internal review of a complaint or report received, 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.

While the OCA reviews all complaints and reports received from or about all child-serving state agencies, the OCA's mandate is to focus on the children in the care and/or custody of DCF and DYS.[31] Complaints about DCF and reports received 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, and identify state agency policy, case practice, and service delivery concerns. **When the OCA determines follow-up with a state agency is necessary, we confirm that the agency involved received the OCA feedback and that all 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 to improve services for the family.**

In addition to our work improving the individual quality and delivery of services to children and families, the OCA uses the information reported to our office in these key areas to inform our

[30] This number includes both complaints and inquiries related to information and referrals. Complaint Line inquiries do not always involve a specific child, nor do individuals always share details about specific children for whom they have a concern or request.

[31] See Appendix E: Glossary of Terms for a definition of state custody. Please note, children in state custody are not always placed out-of-home.

work across the state child-serving systems. This includes identifying preventative actions the Commonwealth can take to reduce the incidence of harm to all children and young adults, making recommendations for policy and practice changes to prevent future risks to children, and identifying trends where the Commonwealth would benefit from additional data gathering and analysis. Our quality assurance work also informs us of our day-to-day oversight of state agencies, our participation in the Child Fatality Review program, our various other boards and commissions, and related research projects.

The following section of this report explains the OCA quality assurance core functions, findings, and actions taken based on the improved data captured in FY24. Additional years of data are presented where necessary to provide context and show 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 for anyone to express concerns or seek information and resources about a state service a child is receiving or is eligible to receive. While the Complaint Line operates Monday through Friday, 9 a.m.-5 p.m., anyone can email, submit a webform, or leave a voicemail at any time, and OCA staff will reach out within two business days. Anyone with concerns for a child receiving state services is encouraged to contact the OCA Complaint Line.

Complaint: An expression of dissatisfaction with any agency or program that provides services to a child of the Commonwealth.

Information and referral: A request for information, referral, or education on a specific topic.

OCA Complaint Line staff are skilled social workers who serve as system navigators and are available to provide support, information, resources, non-legal advice and, at times, be a neutral arbitrator between an individual and the agency of concern. When Complaint Line staff determine that the decision making or practices of a state agency places—or could place—a child at substantial risk, we contact the appropriate state agency through designated liaisons to ensure the child's safety and well-being as well as improvement of services. As mandated reporters, if the OCA staff have reasonable cause to believe a child has been maltreated or is at substantial risk of maltreatment, we immediately file a report of child abuse and/or neglect with DCF.

In FY24, the OCA received 532 Complaint Line inquiries. This is a 10% increase in inquiry volume compared to FY23 and is the highest volume of inquiries the OCA has ever received in a fiscal year.

As in prior years, 80% (424) of the Complaint Line inquiries involved a complaint while 20% (108) were requests for information or a referral. While each inquiry is presented as one case in

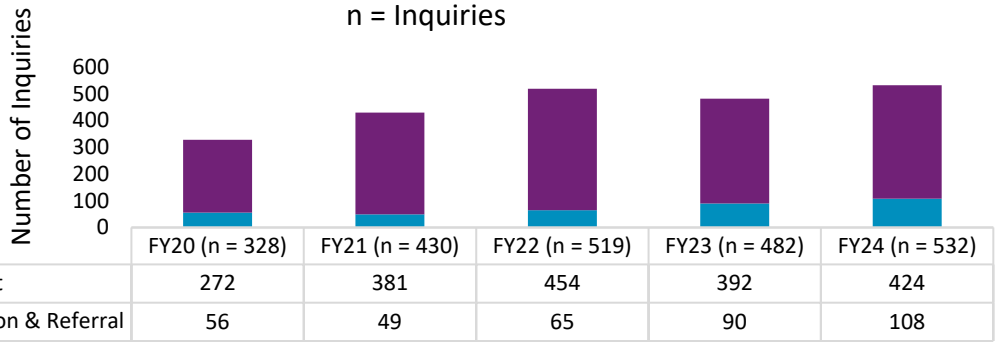
our data reporting here, each inquiry involves additional conversations and information-gathering efforts between the OCA, the individual, and the state agency involved.

Table 2: Complaint Line Key Metrics		
Metric	**Definition**	**FY24**
New Contacts	The number of individuals who contacted the OCA Complaint Line for the first time in FY24	325
Individuals Served	The total number of individuals who contacted the Complaint Line	379
Inquiries	The number of complaints and information/referral requests received through the Complaint Line	532

Figure 1:

Complaint Line Inquiries by Type of Inquiry and Fiscal Year

n = Inquiries



	FY20 (n = 328)	FY21 (n = 430)	FY22 (n = 519)	FY23 (n = 482)	FY24 (n = 532)
Complaint	272	381	454	392	424
Information & Referral	56	49	65	90	108

Demographics

The OCA collects demographic and social identity characteristics of the individuals who contact the Complaint Line. This data collection is intended to identify populations that could benefit from additional outreach, to allow for comparison to state service numbers for equitable representation, and to assess our own response.[32] Table 3 describes the percentage of the 379 individuals who contacted the Complaint Line for whom the OCA was able to collect identity characteristics.

Table 3: Collection of Identity Characteristics		
Characteristics	**Percent of Individuals with Data**	**Count of Individuals with Data**
Sex Assigned at Birth	82%	311
Gender Identity	58%	219
Race, Ethnicity	49%	186
Role/Relationship to Child	94%	357
Sexual Orientation	13%	50

[32] The OCA is continuously working to improve data collection for identity characteristics including race, ethnicity, sex assigned at birth gender, and sexual orientation.

As the majority of inquiries the OCA receives is about services to DCF-involved individuals, the OCA analyzed the above data and determined that the Complaint Line population is more representative of individuals served by DCF than it is of the general population, with Black, non-Hispanic (NH) and Hispanic individuals overrepresented compared to the general population. [33] Individuals who contact the Complaint Line are disproportionally multiracial compared to the Massachusetts population and DCF consumer population. White non-Hispanic individuals are also overrepresented in Complaint Line data compared to the population served by DCF. The data below show that Complaint Line awareness could be improved for individuals who are Hispanic or Latino, American Indian/Alaska Native, and Asian. The OCA recognizes that not all Complaint Line inquiries are made by people with state system involvement themselves, so the comparisons below are of interest but are not determinative of the reach the OCA has to persons who may find the Complaint Line helpful.

Table 4: Race and Ethnicity of Individuals Who Contact the Complaint Line Compared to the DCF Consumer Population and the Massachusetts Population

Race, Ethnicity	Individuals Who Contacted the OCA Complaint Line	DCF Consumer Population[34]	Massachusetts Population[35]
American Indian/Alaska Native, NH	0%	0%	1%
Asian, NH	0%	1%	8%
Black, NH	15%	16%	10%
Hispanic or Latino	21%	35%	14%
Multiple Races, NH	12%	5%	3%
White, NH	52%	43%	69%

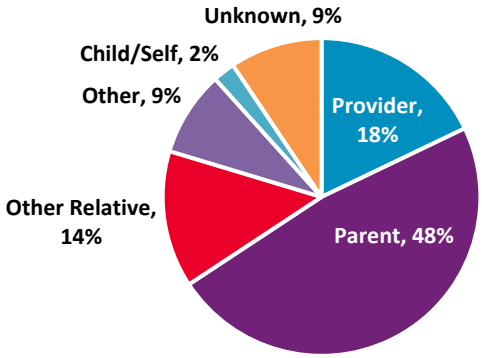
Individuals who contacted the Complaint Line were usually parents (48%), followed by providers (18%), and other relatives (14%).[36] Children themselves (2%) rarely contacted the Complaint Line. In FY24 the OCA began a targeted outreach campaign to youth living in congregate care settings to better reach and serve that population. To learn more, see Youth Engagement Initiative and Increased Complaint Line under Goal 6 of this report.

Individuals who contact the Complaint Line are slightly more frequently female than male (52% female, 48% male), with eight individuals identifying as transgender, gender-nonconforming, androgenous, or another gender identity (2%). Seventeen individuals who contacted the

[33] Because most inquiries to the Complaint Line involve inquiries or complaints about DCF or people with DCF involvement, Complaint Line data are compared with DCF consumer data.
[34] Excludes unknown and could not be determined. Asian includes Pacific Islander. Calculated based on child, youth, and adult consumers. FY23 DCF Annual Report, Table 7. https://www.mass.gov/doc/fy2023-dcf-annual-report/download
[35] U.S. Census Bureau, Quick Facts Massachusetts 2023. Accessed 10/25/2024. https://www.census.gov/quickfacts/fact/table/MA/PST045223
[36] In order of prevalence, providers were foster parents, mental health/therapeutic providers, case managers/advocates, attorneys, medical providers, school personnel, legislators/legislative staff, and law enforcement. Other relatives include grandparents (56%), aunts, and others (43%).

Complaint Line identified as asexual, bisexual, gay, questioning, or another sexual orientation (4%).

Figure 2:
FY24 Complaint Line Contacts by Role/Relationship to Child
n = 379



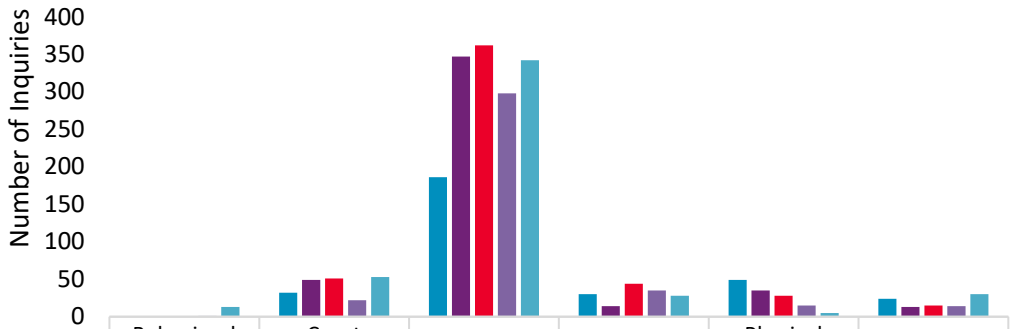
Overview of Complaints

The OCA recorded 424 **complaint** inquiries in FY24, an 8% increase compared to FY23. Figure 3 provides a comparison of complaint classifications year over year from FY20 through FY24. Complaints most frequently relate to DCF (342, 81%).[37] This is expected given the OCA's mandate to focus on children in the care and/or custody of the Commonwealth and that DCF serves the most children in the care and/or custody of the Commonwealth. The Complaint Line received approximately 38 inquiries related to services provided, licensed, or regulated by child-serving state agencies other than DCF. Twenty-one related to schools; six involved DMH; four involved DDS; one involved MassHealth; one involved DPH; one involved DYS; one involved DTA; two involved EEC; and one involved EOHHS.

Individuals also contacted the Complaint Line with concerns about court involvement (53, 13%), education (28, 7%), behavioral health (13, 3%), physical health (5, 1%), and other (30, 7%).[38] Behavioral Health complaints were collected as a distinct category for the first time in FY24. The data presented in this report should not be interpreted as a decline in the quality of services provided by the behavioral health system in Massachusetts. Complaints in the "other" category related to housing and homelessness, financial resources and vouchers, and concerns for the physical conditions of a child's living space. Except for education and physical health, there was an increase in every complaint category in FY24 compared to FY23. The volume of DCF and court-related complaints are within normal range compared to prior years.

[37] DCF served 98,647 parents/caregivers, children and youth involved in 35,639 cases, including 64,264 children of any age open for services (i.e., open in an assessment or in a clinical/adoption case) at minimum one day within the fiscal year.
[38] Percentages will not sum to 100 because individuals may mention more than one area of concern.

Figure 3:
Complaints by Fiscal Year (FY20-FY24)
n = Inquiries



	Behavioral Health	Court Involvement	DCF	Education	Physical Health	Other
FY20	0	32	186	30	49	24
FY21	0	49	347	14	35	13
FY22	0	51	362	44	28	15
FY23	1	22	298	35	15	14
FY24	13	53	342	28	5	30

DCF Complaints

The 342 complaints received on the Complaint Line involving DCF reflect a small number of the nearly 65,000 children, youth, and young adults served by DCF, including the nearly 10,000 children DCF serves in an out-of-home placement every year.[39] The comparatively small number of cases that come to our attention out of the number of families served is not a commentary on the seriousness of the complaints raised. The OCA processes complaints through the lens of individual cases and through the lens of trends across the system. The OCA works to verify the concerns raised by individuals and remedy situations when our independent assessment indicates that the agency should take action. The OCA also provides additional resources to individuals to ensure that they bring their complaints forward in appropriate venues.

Individuals complaining about DCF most frequently alleged concerns about DCF personnel (149, 44%). These concerns include allegations of DCF staff not responding to an individual's outreach, alleged disrespect by DCF personnel, missing paperwork (including safety plans and family assessments), and lack of follow-through of a family member's visitation rights with children in out-of-home placements.

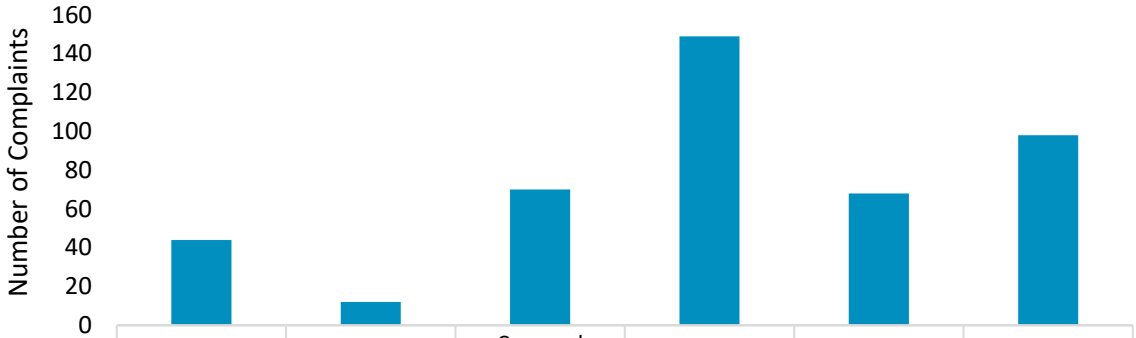
The second largest DCF complaint category involves placement of a child(ren) in out-of-home settings (98, 29%).[40] In this area, individuals expressed concerns that a child's placement is inappropriate for them, a placement request or change was denied, a placement is changing inappropriately, the time a child spent in a placement is inappropriate, and the quality of a

[39] Massachusetts Department of Children and Families Annual Report FY2023 (2024). Retrieved from https://www.mass.gov/doc/fy2023-dcf-annual-report/download
[40] Placement refers to an out-of-home placement. See Appendix E: Glossary of Terms for more information.

placement is problematic. Some individuals expressed concerns about the type of placement, or inconsistent placement visits by workers.

Similarly, 70 inquiries involved a concern about the care and/or custody of a child involved with DCF, and 44 involved concerns that a child with DCF involvement—those being served by DCF in their home setting as well as in out-of-home settings—is being abused or neglected. Others expressed concerns about the Family Assessment and Action Plan and a variety of other issues, including DCF investigations, family visitation, delays in establishing an Interstate Compact on the Placement of Children, fair hearings, payments and vouchers, and records requests.

Figure 4:
Description of Complaints Involving DCF
n = 342



	Abuse/ Neglect	Assessment	Care and Custody of Child(ren)	DCF Personnel	Other	Placement
DCF Complaint	44	12	70	149	68	98

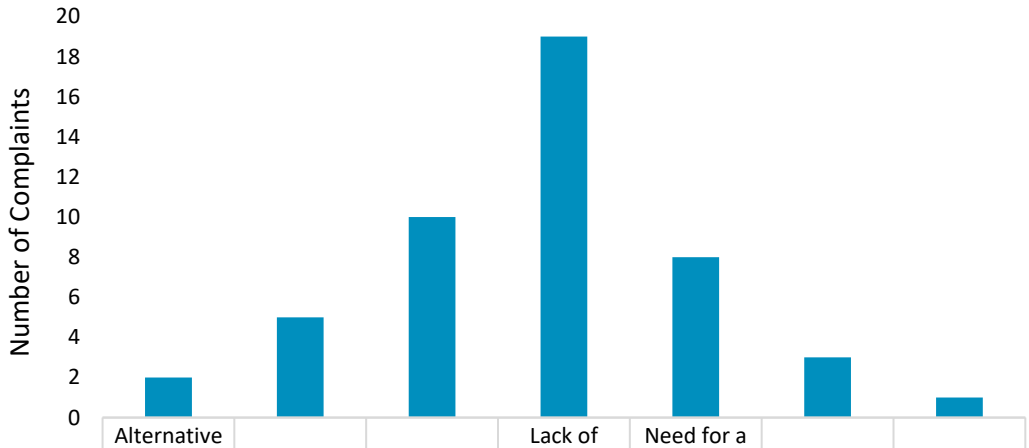
Court Involvement Complaints

Of the 53 complaints about the court process, 43% involved disagreement with the judge's decision, often as it related to the custody of a child. A handful of inquiries also expressed complaints about legal representation, a delay in court proceedings, and alleged bias during court proceedings. Other complaints included nonadherence to, or enforcement of, a judge's orders, and perceived conflicts of interest with judges and attorneys.

Education Complaints

Of the 28 inquiries involving complaints about education, 68% were about the school administration's response to a student's needs or concerns. Individuals also complained about accessing or adhering to an Individualized Education Plan (IEP) or 504 plan and/or the need for a different educational placement (10, 36%). Five inquiries involved bullying, three involved alleged unfair or inappropriate school discipline, and one involved dissatisfaction with school transportation services.

Figure 5:
Description of Complaints Involving Education
n = 28



	Alternative Education Placement Payment	Bullying	IEP or 504 Plan	Lack of Responsiveness of School Staff	Need for a Different Educational Placement	School Discipline	Transportation Services
Education Complaint	2	5	10	19	8	3	1

Behavioral or Physical Health Complaints

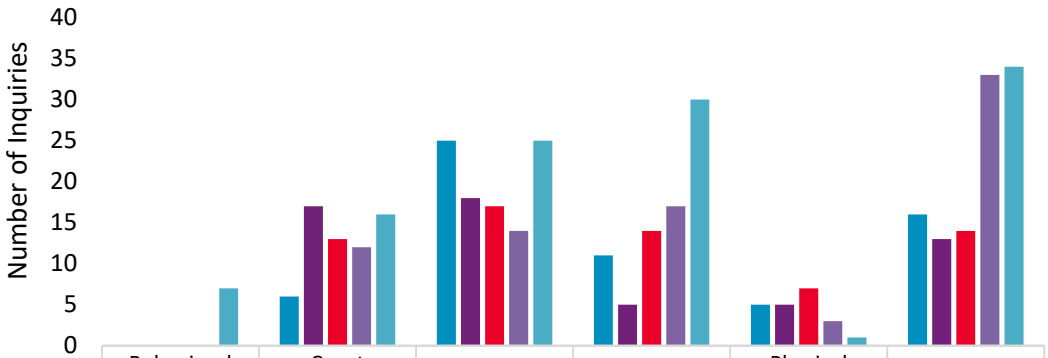
Of the 18 inquiries related to behavioral or physical health (13 and 5 respectively), complaints mostly related to medication errors or medication mismanagement by non-parental caregivers, hospital or emergency department boarding, hospitalizations, and adequacy or quality of therapeutic services.

Overview of Information and Referral Inquiries

The OCA received 108 information and referral inquiries in FY24, a 20% increase compared to FY23. Inquiries about education (30), DCF (25), and other (34) were the most common. [41] Inquiries related to DCF, education, and court involvement increased while requests related to physical health decreased. That decrease may be due to the updated Complaint Line categorization schema: Behavioral health requests were not collected as a distinct category until FY24 and may have previously been classified as physical health inquiries.

[41] Counts will not sum to total number because there may be multiple requests for information and referral in a single inquiry.

Figure 6:
Categories of Information and Referral Inquiries (FY20-FY24)
n = Inquiries



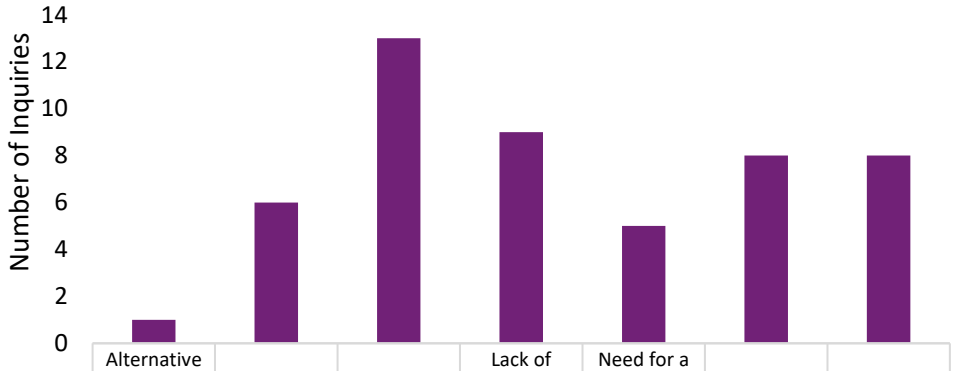
	Behavioral Health	Court Involvement	DCF	Education	Physical Health	Other
FY20	0	6	25	11	5	16
FY21	0	17	18	5	5	13
FY22	0	13	17	14	7	14
FY23	0	12	14	17	3	33
FY24	7	16	25	30	1	34

Education Information and Referral

Inquiries about the education system have increased year over year since FY21. The increase from FY23 to FY24 is larger than previous increases (21% from FY22 to FY23 compared to 76% from FY23 to FY24). This may indicate more awareness of the Complaint Line and the OCA's ability to provide support or information. Of particular note, the OCA's launch of a mandated reporter training with a profession-specific module for education professionals may explain some of this increase, as the training may raise awareness about the OCA and its functions.

Nearly half of the 30 education information and referral inquiries in FY24 involved IEPs or 504 plans. Topics included how to request special education, best practices in the development of an education plan, and special education options. Individuals also asked for information about expectations for school responsiveness, school discipline, bullying, how to change school enrollment, and funding of out-of-district education placements. Other inquiries involve requests for general information about education and immigration, the DESE problem resolution system, how to request education records, and how to access an educational advocate.

Figure 7:
Description of Information and Referral Inquiries Involving Education
n = 30

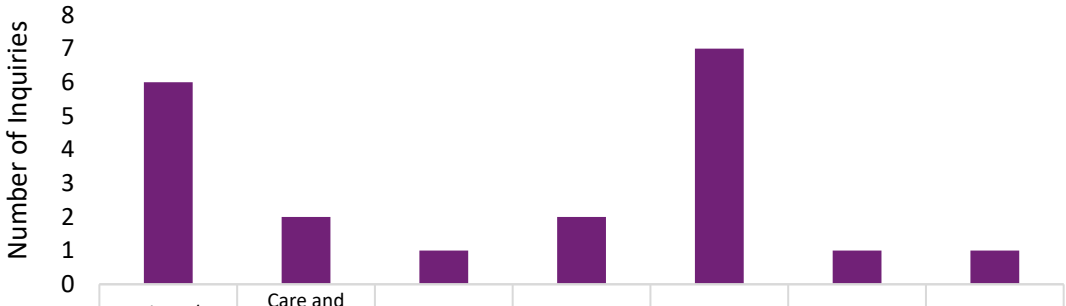


	Alternative Education Placement Payment	Bullying	IEP or 504 Plan	Lack of Responsiveness of School Staff	Need for a Different Educational Placement	Other	School Discipline
Education Information & Referral	1	6	13	9	5	8	8

DCF Information and Referral

Information and referral inquiries related to DCF increased 79% from FY23 to FY24 after having decreased the prior year. These 25 inquiries included what to do in case of suspected abuse and/or neglect, questions about the care and/or custody of a child, case management, DCF personnel, child placement, and service coordination.[42] Other topics included payments and vouchers, records requests, and suggested policy changes.

Figure 8:
Description of Information and Referral Inquiries Involving DCF
n = 25



	Abuse/ Neglect	Care and Custody of Child(ren)	Case Management	DCF Personnel	Other	Placement	Service Coordination
Information & Referral	6	2	1	2	7	1	1

[42] Figure 8 does not include individuals who contacted the OCA for information regarding DCF where their specific topic area for DCF is unknown.

Other Information and Referral

Inquiries related to "other" issues increased 3% from FY23 to FY24. These inquiries included state service and systems navigation, the OCA's position on policy debates and legislative actions, information about the OCA's mandated reporter training, and requests for previously released OCA reports.[43]

Inquiries regarding the legal system increased 33% from 12 in FY23 to 16 in FY24. The most frequently occurring request for information was what to do in case of disagreement with a judge. Individuals who contacted the Complaint Line also asked questions about legal representation and a host of other topics, such as visitation rights and opportunities, how to obtain a legal advocate, and navigating the legal system.

As previously mentioned, behavioral health and physical health inquiries were not categorized separately in prior fiscal years and are broken out for the first time in this FY24 Annual Report. Data collection will improve over time and the data presented in this report should not be interpreted as a decline in the quality of services provided by the behavioral health system in Massachusetts. The most frequently occurring behavioral health inquiry was about out-of-home placement that did not involve DCF (3, 43%). Individuals also asked questions about navigating behavioral health services and supports, service delivery expectations, and emergency department boarding. Other behavioral health topics include requests for information about how to support a child's mental health during their parent's divorce and parental engagement with mental health treatment.

The OCA in Action: Supporting Kinship Families

Rebecca contacted the OCA with concerns for her 2-year-old grandson Joshua,* who is in the custody of the Department of Children and Families. Rebecca stated that she is the kinship placement for Joshua. Rebecca reported that prior to Joshua being placed in her home, DCF agreed to pay for daycare. Rebecca stated that once Joshua started daycare, DCF refused to pay. Rebecca was able to show the OCA communications between herself and DCF where DCF initially stated they would pay for daycare. Rebecca noted this is a big financial strain on her and her family as she was not expecting to pay. The OCA contacted DCF inquiring about what their plan is regarding daycare payments, as this is something they agreed upon prior to Joshua being placed in Rebecca's home. DCF initially responded back to the OCA that they will pay for two months and then will assess monthly. The OCA reached back out to DCF for clarification, and DCF reported they will continue to pay for daycare monthly until Joshua is adopted.*

[43] Some of these requests may have qualified as public records requests and were handled accordingly by the OCA general counsel.

Critical Incident Reports

The OCA statute requires state agencies providing services to children or youth to notify the OCA if a child who is receiving a state service suffers a fatality, near fatality, serious bodily injury, or emotional injury. [44,45] These are called critical incident reports (CIRs). The OCA categorizes and analyzes all events that led to the injury or death of the child involved in the critical incident. The Office of the Chief Medical Examiner makes the final determination regarding the cause and manner of death; 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 youth as reported to us.

CIRs do not necessarily reflect evidence of wrongdoing by an agency; a critical incident can result from a car crash, illness, or other reasons that are likely unrelated to the services provided by the reporting agency.

The number of CIRs submitted by each agency is **not a qualitative comparison between agencies**. The number of children and youth served by each agency varies significantly as do the challenges faced by the populations served.

In FY24, the OCA received 278 CIRs involving 388 critical incidents and 380 children/youth. A CIR can contain more than one critical incident (fatality, near fatality, serious bodily injury, emotional injury) and/or pertain to more than one child.[46] Additionally, multiple agencies may submit a report regarding the same child or youth if the child or youth receives services from more than one agency. For this reason, the number of CIRs does not equal the number of critical incidents or the number of children and youth involved.

Critical Incident Report Overview

The OCA received 278 CIRs in FY24, which is lower than the number the OCA received in previous years. Figure 9 shows year-over-year trends related to CIRs received from state agencies for the past five fiscal years. Given the high volume of children and families involved with DCF and the nature of DCF's work, DCF unsurprisingly continued to submit the majority (87%) of the total number of CIRs the OCA received in FY24.[47] Notably, the number of reports DCF submitted decreased for the third fiscal year in a row, and DPH reported substantially fewer CIRs in FY24. The Massachusetts Commission for the Blind submitted their first CIR in FY24.

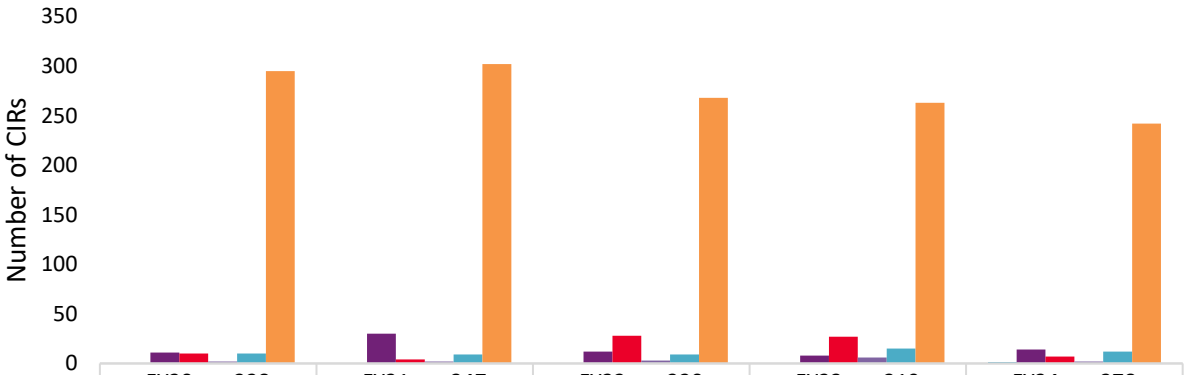
[44] Most often, the OCA receives CIRs from the state agencies organized under EOHHS. See Figure 9: CIRS Received by State Agencies p. 41 for more information.

[45] See Appendix E: Glossary of Terms for definitions of fatality, near fatality, serious bodily injury, and emotional injury.

[46] See Appendix C. Additional Core Function Data and Context, Critical Incidents for more information.

[47] DCF reports critical incidents involving children in its custody, children and youth receiving services, and children and youth whose families had any DCF involvement within the preceding 12 months. Other EOHHS child-serving agencies only report critical incidents to the OCA for children and youth currently receiving services. This difference in reporting contributes to the higher volume of reports submitted to the OCA compared to other child-serving agencies.

Figure 9:
CIRs Recieved by State Agencies (FY20-FY24)
n = Distinct Reports

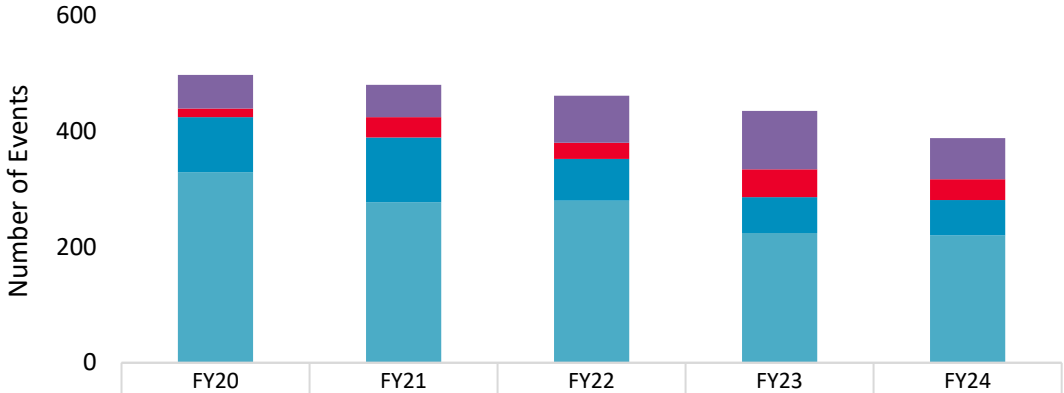


	FY20 n = 328	FY21 n = 347	FY22 n = 320	FY23 n = 319	FY24 n = 278
MCB	0	0	0	0	1
DYS	11	30	12	8	14
DPH	10	4	28	27	7
DMH	2	2	3	6	2
DDS	10	9	9	15	12
DCF	295	302	268	263	242

Critical Incidents Overview

Figure 10 describes trends in the outcome of critical incidents from FY20 to FY24. There was a substantial decrease in the number of reported child fatalities (101 to 71) and near fatalities (48 to 36). Reports of emotional injury (220) and serious bodily injury (61) remained relatively stable compared to FY23.

Figure 10:
Critical Incident Outcomes by Fiscal Year (FY20-FY24)



	FY20	FY21	FY22	FY23	FY24
Fatality	58	56	81	101	71
Near Fatality	15	35	28	48	36
Serious Bodily Injury	95	112	72	62	61
Emotional Injury	329	277	280	224	220

Fatality

A fatality occurs when a child who is receiving state services dies.[48]

In FY24, the OCA received 72 fatality CIRs related to the death of 71 children, which is less than those received in the past two years (FY23, 101; FY22, 81; FY21, 56; FY20, 58; and FY19, 61). This decrease does not reflect public health data; nationally and in Massachusetts, child fatalities increased for the first time in three decades in 2021 and continued to rise in calendar year 2023, with another rise projected in 2024.[49]

The decrease in critical incident report fatalities **was the result of fewer reported deaths from injuries, medical events and overdose, with the most substantial reduction from medical events, such as complex medical conditions, heart attacks and seizure disorders (52 to 32).** The reduction in reported medical event fatalities coincides with a decrease in reporting from DPH. The cause and manner were not initially known for a larger portion of the reported deaths compared to prior years. Deaths from physical abuse, suicide, and sudden unexpected infant death (SUID) remained relatively the same while reported deaths from violence increased for the third year in a row.

Near Fatality

Near fatalities are accidental and can be the result of a medical condition or the result of abuse and/or neglect. A verbal certification by a physician that the child or young adult's condition is considered life-threatening is needed for an incident to meet the CIR definition of a near fatality .

In FY24, near fatality CIRs remained comparable to previous years (36 near fatalities were reported in FY24, compared to 48 in FY23, 28 in FY22, 35 in FY21, and 15 in FY20). While the overall number remained stable, the causes of the events were different, with more deaths from medical events and violence and fewer from overdoses and suicides.

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."[50]

The number of CIRs involving serious bodily injuries remained about the same in FY24, with 61 reported serious bodily injuries compared to 62 in FY23, 72 in FY22, 112 in FY21, and 95 in FY20. While the overall number remained stable, the causes of the events were different. Compared

[48] The cause and manner of death presented in this report is based on preliminary reporting and may not reflect the eventual findings of the Office of the Chief Medical Examiner.

[49] Child Fatality Review FY23 Annual Report, FY23 Child Fatality Review Annual Report, https://www.mass.gov/doc/fy23-ocme-annual-report/download ; Woolf, S. H., Wolf, E. R., & Rivara, F. P. (2023). The New Crisis of Increasing All-Cause Mortality in US Children and Adolescents. *JAMA*, *329*(12), 975–976. https://doi.org/10.1001/jama.2023.3517 ; In calendar year 2022, 403 Massachusetts children under the age of 18 died, whereas 397 died in 2021. (Open Death File, accessed December 2024).

[50] M.G.L. c. 18C § 5.

to FY23, there were more serious bodily injuries due to violence and sexual assault in FY24 and fewer from overdoses.

Emotional Injury

An emotional injury occurs when a child is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, suicide, or violent act.[51]

Emotional injury is consistently the most frequent critical incident reported. The number of CIRs involving an emotional injury remained about the same in FY24, with 220 reported compared to 224 in FY23. This is low compared to previous years.

Witnessing an overdose remained the leading cause of reported emotional injuries in FY24; the OCA received 111 witness-to-overdose CIRs. This represents the lowest number of witnesses-to-overdose emotional injury reports the OCA has received since FY20 and a five-year downward trend in the number of witnesses-to-overdose reports received. This coincides with a reported reduction in overall deaths from overdose by DPH in 2023 and continuing in 2024.[52,53]

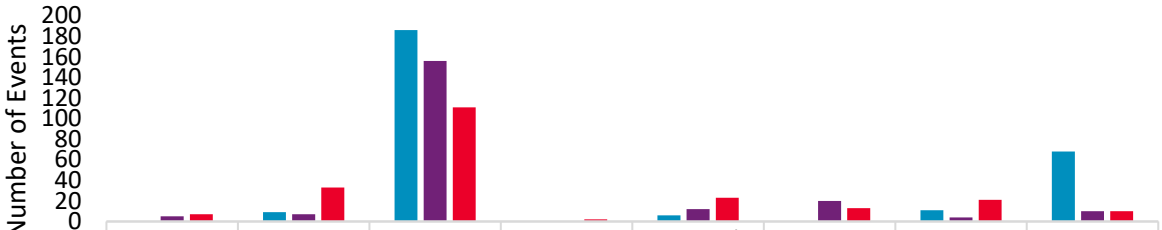
The OCA also received 23 reports regarding a child witnessing a person attempt or die by suicide in FY24. This number is closer to the number of reports received in FY21 and FY20, but higher than what we have seen in the recent past. Reports regarding a child or youth witnessing violence also increased substantially in FY24 compared to prior years, with 21 such reports received. CIRs about children witnessing unexpected medical events that lead to a fatality or near fatality increased the most, to 33 in FY24. This is the highest number of witnesses to medical events that the OCA has received. Figure 11 presents year-over-year data about the nature of emotional injuries children experienced as described in the CIRs received by the OCA.

[51] 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 (ACE), a term coined by the Centers for Disease Control and Prevention (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 (e.g. seeing a caregiver overdose) and a child being the direct victim of the event (e.g. overdosing themselves) in any setting, such as a home, community, or other out-of-home setting.

[52] Department of Public Health Report: Massachusetts Opioid-Related Overdose Deaths Decreased 10 percent in 2023. (2024, June 12). Retrieved from https://shrewsburyma.gov/DocumentCenter/View/16649/MDPH-Press-Release-06-12-24-PDF

[53] For more information see Overdose under Causes of Critical Incidents in this report.

Figure 11:
Cause of Emotional Injuries in CIRs (FY22-FY24)

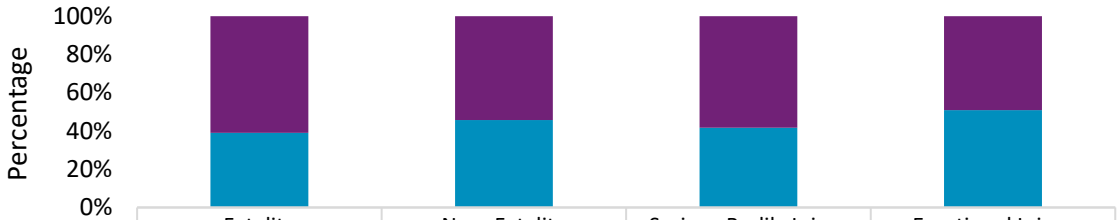


	Injury	Medical	Overdose	Physical Abuse	Suicide/ Suicide Attempt	SUID	Violence	Other
FY22	0	9	186	0	6	0	11	68
FY23	5	7	156	0	12	20	4	10
FY24	7	33	111	2	23	13	21	10

Demographics[54]

Of the 380 children who experienced a critical incident, sex assigned at birth is available for 367 of them (97%). Of those, approximately 53% were identified as male and 47% were identified as female. While emotional injury CIRs were slightly skewed toward females, males were more likely to be the subject of a reported fatality, near fatality, or serious bodily injury. Figure 12 describes the proportion of reported outcomes for children identified as male compared to female.[55]

Figure 12:
Sex of Children Appearing in CIRs, Stratified by Event Outcome
n = Unique Children



	Fatality	Near Fatality	Serious Bodily Injury	Emotional Injury
Male n = 194	39	19	35	107
Female n = 173	25	16	25	111

[54] 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 DCF's electronic database. Sex/gender is as reported by agency; collection methodology may vary by agency and may not reflect the child's identity or sex identified at birth. Data on the sexual orientation of children who are the subject of a report, and whether they identify as transgender, is currently only available for a very small proportion of CIRs the OCA receives. Given the very high percentage of "unknowns," that data is not reported here. However, the OCA continues to prioritize improving the frequency and accuracy of demographic information reported to the OCA, including sexual orientation and gender identity, and we hope to be able to provide additional demographic data in future reports.

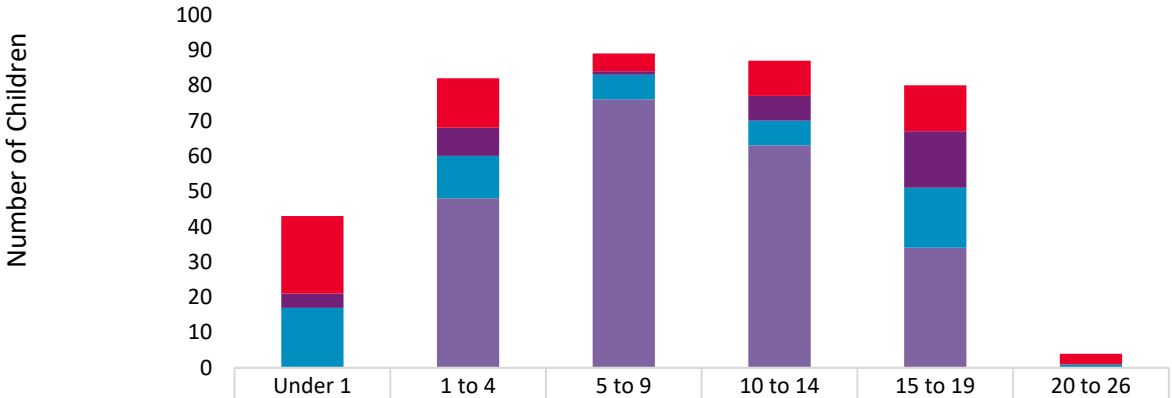
[55] Figure 12 does not include counts for unknown sex assigned at birth. Totals for event outcomes may not equal totals shown above because of this.

Age is available for all but four children appearing in CIRs. The children involved ranged from infants under 1 year of age to 26 years old, and primarily involved those ages 1 to 17 years old.[56] We observed the following trends and themes for age cohorts of children involved:

- Fewer CIRs involving infants were reported in FY24 compared to FY23 (43 compared to 85). This fiscal year's reports were mostly the result of a death from SUID or a complex medical condition, or suspected abuse resulting in serious bodily injury.
- Reports involving children ages 1 to 14 years old were overwhelmingly related to emotional injuries, specifically witnessing someone overdose.
- Fatalities were least prevalent in the 5 to 9 age group, and the OCA received many more CIRs for this age group in FY24 compared to FY23 (89 compared to 60).
- Reports involving 15-to-19-year-olds were more frequently related to physical harm, especially serious bodily injuries, compared to the other age groups.
- The rare reports related to young adult consumers that meet OCA reporting criteria predominately resulted in fatality related to substance use and unintentional injuries, such as car crashes.[57]

Figure 13 describes the number of incidents received for each age group and the outcome the child experienced.[58]

Figure 13:
Age of Children Appearing in CIRs, Stratified by Event Outcome
n = Unique Children



	Under 1 (n = 43)	1 to 4 (n = 82)	5 to 9 (n = 89)	10 to 14 (n = 85)	15 to 19 (n = 80)	20 to 26 (n = 4)
Fatality	22	14	5	10	13	3
Near Fatality	4	8	1	7	16	0
Serious Bodily Injury	17	12	7	7	17	1
Emotional Injury	0	48	76	63	34	0

[56] The OCA does not receive emotional injury CIRs for children under 1 year old.
[57] Reports related to young adult consumers that meet OCA reporting criteria are rare because of the reporting categories for the agencies, not because this age group is not experiencing harm.
[58] Totals will be greater than totals for number of children involved, as one child may experience more than one event outcome.

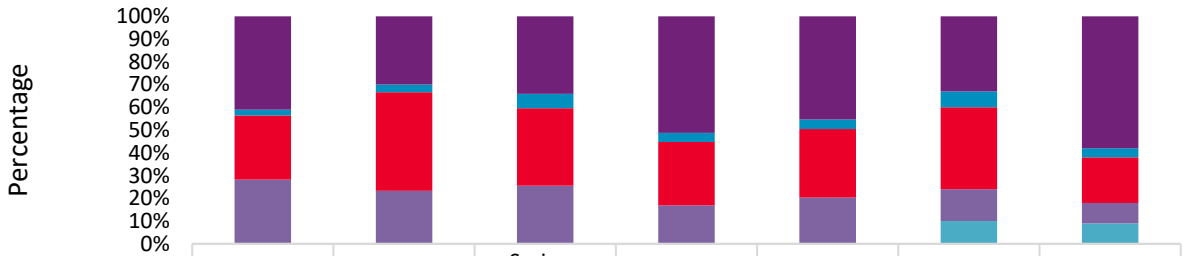
Race and ethnicity information is available for 66% of the children appearing in CIRs (288 children). Figure 14 describes the proportion of reports that involved children of specific races and ethnicities by event outcome and excludes cases where the race/ethnicity was unknown. This analysis should be interpreted with caution, as conclusions may be skewed by the limited availability of data. The figure provides context on under- and overrepresentation by outcome, and the most frequently occurring critical incidents for each race/ethnicity group.

Children who are Black non-Hispanic or multiracial non-Hispanic are disproportionately represented in serious bodily injuries and fatalities compared to the overall population and the DCF consumer population. In particular, fatalities occur disproportionately among Black non-Hispanic children. The Child Fatality Review program explores root causes of inequities for children in its FY22 Annual Report.

White children are disproportionally overrepresented in CIRs compared to the DCF child consumer population.[59] This overrepresentation is driven by the number of White children experiencing emotional injuries resulting from witnessing an overdose.

Figure 14:

Outcome of CIRs Stratified by Race and Ethnicity of Children in the CIR



	Fatality	Near Fatality	Serious Bodily Injury	Emotional Injury	All CIRs	DCF Population	MA Population
White , NH (n = 132)	41%	30%	34%	51%	44%	33%	58%
Multiracial, NH (n = 13)	3%	3%	6%	4%	4%	7%	4%
Hispanic (n = 93)	28%	43%	34%	28%	29%	36%	20%
Black , NH (n = 53)	28%	23%	26%	17%	20%	14%	9%
Other, NH (n=0)	0%	0%	0%	0%	0%	10%	9%

Data Note: Other includes Asian, NH (8%), American Indian Alaska Native, NH <1%, Pacific Islander, NH <1%.

Causes of Critical Incidents

The OCA categorizes and analyzes all events that led to the injury or death of the child involved in the critical incident. The Office of the Chief Medical Examiner makes the final determination regarding the cause and manner of death; the critical incident report to the OCA provides

[59] DCF submitted 87% of CIRs; use caution while interpreting this data.

important information about the nature and circumstances of the event that led to the injury or death of a child or young adult.[60]

The OCA is committed to working across the various child-serving systems, and particularly in collaboration with state agencies, to prevent the physical harm and/or death of all children and young adults due to injury, overdose, suicide, and violence. In addition to the information and efforts described below, the OCA will continue to work with the reporting agencies to develop strategies aimed at protecting children's safety.

Injury

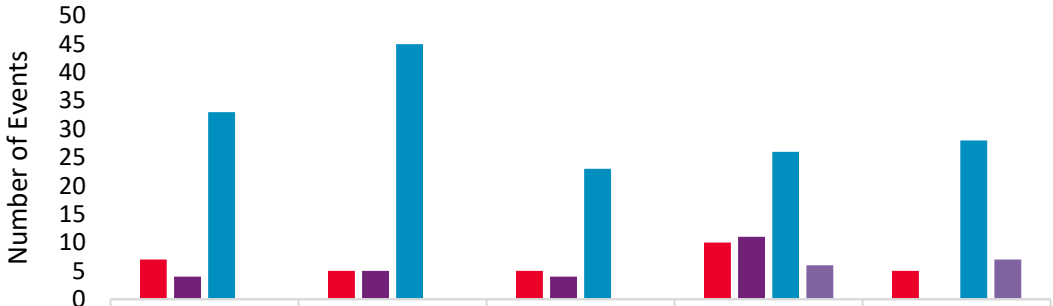
Childhood injury is often preventable, yet nationwide more than 7,000 children and youth ages birth to 19 die each year because of unintentional injuries.[61] According to DPH, injuries are a leading cause of death among Massachusetts children, particularly drowning, poisoning, and transportation injuries.[62] There were fewer CIRs about an unintentional injury to a child in FY24 (40) compared to FY23 (53). In FY24 injury-related trends from the OCA data included:

- The most frequently reported unintentional physical injuries are falls (12), car crashes (8), fires/burns (7), and drowning (3), which most frequently result in serious bodily injury.
- Five unintentional injury-related fatalities resulted from drowning (3), a car crash (1) and fire/burn (1).
- No unintentional injury-related near-fatalities were reported.
- Seven emotional injuries were caused by a child witnessing the fatal or life-threatening injury of another individual due to a firearm (3), fall (2), car crash (1), and fire/burn (1).

For more information, see Appendix C: Additional Core Function Data & Context, Figure 27: Number of Children Who Sustained Specific Types of Injuries and the Injury Outcome.

[60] The cause and manner of death presented in this report is based on preliminary reporting and may not reflect the eventual findings of the Office of the Chief Medical Examiner.
[61] West, B. A., Rudd, R. A., Sauber-Schatz, E. K., & Ballesteros, M. F. (2021). Unintentional Injury Deaths in Children and Youth, 2010–2019. Journal of Safety Research, 78, 322–330. https://doi.org/10.1016/j.jsr.2021.07.001
[62] Injury Surveillance Program, Injury Fatalities Among MA Children Aged 0-17 Years 2021 (2023). Retrieved from https://www.mass.gov/doc/2021-child-injury-deaths-summary-pdf/download#:~:text=In%202021%2C%20there%20were%2065,suffocations%2C%20poisonings%2C%20and%20drownings

Figure 15:
Injuries in CIRs by Outcome (FY20-FY24)



	FY20 (n = 44)	FY21 (n = 55)	FY22 (n = 32)	FY23 (n = 53)	FY24 (n = 40)
Fatality	7	5	5	10	5
Near Fatality	4	5	4	11	0
Serious Bodily Injury	33	45	23	26	28
Emotional Injury	0	0	0	6	7

Overdose

The critical incidents reported to the OCA reflect children experiencing drug exposure or a child witnessing a fatal or life-threatening overdose, and OCA data do not account for overdoses experienced or witnessed by children in Massachusetts who were not receiving state services. In this context, the OCA recognizes the issue is much more widespread than the OCA data reflect, and there continues to be a deep impact of the ongoing opioid epidemic on children.

In FY24 the OCA saw a sizable reduction in the number of critical incidents involving children who suffered a fatality, near fatality, or serious bodily injury, or who witnessed someone overdose. The number of reported critical incidents in which a child experienced an overdose decreased in FY24 to 23 (1 fatality, 19 near fatalities, and 3 serious bodily injuries). This breaks a five-year trend of increasing reports of physical harm to children from overdose (from 15 in FY19 to 22 in FY20, 32 in FY21, 34 in FY22, 37 in FY23, and 23 in FY24). This also coincides with a DPH-reported reduction in overall deaths from overdose in 2023 and continuing in 2024.[63] According to DPH, "[T]here were 2,125 confirmed and estimated opioid-related overdose deaths in 2023, which is 232 fewer than in 2022" and is a 10% reduction in the overdose death rate.[64]

DPH data show that males are disproportionately represented in overdose deaths and that, while the overall death rate is decreasing, the decrease is not spread equitably across race/ethnicity groups. The DPH-reported reduction was driven by a significant reduction in the rate of White non-Hispanic people dying, but overdose death rates increased among Black non-

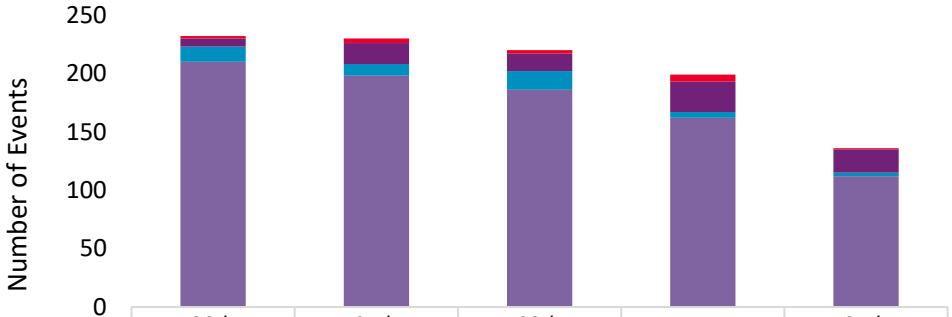
[63] Department of Public Health Report: Massachusetts Opioid-Related Overdose Deaths Decreased 10 percent in 2023. (2024, June 12). Retrieved from https://shrewsburyma.gov/DocumentCenter/View/16649/MDPH-Press-Release-06-12-24-PDF
[64] Department of Public Health Report: Massachusetts Opioid-related Overdose Deaths Decreased 10 percent in 2023. (2024, June 12). Mass.gov. Retrieved from https://www.mass.gov/news/dph-report-massachusetts-opioid-related-overdose-deaths-decreased-10-percent-in-2023

Hispanic people, and people who are Hispanic experienced a smaller reduction in the overdose death rate.

The 23 children who overdosed and were reported to OCA ranged from infants to youth and were evenly divided between boys and girls. The children were predominately Hispanic (45%). Most were not in state custody and/or care at the time of the event (21 not in state custody, 2 in state custody). Of the two children who were in state custody at the time of the overdose, one experienced a fatality and the other experienced a near fatality, and both were in a public place at the time of their overdose. One was 26 years old and the other was 17. One overdose involved fentanyl, benzodiazepines, and marijuana, while the other involved an unknown substance. Neither individual was in an out-of-home placement.[65]

Experts point to witnessing an overdose as an adverse childhood experience (ACE).[66] ACEs are linked with negative health and well-being outcomes for the child later in life. The negative impact of witnessing an overdose is compounded by the fact that children exposed to overdoses are often also victims of neglect, which puts them at an increased risk of complex trauma. Critical incidents involving children who witnessed an overdose comprised two-thirds (or more) of all emotional injury events from FY19 through FY24. The OCA received 111 CIRs involving 112 children witnessing an overdose in FY24. More than half were under the age of 10 (56%). In FY24, of the 112 children reported to the OCA who witnessed an overdose, 80% resulted in near fatalities to the person who overdosed while 20% resulted in fatalities. Two of those children were in state custody when they witnessed the overdose. One overdose took place in the child's home, while the other took place in a shelter.

Figure 16:
Overdose Events in CIRs by Outcome (FY20-FY24)



	FY20 (n = 232)	FY21 (n = 230)	FY22 (n = 220)	FY23 (n =199)	FY24 (n = 136)
Fatality	2	4	3	6	1
Near Fatality	7	18	15	26	20
Serious Bodily Injury	13	10	16	5	3
Emotional Injury	210	198	186	162	112

[65] When DCF takes custody of a child, that child may be placed in an out-of-home setting or may remain at home.
[66] Wisdom, A. C., et. Al. (2022). Adverse Childhood Experiences and Overdose: Lessons from Overdose Data to Action. American Journal of Preventive Medicine, 62(6). https://doi.org/10.1016/j.amepre.2021.11.015

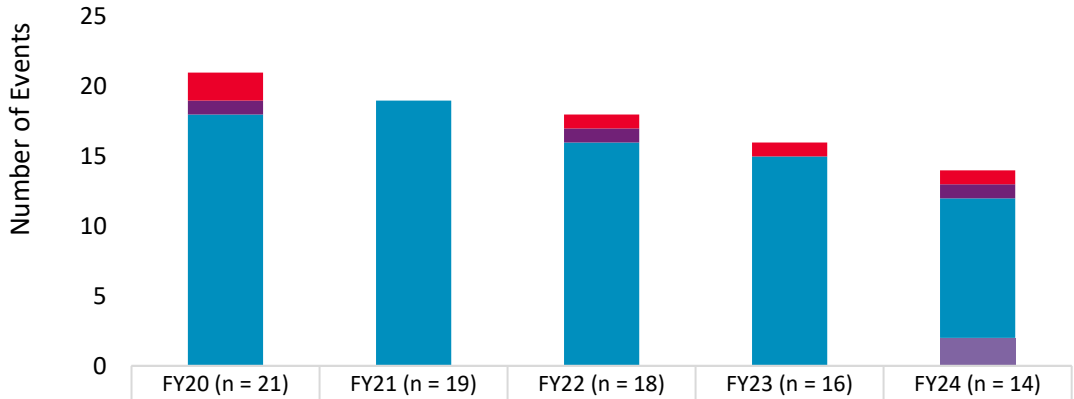
Physical Abuse

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.[67]

While the overall number of physical abuse critical incidents increased sharply from FY19 (6) to FY20 (21), they decreased from FY21 to FY24 (19, 18, 16, and 14 respectively). These reports resulted in a fatality, a near fatality, 10 serious bodily injuries, and 2 emotional injuries of 12 children. In addition:

- Eight of the 12 children involved in a physical abuse critical incident were 1 year old or younger (66%).
- One infant was in foster care at the time of the incident, though the setting of where the injuries occurred could not be determined.
- In DCF's investigation of the allegation of abuse, the child's parent was determined to be the perpetrator in 85% of the incidents. The perpetrator could not be identified in the remaining cases.

Figure 17:
Physical Abuse Events in CIRs by Outcome (FY20-FY24)



	FY20 (n = 21)	FY21 (n = 19)	FY22 (n = 18)	FY23 (n = 16)	FY24 (n = 14)
Fatality	2	0	1	1	1
Near Fatality	1	0	1	0	1
Serious Bodily Injury	18	19	16	15	10
Emotional Injury	0	0	0	0	2

[67] For information about DCF's intake and response to allegations of abuse and neglect, refer to the DCF Protective Intake Policy.

Suicide and Suicide Attempts

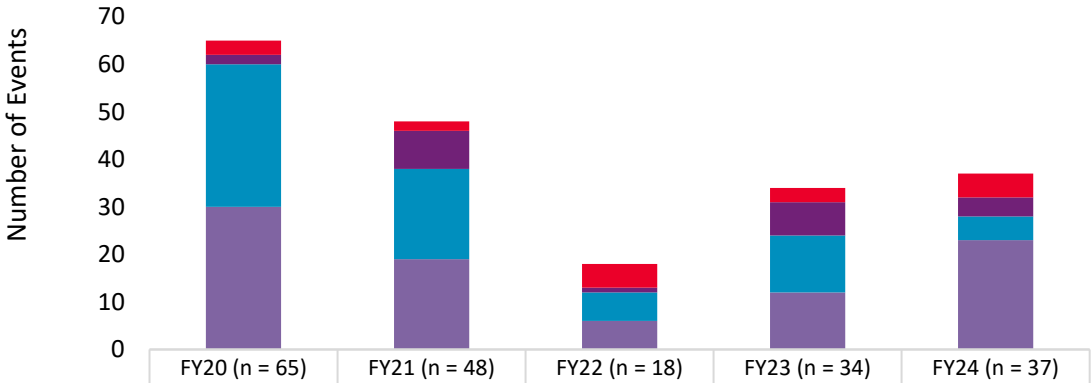
According to DPH, "[S]uicides are a significant yet largely preventable public health problem."[68] Suicide and suicide-attempt critical incidents increased in FY23 and FY24 after a low in FY22. CIRs regarding suicide or suicide attempts are still lower than pre-pandemic levels. Suicide is complex and multifactorial; the OCA continues to seek to understand and work toward prevention of suicide, particularly for agency-involved children and youth.

In FY24 the OCA received 14 reports of a physical injury due to suicide, including five fatalities, four near fatalities, and five serious bodily injuries. All suicides and attempts resulting in death or bodily injury involved youth ages 12 to 20. Six of those youth were in the care and/or custody of the state at the time of the event. Of those six reports, one resulted in fatality, two resulted in near fatalities, and three resulted in serious bodily injuries. Four were in a secure facility,[69] one was in their home, and one was in a public place.

Emotional injuries caused by witnessing suicide or suicide attempts increased from 12 in FY23 to 23 in FY24; this is the highest number of reports received since FY20. Eleven of the events resulted in a fatality and 12 resulted in a near fatality. In 80% of the reports a child witnessed their parent's suicide or suicide attempt (19), and in four reports they witnessed their sibling's suicide attempt or death. Children who witnessed a suicide or suicide attempt ranged from 3 to 17 years old, and 35% were younger than 10.

Figure 18:

Suicide and Suicide Attempt Events in CIRs by Outcome (FY20-FY24)



	FY20 (n = 65)	FY21 (n = 48)	FY22 (n = 18)	FY23 (n = 34)	FY24 (n = 37)
Fatality	3	2	5	3	5
Near Fatality	2	8	1	7	4
Serious Bodily Injury	30	19	6	12	5
Emotional Injury	30	19	6	12	23

[68] Injury Surveillance Program, 2021.

[69] See Appendix E: Glossary of Terms for a definition.

Unexpected Medical Events

Some CIRs reported to the OCA involve the fatality or near fatality of a child due to life-limiting medical conditions or other complex health needs; these numbers are small compared to other categories of CIR. These types of reports are most often received from DPH and DDS. In FY24, 31 children reported to the OCA died from medical events, while six experienced a near fatality and one experienced serious bodily injury. The number of reported fatalities decreased in FY24, which coincides with a decrease in overall reports from DPH. (See Figure 9: CIRs Received by State Agencies (FY20-FY24) p. 41.) Fatalities reported by DPH frequently involve a child receiving care coordination services provided by the 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.

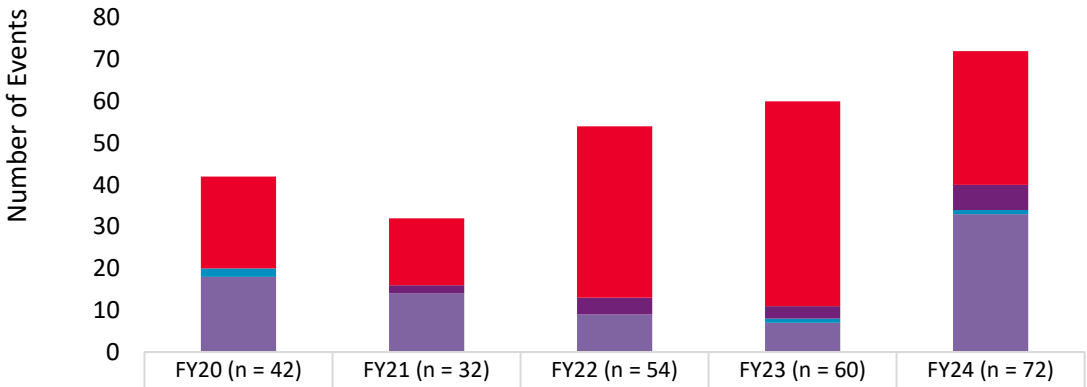
The children reported to the OCA who suffered a fatal medical event ranged from birth to 17 years old. Fifty-eight percent (58%) of reported medical event fatalities were children 10 years old or younger, including seven children who were 1 year old or younger. Fifty-four percent (54%) of the children were identified as males and 42% as females. Three were in state custody at the time of the event, including one fatality and two near fatalities.

The OCA received substantially more reports of children witnessing unexpected fatal medical events in FY24 than we have in the past. Of the 33 children who witnessed an unexpected medical event in FY24, 45% resulted from a parent's medical event, 42% from a sibling's medical event, 9% from another family member's event, and 3% from a non-relative's event. The events were the result of complications from pre-existing medical conditions as well as incidents of cardiac arrest. Children who witness an unexpected or untimely death experience more difficulty in the initial acceptance and long-term adjustment than children who witness anticipated/natural deaths.[70] It is estimated that about 10% of bereaved children experience grief reactions of sufficient severity to produce clinically significant impairment.[71]

[70] Lehman, D. R., et. Al. (1989). Long-Term Effects of Sudden Bereavement: Marital and Parent-Child Relationships and Children's Reactions. Journal of Family Psychology, 2(3), 344–367. https://doi.org/10.1037/h0080505

[71] Kaplow, J. B., et, al. (2013). Using Multidimensional Grief Theory to Explore the Effects of Deployment, Reintegration, and Death on Military Youth and Families. *Clinical Child and Family Psychology Review*, *16*(3), 322–340. https://doi.org/10.1007/s10567-013-0143-1

Figure 19:
Medical Events in CIRs by Outcome (FY20-FY24)



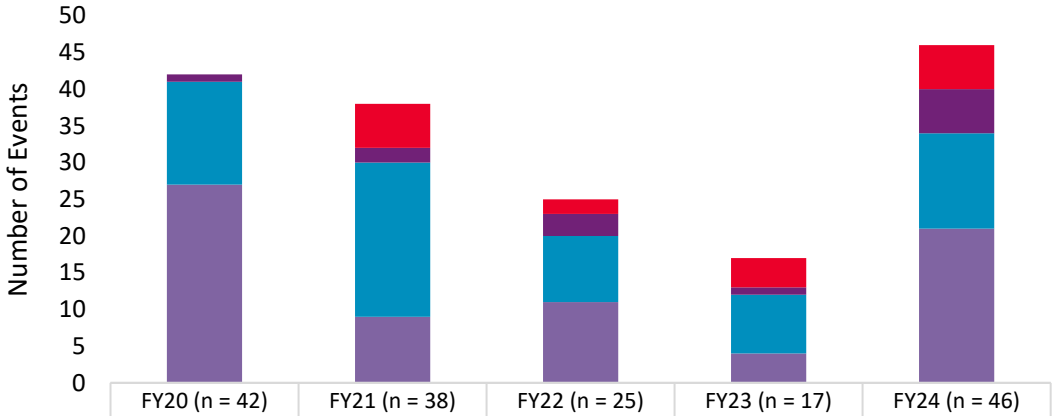
	FY20 (n = 42)	FY21 (n = 32)	FY22 (n = 54)	FY23 (n = 60)	FY24 (n = 72)
Fatality	22	16	41	49	32
Near Fatality	0	2	4	3	6
Serious Bodily Injury	2	0	0	1	1
Emotional Injury	18	14	9	7	33

Violence

Reported events in which a child was a victim of, or witness to, community violence increased substantially in FY24 compared to prior years and were the same as FY20 reporting levels. In FY24, 25 children reported to the OCA were victims of community violence, and 21 witnessed violent events. The physically harmed children were between the ages of 10 and 21, and 28% were between the ages of 18 and 21. Firearms played a role in 88% of these physical injuries, with the remaining 12% caused by stabbing. Seventy-two percent (72%) of these youth were receiving services from DCF while 24% were involved with DYS and one was involved with the Massachusetts Commission for the Blind. Six children were in state custody at the time of the event, including one who died, two who were near fatally injured, and three who sustained serious bodily injuries. Four incidents took place in a public place, one took place at home, and it is unclear where the other event took place. None of the children were in an out-of-home placement at the time of the incident.

Twenty-one children reported to the OCA witnessed violence; the victim of violence was their parent's spouse or partner in 29% of the reports, a parent in 24%, a sibling in 19%, a peer in 14%, and another family member or person in 14%. Nineteen incidents were reported by DCF while DYS and DMH each reported one incident. Three of the child witnesses were in state custody at the time of the incident; one occurred after a youth absconded from a DYS secure facility, and two involved children in DCF foster care. All three occurred in a public place.

Figure 20:
Violence in CIRs by Outcome (FY20-FY24)



	FY20 (n = 42)	FY21 (n = 38)	FY22 (n = 25)	FY23 (n = 17)	FY24 (n = 46)
Fatality	0	6	2	4	6
Near Fatality	1	2	3	1	6
Serious Bodily Injury	14	21	9	8	13
Emotional Injury	27	9	11	4	21

Foster Care Review Safety Alerts

Federal and state laws require that DCF implement a Foster Care Review (FCR) process.[72] This review applies only to children who are removed from the custody of their parents and occurs at least every six months while the child remains in placement. The review is a monitoring mechanism to measure progress toward a child's permanency goal.

A Foster Care Review is facilitated by a three-person panel consisting of a member of the DCF Foster Care Review Unit (an independent unit within DCF), an administrator from a DCF area office, and a community volunteer. When the FCR panel, through its review of progress toward a child's permanency goal, becomes concerned for the safety of a child in out-of-home care, the panel generates a safety alert. In July 2022 the OCA began receiving Foster Care Review safety alerts as part of the OCA's long-term efforts to strengthen the Foster Care Review process. By receiving the FCR safety alert and conducting a review of the related DCF case, the OCA provides an additional layer of oversight to ensure that the needs and well-being of the child(ren) are addressed.

In the second year of implementing this new protocol, the OCA received 15 Foster Care Review safety alerts from the more than 11,000 Foster Care Reviews that took place. This represents a substantial reduction in reports received by the OCA compared to FY23, when 36 safety alerts were submitted.

The FCR safety alerts received by the OCA were predominately for female children (71%) and children of color (93%). The children ranged in age from 1 to 18 years old. Reports predominantly involved children with whom the reviewers felt there was insufficient DCF caseworker contact. Insufficient DCF caseworker contact resulted from various issues, such as

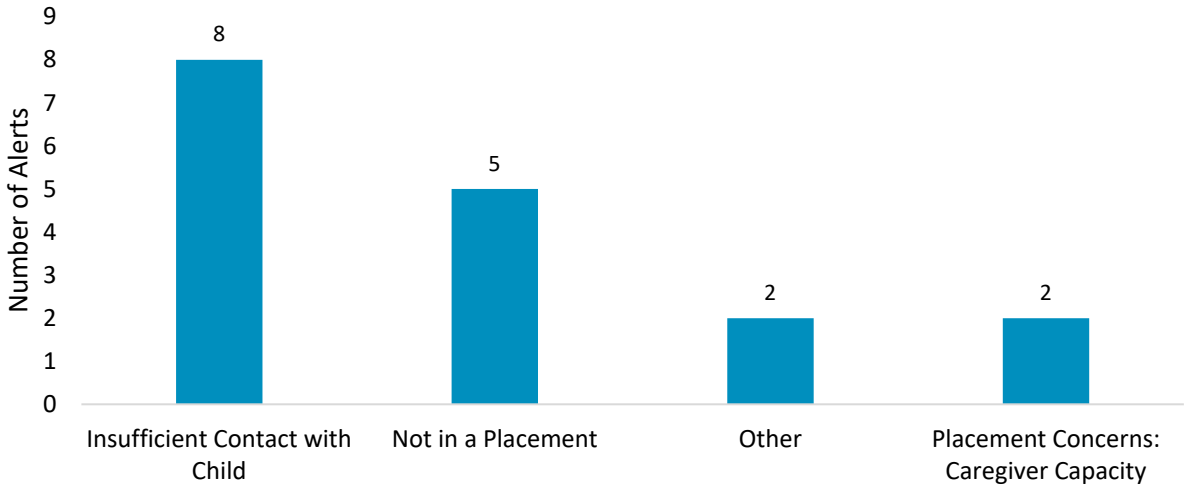
[72] United States Social Security Act, 42 USC 675 Sec 475 (5) (B) ; Department of Children and Families statute MGL c. 18B, §6A.

inconsistent visits to the placement, poor communication with out-of-state counterparts, and refusal of a foster parent to allow DCF into a home. They also involved children who were missing or absent from their placement at the time of the review, for whom reviewers felt additional efforts from DCF were necessary to locate and engage the child. Children with whom there was insufficient contact were mostly between the ages of 16 and 18, although a 3- and a 9-year-old were also insufficiently contacted while in the physical custody of their biological parent(s).

Five of the 17 children named in these reports were not in foster care at the time of the Foster Care Review. Those children had sibling(s) in foster care. When reviewers convened to review progress in the foster child's case, they identified concerns about the biological parents' inadequate progress in meeting family action and assessment plan goals. The inadequate progress caused enough concern for the reviewers to submit a safety alert on behalf of the sibling who was still residing in their home. These children were between the ages of 1 and 11.

Two FCR safety alerts involved concerns about the caregiver's capacity to meet the needs of the foster child, one involved injuries a foster child sustained, and another expressed concerns about premature reunification between the child and their family.[73]

Figure 21:
FY24 Reason for Foster Care Review Safety Alert



Supported Reports of Abuse & 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, with a particular focus on children in out-of-home settings.[74] The Massachusetts system of investigating child abuse and/or neglect[75] includes a mandatory report

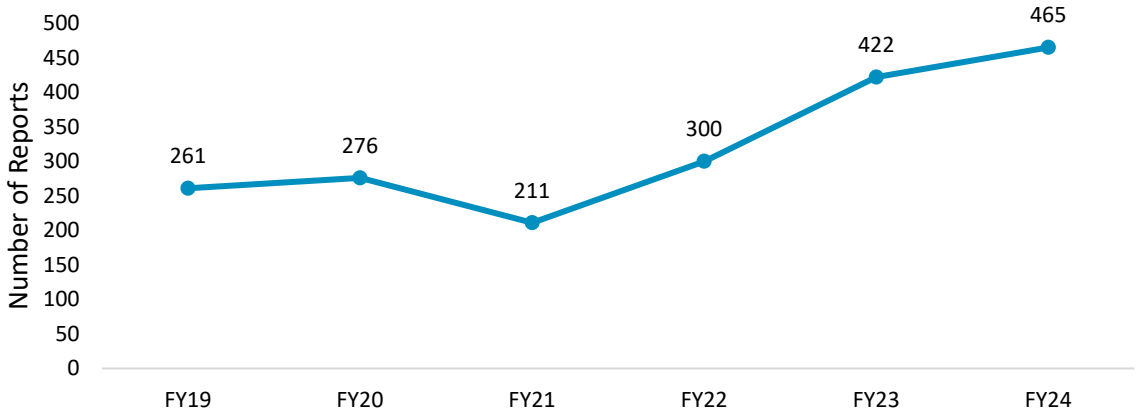
[73] For more information about actions taken by the OCA related to these and other concerns, please see Findings & Interventions, page 59.
[74] Out-of-home settings include foster care, congregate care, child care, public and private schools, after-school and summer programs, school-funded transportation, and hospitals. See Appendix E: Glossary of Terms for definitions.
[75] The Massachusetts system is governed by M.G.L. c. 119 § 51B(l).

to the OCA (among other agencies) when DCF[76] determines that a child was abused and/or neglected in certain out-of-home settings. Out-of-home settings include foster care, congregate care, child care, public schools, private schools, after-school and summer programs, residential and inpatient therapeutic programs, and school-funded transportation companies.[77]

OCA staff review and analyze each report to evaluate the safety and well-being of the child(ren) involved in the incident, policy and practice concerns with the particular out-of-home setting, the quality of the DCF investigation, and trends and patterns related to the care of children in out-of-home settings. If the OCA identifies a significant concern in any of these areas, the OCA will immediately follow up with DCF as either the investigator of the report of abuse and/or neglect or the entity responsible for providing ongoing case management services to the child and family and/or the licensing, regulatory, or funding agency to gather more information and ensure the concerns are addressed.

In FY24, the OCA received 465 supported reports of abuse and/or neglect in out-of-home settings involving 676 children and 515 alleged perpetrators. This is the highest volume of reports ever received by the OCA. It was a 10% increase from FY23 and a 55% increase from FY22.

Figure 22:
Supported Reports of Abuse and Neglect in Out-of-Home Settings, Year Over Year (FY19-FY24)



One-third of the reports (31%) concerned children or youth in congregate care, 20% in a public-school setting, 20% in child care, and 18% in foster care.[78] The OCA received 58% more reports from settings in the "other" category compared to FY23. Those reports came from hospitals (16), transportation companies (14), private schools (9), community-based programs (8), and unknown settings (2).

[76] Only DCF is mandated to send abuse and/or neglect reports to the OCA. However, the OCA may request reports of abuse and/or neglect from other agencies, such as EEC, as necessary.
[77] For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.
[78] See Appendix C: Additional Core Function Data & Context for additional data by congregate foster care type.

The number of reports regarding congregate care and foster care remains stable, while reports about public schools increased 22%, and reports about child care increased 12%. The reason for this increase in supported reports of abuse and/or neglect in out-of-home settings is not yet known.

Table 5: Supported Reports of Abuse and/or Neglect in Out-of-Home Settings, FY23 and FY24

Type of Institution	FY23 Reports	FY24 Reports	Percent Change
Congregate Care	147	145	-1%
Public School	77	94	22%
Child Care	83	93	12%
Foster Care	84	84	0%
Other	31	49	58%
Grand Total	**422**	**465**	10%

Child Care

In FY24 the OCA received **93 supported reports** of abuse and/or neglect in childcare settings involving **149 children**. For context, in FY23 EEC licensed 8,351 family childcare, group, and school-age programs with the capacity to serve 271,437 children.[79] Reports were regarding center-based (76, 82%) and independent home-based (17, 18%) programs.[80] **Of those 93 supported reports, 99% involved neglect, 30% involved physical abuse, and 3% involved sexual abuse and/or sexual exploitation**.[81] The OCA reviews of these incidents categorized risk of emotional/psychological harm as the most prevalent incident concern (43), followed by improper behavior management (41), and improper/inadequate supervision (40).[82] There were reported increases across all the OCA-created incident concern categories, however, the increase was largest for risk of emotional or psychological harm and improper behavior management.

Congregate Care

Year over year, congregate care settings yield the most supported reports of abuse and/or neglect in out-of-home settings. In FY24, the OCA received **145 supported reports** of abuse and/or neglect in congregate care settings involving **198 children.** This is two fewer reports than the OCA received in FY23 but is still substantially higher than in prior years.[83] For context, in FY23 DCF served 1,299 children in congregate care, DYS served 162 children in residential commitment and 647 overnight arrest admissions, and the Bureau of Substance Abuse and

[79] Massachusetts Department of Early Education and Care. (2023, November 13). Licensed and Funded Child Care Providers: E2C Hub. Massachusetts Education-to-Career Research and Data Hub. https://educationtocareer.data.mass.gov/Early-Education-and-Care-/Licensed-and-Funded-Child-Care-Providers/dn4d-tjbb/about_data Open XLSX file, 12.22 MB, Licensed and Funded Programs (FY23: July22 - June23)

[80] For more information about childcare setting classifications, see Appendix E: Glossary of Terms and M.G.L. c. 15D § 1A.

[81] Some cases involve more than one type of abuse/neglect; sums will not equal 100%.

[82] The OCA may identify more than one incident concern per supported report; sums will not equal total.

[83] The OCA received 126 supported reports of abuse and/or neglect in congregate care in FY20, 107 in FY21, 100 in FY22, and 147 in FY23.

Addiction served 51 .[84] Though the volume of reports is lower this year, the number of children involved is substantially higher. These reports came from residential schools (79, 54%), group homes (41, 28%), and secure facilities (25, 17%). **Of the 145 supported reports in FY24, 97% involved neglect, 29% involved physical abuse, and 6% involved sexual abuse, exploitation or human trafficking**.[85,86] The OCA's review of these cases found that improper or inadequate supervision is the most prevalent concern category (69), followed by improper behavior management (48), and boundary issues (31). A small portion of cases (3) involve failure to provide health and/or medical care.[87]

Foster Care

In FY24 the OCA received **84 supported reports** of abuse and/or neglect in foster care involving **132 children**. This is the same as the number of reports received in FY23. For context, approximately 6,000 children and youth receive foster care services through DCF, including kinship placements, in any given year. Supported reports of abuse and/or neglect occurred in less than 1% of DCF foster care placements in FY24. **Of the 84 supported reports, 94% involved neglect, 17% involved physical abuse, and 13% involved sexual abuse and/or sexual exploitation**.[88] Reports came from comprehensive foster care (10), kinship foster care (27), and unrelated foster care (47).[89] Prior to FY23, reports from kinship placements were the largest portion of reports; this is the second year in a row that unrelated foster care placements represent the largest portion of reports. The most prevalent OCA-identified incident concern category for foster care is risk of emotional and/or psychological harm (52) followed by improper or inadequate supervision (26) and failure to provide basic needs (16). A handful of cases involved failure to provide health and/or medical care (5) and educational neglect (3).[90]

Data Correction: In prior OCA annual reports, the total number of children in a placement was presented as foster care service numbers. The numbers in this report accurately reflect children in foster care placement, excluding those in independent living, congregate care, treatment, and other placements.

[84] Justice Data and Policy Board (JJPAD). (2024). FY2023 Annual Report. https://www.mass.gov/doc/jjpad-2023-annual-report/download
[85] Numbers will not sum to 100% because reports can be supported for multiple allegations, such as abuse and neglect.
[86] Some cases involve more than one type of abuse; sums will not equal 100%.
[87] The OCA may identify more than one incident concern per supported report; sums will not equal total.
[88] Some reports involve more than one type of abuse; sums will not equal 100%.
[89] See Appendix E: Glossary of Terms for a definition of the various foster care settings.
[90] The OCA may identify more than one incident concern per supported report; sums will not equal total.

Table 6: Total Foster Care Reports, Children Involved, and Service Numbers[91]					
Fiscal Year		**FY21**	**FY22**	**FY23**	**FY24**
Total Supported Reports		58	63	84	84
Number of Children Appearing in Reports		92	112	142	132
Reports from:	Comprehensive Foster Care	5	12	22	10
	Kinship Foster Care	34	34	24	27
	Unrelated Foster Care	15	12	37	47
Total Number of Children Served in Foster Care[92]		7,159	6,991	6,497	5,838

See Appendix C: Additional Core Function Data & Context for additional information about abuse, neglect, and neglect subclassification by type of foster care and type of congregate care.

Findings & Interventions

The OCA uses the information reported to our office through our statutory functions to inform our work across the state child-serving systems. When a complaint, critical incident report, Foster Care Review safety alert, or DCF supported report of abuse and/or neglect in an out-of-home setting is received, the OCA quality assurance staff conducts an immediate administrative review to learn more about the circumstance that brought it to the attention of the OCA and state agency involvement with the child and family. When the OCA identifies a need for clarifying information, an individual case practice concern, or a system-wide pattern or trend, we follow a standard operating procedure of contacting a designated senior leadership liaison at the agency involved. Through these liaisons, the OCA receives information requests or works collaboratively to ensure necessary actions are taken to resolve the OCA concerns, thereby improving state services to children and families.

The OCA responds to and offers guidance to all individuals who contact our **Complaint Line**. After an in-depth assessment of the situation presented and after the provision of guidance and referrals to support the individual, the OCA may also decide to follow up with the state agency involved. The OCA takes such action when we identify the need for additional or clarifying information, share the concerns brought to our attention, and/or determine that OCA intervention is required to assist in resolving those concerns. In all instances of state agency follow-up, the OCA continues regular communication with the relevant state agency liaison until our concerns are alleviated.

The OCA staff conduct an immediate review of all **CIRs** and **Foster Care Review safety alerts** to learn more about the circumstances 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 played a role in the incident or that the child, young adult, or family, is not

[91] These figures do not include independent living.
[92] Defined as children and young adults in departmental kinship, unrelated, pre-adoptive, and comprehensive foster care categories.

receiving quality services to meet their needs, we may obtain additional reports from the agency, speak with agency senior leadership staff, and further review case records to learn more about the family's history and involvement with the agency.

OCA staff review and analyze each **DCF supported report of abuse and/or neglect** in an out-of-home setting. The purpose of this review is to evaluate the immediate safety and well-being of the child(ren) involved and the thoroughness of the DCF investigation. After a review, the OCA may reach out to the reporting agency or a licensing entity to obtain and review their investigations and corrective actions plans. The OCA obtains this information to review any challenges the out-of-home setting is experiencing, such as workforce retention, staff training, or unclear or lacking programmatic policy. The OCA may also obtain this information to ensure that proper follow-up has been done to reduce or eliminate the risk to children who remain in the setting or to prevent further harm.

In FY24, the OCA followed up with designated state agency liaisons at DCF, DMH, DPH, DYS, EEC, DESE, DDS, DTA, and EOHHS about service delivery in 426 reports and inquiries.[93] This includes:

- 109 of 532 Complaint Line inquiries (103 complaints and six requests for information or a referral).
- 158 of 465 DCF supported reports of abuse and/or neglect in out-of-home settings.
- 148 of 278 CIRs.
- 11 of 15 Foster Care Review safety alerts.

The reasons for follow-up varied by agency, as did the actions taken by an agency to resolve the issues. Table 7 provides an agency-by-agency overview of the number of reports or inquiries about which the OCA followed up and the reasons for that follow-up.

[93] As of the writing of this report, an additional 31 reports or inquiries were still under review with a pending determination about the need to follow up with an external agency (18 CIRs, 1 Complaint Line inquiry, 12 supported reports of abuse and/or neglect in an out-of-home setting).

Table 7: Number of Reports or Inquiries About Which the OCA Reached Out to a State Agency and the Reason for the Follow-Up[94]			
Agency	**Report or Inquiries**	**OCA's Reason for Follow-Up**	**Response to OCA's Feedback**
DCF	356	See DCF Case Practice Concerns and Response (below)	
DESE	15	Information about hiring practices for school staff Information about reporting protocols between schools and DESE Developmentally appropriate education about sexual abuse and CSEC	Concerns were addressed with appropriate individuals
DMH	3	Information about actions taken following a supported report of abuse and/or neglect in an out-of-home setting	Concerns were addressed with appropriate staff
DPH	3	Reporting protocols and assessment for abuse Information regarding an ongoing investigation	Concerns were addressed by agency leadership
DYS	12	Status updates about youth involved with DYS following an incident: health, well-being, location, and safety. Feedback about safety planning Clarity about the circumstances of events	Provided OCA with additional information or context that resolved any concerns
EEC	41	Information about hiring practices for licensee staff Information about contracting with workforce relief agencies Clarification about cross-provider record sharing Clarification about disciplinary/accountability actions taken following supported allegations of abuse and/or neglect Information about trainings provided regarding trauma-informed and responsive practices, mandated reporting, supervision, restraints, de-escalation tactics and more Information about conditions of facilities where children reside Information about children's access to therapeutic services Overnight shift policies	Provided OCA with additional information or context that resolved any concerns and took steps that resolved concerns
Other	7	EOHHS: Referral to the EOHHS ombuds process DDS: Employment status of individuals of concern DTA	Action steps were taken to resolve concerns

[94] Number will not sum to total because the OCA occasionally reached out to more than one agency based on a report or inquiry.

DCF Case Practice Concerns and Response

While the OCA receives and reviews reports and inquiries coming from EOHHS child-serving state agencies, the OCA's statutory mandate is to focus particularly on children in the care or custody of the Commonwealth. When a report or inquiry involving DCF comes to our attention, OCA staff conduct a thorough review of the family's DCF electronic record. The purpose of this review is to understand the child's and family's needs, to substantively review DCF's understanding of the family's needs, and to evaluate DCF's efforts to assist and engage the family and protect the child from harm. In this context, the OCA identifies what worked well in DCF case practice and where there are opportunities for improvement at the area office level, at the regional level, and across the system or with a specific family.

Regardless of the method by which the OCA receives information, the OCA communicates identified case practice concerns to a designated liaison at DCF on an immediate and ongoing basis. This liaison shares the information with the regional and area office management where the family receives services and ensures that the DCF 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 ensures that all 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, as appropriate, to improve services to the child and family.**

In FY24, the OCA identified case practice concerns in 329 of the 1,342 (24%) reports and inquiries that the OCA reviewed.[95] This includes case practice concerns in 125 CIRs (38%), 88 Complaint Line inquiries (17%), 12 FCR safety alerts (80%), and 104 DCF supported reports of abuse and/or neglect in out-of-home settings (22%).

Case practice concerns were stratified into two categories: intake/response and ongoing case practice.[96] These two categories are based on DCF's policies and procedures and how they structure familial engagement. One-hundred-fourteen cases had intake or response concerns, 237 had ongoing case practice concerns, and 22 had both intake/response and ongoing case practice concerns for a total of 329 cases with at least one concern at either process point.[97] Concerns with ongoing case practice were more prevalent than concerns with intake/response. Table 8 describes the most frequently identified concerns for intake/response and ongoing case practice.

Adult consumer engagement, especially regarding father engagement, was the most frequently occurring concern, and predominately took place during ongoing case practice. That is followed by concerns about clinical formulation during ongoing case practice, and administrative concerns, such as documentation and dictation, which occurred during both intake/response and ongoing case practice, though these concerns were more prevalent at intake/response.

[95] The OCA may reach out to an agency even if there are no identified concerns, or we may not reach out about all cases with an identified concern. Therefore, the number of cases with a concern and the number of cases about which the OCA reached out are not equal.

[96] See Appendix E: Glossary of Terms for definitions.

[97] Numbers will not sum to total because any given case may yield more than one concern at either process point.

Table 8: Case Practice Concerns Identified in DCF-Involved Reports and Inquiries		
Concern Category	**Intake/ Response**	**Ongoing Case Practice**
Adult Consumer Engagement	2	82
Clinical Formulation	6	70
Administrative	38	23
Collateral Contact	6	48
DCF Specialist Consultation	3	51
Outcome Decision	52	0
Safety Planning	14	28
Inconsistent Placement Visits	NA	36
Other Concern	9	26
Policy Compliance/Non-Compliance	11	23
Permanency Planning	NA	28
Care and Custody of Child	5	22
Inconsistent Home Visits	NA	27
Interviewing/Engaging Children	6	19
Interagency Collaboration	NA	13
Premature Case Closing	NA	3

When OCA staff members 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 also provides this feedback to DCF. The OCA recognizes that positive feedback helps recognize good work and supports a culture of productive and fair engagement with families.[98] Positive case practices can occur during intake/response or ongoing case practice. Of the 769 cases reviewed for which information about positive case practices is available, the OCA identified 79 cases with exceptional practices (19 CIRs, 40 Complaint Line inquiries, 20 supported reports of abuse and/or neglect in out-of-home settings). Table 9 describes the nature of the positive case practices. Other positive practices include trauma-informed and responsive support, proactive referrals and outreach, and sibling visitation support.

Table 9: Number of Reports or Inquiries with Positive Case Practices	
Category	**Inquiries/Reports**
Other Practice	16
Clinical Formulation	15
DCF Specialist Consultation	12
Administrative	11
Collateral Contact	11
Adult Consumer Engagement	10
Interviewing/Engaging Children	8

[98] This approach began midyear, leading to incomplete data.

Table 9: Number of Reports or Inquiries with Positive Case Practices	
Safety Planning	8
Home Visits	6
Care and Custody of Child	5
Interagency Collaboration	4
Permanency Planning	3
Placement Visits	1

Of the 356 reports and inquiries about which the OCA followed up with DCF, the OCA did not require a response in 93 cases. An additional 26 cases are pending response or are not fully resolved as of the writing of this report. DCF provided a response for the remaining 237 instances. According to DCF, nearly half (110, 47%) of the OCA-identified concerns resulted from pertinent information not being documented in the DCF electronic record at the time of the OCA review.

For other cases, DCF responded by acknowledging the OCA-identified concerns. Those concerns were addressed directly with the staff involved in 87 cases, including 17 instances where DCF Central Office or upper management became involved in the resolution.

DCF also convened an Area or Regional Clinical Review Team (ACRT/RCRT) or specialist consultation to address the case practice concerns within the appropriate area office in 39 cases, took action to retrain staff using case examples highlighted by the OCA in 14 cases, corrected 11 administrative issues, and changed six case decisions. DCF also filed two reports of abuse or neglect and modified two permanency plans based on OCA feedback. The 75 cases with other responses include DCF's provision of additional clarifying information to the OCA that resolved the concern, and disagreements in policy interpretation.

Table 10: DCF's Response to OCA Feedback	
DCF's Response	**Inquiries/Reports**
Documentation Issue	110
Concerns Addressed with Appropriate Staff	70
Other	49
ACRT/RCRT/Specialist Consultation was Convened to Review Case	39
Concerns Addressed by Agency Leadership	17
Case Used as Example for Retraining	14
Administrative Issue Corrected	11
Case Decision Change	6
Filed a Report of Abuse or Neglect	2
Permanency Plan Changed or Paused	2

The OCA monitors the effects of our case practice identification as part of our ongoing oversight of DCF and internal quality assurance practices. The OCA does not cease communication with DCF regarding our concerns until they are fully addressed. As noted above, 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.). Additionally, our improved data collection and reporting helps the OCA focus our interventions across the child-serving system on what is most relevant to children and families.

Final Thoughts

As evidenced by the information in this report, there is a broad array of pressing issues facing the children of the Commonwealth. With that in mind, the OCA's annual strategic planning process included a focus on the intended impact of our work. We reflected on our statutory mandate, and through engagement with and by OCA staff, we worked to answer questions about the values underpinning the agency's work, what impact the OCA hopes to achieve, and the OCA's vision for the future of the children of the Commonwealth. Together, we crafted core values to reflect our agency's approach to the work and to guide our agency as our office continues to develop. The following values are the guiding principles for which we stand as an organization:

We are Child-Centered: We put children and their ability to thrive at the center of our work. We seek to uphold the human rights of children in the Commonwealth and ensure that they are treated with the respect and dignity they deserve. We commit to bringing the voices of children and youth into our work. We recognize that helping children to thrive often requires helping their families to thrive as well. We are dedicated to actively addressing policies, protocols, and practices that disenfranchise children and their families.

We are Trauma-Informed and Responsive: We are committed to creating environments and systems that promote growth, resilience, and empowerment for children, families, staff, and communities impacted by trauma. While caring for ourselves and each other in the face of secondary traumatic stress, we prioritize self-awareness and well-being practices, and foster a culture of compassion, empathy, and support.

We Believe Diversity, Equity, Inclusion, and Belonging are Central to our Work: We believe outcomes for children improve when they are supported by diverse, equitable, and inclusive communities and services. The OCA is in a continual process of improvement in ensuring that we prioritize diversity and inclusion, especially lived experience, in our operations and all aspects of our work. We commit to checking our biases and assumptions to foster unique perspectives that create a diverse workplace where everyone can thrive, innovate, and contribute to our shared mission. We strive to ensure a future where all children are safe and valued and have equitable access to the services and support they need. We commit to bringing forward actionable, equitable, and practical solutions to reduce systemic drivers of marginalization and inequity.

We Value Collaboration: We respect our relationships with communities, agencies, and organizations and strive to work honestly and collaboratively with all stakeholders and each other. We are committed to listening to, learning from, and acting on the input of all people invested in our mission, including those internal to the agency. We are dedicated to creating a collaborative culture where everyone feels valued, empowered, and included.

We Strive for Excellence: We believe all organizations serving children and their families—including the OCA—must be accountable for providing timely, effective, and culturally responsive services. We are a research and data-driven organization, committed to continuous quality improvement, and we strive to provide high-quality public service.

In coming years, the OCA will report on the results of various projects and initiatives we undertake in service of these values and our strategic goals.

Appendices

This Page Intentionally Left Blank

Appendix A: Legislative Priorities

The Office of the Child Advocate recommends legislative changes only after thorough study and review. The OCA's legislative priorities listed below will, when taken together, help make children safer in our Commonwealth, strengthen our office, and help connect children and families with access to critical resources they need. All of this is in the pursuit of our mission of helping children thrive.

The list below reflects the OCA's legislative priorities during the 193rd Legislative Session (2023-2024). FY24 included the second year of the legislative session, and the OCA continued to advocate for a variety of pieces of critical legislation. Unfortunately, many of our key legislative priorities did not successfully pass the Legislature this session, with one notable exception*: An Act relative to substance exposed newborns*, which we are pleased to report was signed into law in December 2024. We will continue working with our legislative partners to pass legislation to improve the lives of children and families of the Commonwealth and update the OCA's statute to better serve our mission.

Strengthening the Office of the Child Advocate and Child Welfare Protections

H165/S124, An Act enhancing child welfare protections

This piece of legislation would help uphold and enhance the independence of the OCA and help us achieve our mission of protecting the most vulnerable children in Massachusetts. Born out of the tragic deaths of David Almond and Harmony Montgomery, this bill would help better protect children, families, and foster parents.

An Act enhancing child welfare protections reinforces the independence of the OCA, enhances the OCA's powers and responsibilities, enacts educational supports for children in foster care, outlines new data collection requirements for DCF, and clarifies the data reporting structure for DCF. These data collection requirements for DCF and the clarification of the data reporting structures stem from the work of the DCF Data Work Group, which the OCA co-chaired.

Protecting Newborns Exposed to Substances and Providing Supports for Families

H166/S129, An Act relative to substance exposed newborns / An Act relative to medication-assisted treatment

Under current law, health care professionals are required to submit a report of abuse and/or neglect to DCF every time an infant is born exposed to a substance that causes physical dependence—regardless of whether they believe the child's health and well-being is at continued risk. DCF data demonstrate that about half of these infants are not found to be at substantial risk of abuse and/or neglect warranting involvement from DCF at the time of the report.

As an alternative to automatically filing a report when a child is born substance-exposed, this legislation supported by the OCA would:

- Create a dual notification system, whereby healthcare providers systematically send DPH de-identified notifications of substance-exposed newborns, only filing a report to DCF

when they believe the birthing parent might continue to use substances in a way that could lead to child abuse and/or neglect.
- Strengthen our existing systems of support for perinatal individuals with substance use challenges.
- Establish strong data collection and analysis requirements. Additionally, this bill requires DCF, DPH, and the OCA to report on the impacts of the above-mentioned legislative changes on abuse and/or neglect reporting, child safety, service gaps, and any disparate impact this policy change may have had, including those pertaining to racial disproportionality.

This bill promotes the health, well-being, and safety of substance-exposed newborns by protecting infants from unsafe situations, all the while encouraging parents struggling with substance use disorders to seek help and be supported in their recovery journey.

A Bill of Rights for Children in Foster Care

H164/S68, An Act establishing a bill of rights for children in foster care

The OCA supports this proposed change to the law as a complement to the foster parents' bill of rights, which was passed and became Mass. General Laws c.119 § 23C. Just as the Legislature recently passed a bill of rights for foster parents, the OCA agrees strongly that children in foster care deserve similar statutory protections.

Specifically, this bill would ensure that foster children have the right to receive medical, dental, and behavioral health services, as well as access to gender-affirming care—crucial for LGBTQ+ children. It spells out that each child should have access to healthy food, clothing, personal care products, and items that preserve and promote the child's family's culture or religion.

The bill makes clear that each child shall have the right to file complaints with the DCF ombudsman's office and the OCA and shall be free from retaliation or punishment for asserting this right.

Improving the Children Requiring Assistance System

H134/S101, An Act regarding families and children in need of assistance

This bill would address the findings from over two years of study of the current Child Requiring Assistance system by the JJPAD Board, as well as its collaborative work crafting recommendations for improvement. JJPAD's 2022 Children Requiring Assistance (CRA) report details the significant shortcomings of the current CRA system, nearly a decade following major reforms made to what was previously called the Children in Need of Services (CHINS) system.

This legislation would:

- **Expand the role and function of Family Resource Centers** to support more children and families outside of the court process. This was the Legislature's initial intent with setting up FRCs in 2012. This bill codifies processes and, subject to appropriation, gives the FRCs the authority to convene multiple agencies and organizations to support a youth's needs with the goal of keeping them out of the juvenile justice system.

- **Change the juvenile court CRA filing process to ensure the court is a true "last resort"** option by requiring probation officers to determine that all community-based options were exhausted by the petitioner prior to filing a CRA petition, and when those options weren't exhausted, connecting the petitioner with community supports, including local FRCs.
- **Raise the lower age of juvenile court jurisdiction from 6 years old to 12 years old** for CRA filings to align with the state's delinquency system, and ensure that the state is serving our youngest and most vulnerable youth outside of the court process.

For the reforms proposed in this bill to be successful, the OCA strongly emphasizes that statute change must be matched with additional funding to ensure Family Resource Centers can add staff to support the influx of additional cases that may result from this shift in process.

Transfer of Child Fatality Review

H162/S92, An Act relative to child fatality review

This bill would transfer the chairmanship of the Child Fatality Review program 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 supporting the program as well as the funding, facilitation, and policy-setting specialization provided by the OCA. The proposed legislation would also add the EEC to the state Child Fatality Review team. Legislation to this effect has advanced through the legislative process several times.

Strengthening the OCA's Ability to Analyze Data from Juvenile Court Records

H1486/S1000, An Act clarifying the Child Advocate's authority to access juvenile 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, the OCA has 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. Having access to this data would allow the OCA to better fulfill requests for information received from the Legislature.

Bail Procedures for Justice-Involved Youth

H1494/S993, An Act updating 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 that the bail magistrate, rather than the officer in charge, makes 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.

An Act updating bail procedures for justice-involved youth would enact these recommendations from the JJPAD Board. 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. **Bail fees were eliminated as part of an outside section of the FY24 budget.**

Other Legislation the OCA Has Supported

In addition to the top priorities outlined above, the OCA from time to time weighs in on a variety of pieces of legislation. The OCA submitted written testimony with regards to a number of bills in FY24:

- HB4241 / S2703, An Act to prevent abuse and exploitation
- H476, An Act providing for alternatives to fines for failure to send
- H161/S74, An Act relative to children's advocacy centers and the Massachusetts Children's Alliance
- HB1604, An Act addressing investigations of reports of abuse and neglect
- S82, An Act Authorizing the Commonwealth of Massachusetts to establish additional mandated reporters for the purpose of the protection and care of children
- S2593, An Act to prevent the imposition of mandatory minimum sentences based on juvenile adjudications
- S105, An Act relative to supporting families dealing with sudden unexplained death in pediatrics
- SB111, An Act establishing a commission on the status of children and youth
- H189, An Act to establish a Massachusetts children's cabinet
- HB153, An Act to eliminate disproportionality and inequities for at-risk children

Appendix B: Boards and Commissions

Juvenile Justice Policy and Data Board (JJPAD): The OCA chairs the JJPAD Board, which was created as part of *An Act relative to criminal justice reform* (Chapter 69 of the Acts of 2018). JJPAD 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.

Childhood Trauma Task Force (CTTF): The OCA chairs CTTF, which was created by *An Act relative to criminal justice reform* (Chapter 69 of the Acts of 2018). CTTF is a permanent entity 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.

Mandated Reporter Commission (MR Commission): In November 2019, the Child Health and Wellness Bill established the MR Commission. Chaired by the Child Advocate, and with members from a wide range of viewpoints from public entities and groups who have extensive experience with mandated reporting in the Commonwealth, the MR Commission was charged with reviewing the mandated reporter law and regulations for reporting child abuse and/or neglect and making recommendations on how to improve the response to, and prevention of, child abuse and/or neglect. The Commission was sunset on June 30, 2021, following the release of its final report to the Legislature.

Child Welfare Data Work Group (DWG): The DWG, which the OCA co-chaired with DCF beginning in 2017, was charged by the Legislature (Section 128 of Chapter 47 of the Acts of 2017) with reviewing the current list of DCF's statutorily mandated reports and recommending which reports could be eliminated or streamlined, and what new reporting was needed. The DWG was sunset in December 2022 following the release of its final report to the Legislature.

Child Fatality Review (CFR): The CFR program was established in 2000 following the passage of M.G.L. c. 38, § 2A and fulfills a federal requirement for Title IV Part E 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), which are coordinated by the district attorneys, and a state child fatality review team (SCFRT). The OCA provides management and coordination of the CFR program, funds related epidemiological work at the Department of Public Health, and is a statutorily named member of the state and local teams. The OCME currently chairs the body. See Appendix A: Legislative Priorities, Transfer of Child Fatality Review, for more information.

Child Sexual Abuse Prevention Task Force (CSAP): The Massachusetts Legislative Task Force for the Prevention of Child Sexual Abuse was created in 2014 (Section 34 of Chapter 431 of the Acts of 2014) to create a framework for preventing child sexual abuse in the Commonwealth. CSAP is chaired by the director of the OCA and the executive director of the Children's Trust and is composed of 30 legislatively named public and private organizations and elected and appointed

officials. The Task Force's authorization expired in November 2022, but the group continues to meet on important issues related to child sexual abuse prevention.

National Center on Substance Abuse and Child Welfare Policy Academy: In September 2022, DCF and DPH were selected by the National Center on Substance Abuse and Child Welfare (NCSACW) to jointly participate in the *2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Health Development and Family Recovery for Infants, Children, Parents and Caregivers Affected by Prenatal Substance Exposure*. The purpose of the 2023 Policy Academy was to enhance the Commonwealth's capacity to meet the needs of infants and their caregivers affected by substance use disorder and prenatal substance exposure. The OCA senior leadership is a member of the Core Team of cross-agency and cross-system partners who developed the goals. Following the development of these goals, in March 2023, Massachusetts was selected to receive in-depth technical assistance (IDTA) from the NCSACW to support their implementation. The IDTA launched in May 2023 and since this time the OCA has been actively involved in advancing the implementation of these goals through the Child Advocate's leadership on the Oversight Committee and OCA staff representation on the core team and several work groups.

Appendix C: Additional Core Function Data & Context

Revised Complaint Line Reporting Schema

In prior years, the Complaint Line coding schema included options for abuse and neglect and child welfare without much context as to the root of the concern or issue. The OCA developed a new coding scheme that provides more nuance and context about the reasons individuals are contacting the OCA. The team also worked to recategorize prior year data to align with the new data metrics. The new structure provides the following options, which are used for complaints and information and referral inquiries to provide a clearer understanding of issues and needs.

- Court involvement
- DCF
- Education
- Mental and/or behavioral health
- Other
- Physical health

In prior years, inquiries related to behavioral or mental health were not collected as a distinct category. The new reporting schema allows OCA staff to pull out those concerns more readily. When reviewing the FY24 data, please keep this new reporting schema in mind.

Table 11: Areas of Concern or Request

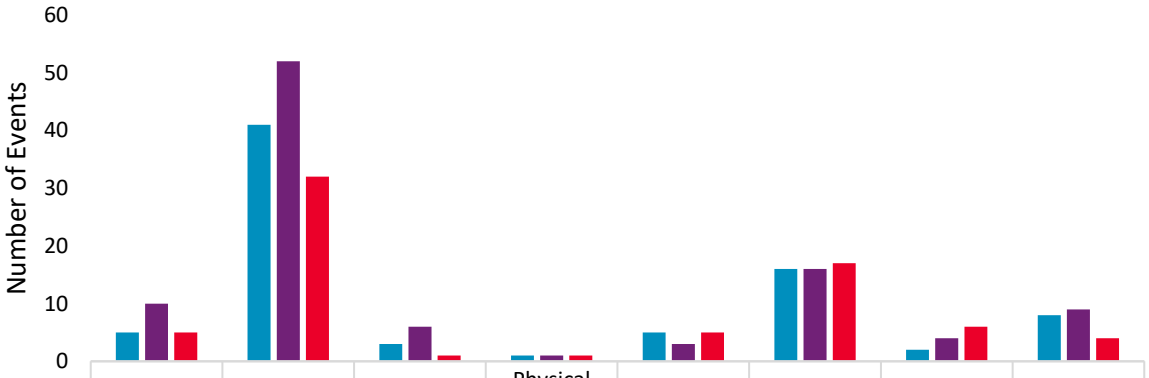
Reason for Call	Detail Mult Picklist that Appears if the Relevant "Reason for Call" Option is Selected
DCF Complaint or request for information about the approach and operations of the Department of Children and Families	Abuse/neglect
	Care and/or custody of child(ren)
	Change of placement
	DCF personnel
	Delayed reunification
	Denied placements
	Family assessment and action plan
	Inappropriate placement choice
	Lack of collateral contacts
	Lack of reunification transition plan
	Lack of/inconsistent home visits or placement visits by social worker
	Length of time in placement or achieving permanency
	Multi-agency-involved youth
	Parental/caregiver engagement
	Permanency goal change
	Quality of placement
	Service coordination
	Type of placement

	Payments and vouchers
	Family visits
	Records requests
Education Complaints or request for information about access to and delivery of education	Bullying
	IEP and/or 504
	Lack of responsiveness of school staff and/or administration
	Need for a different educational placement but school disagrees
	School is refusing to pay for a different educational placement
	Transportation services
	Unfair or inappropriate school discipline
	Other
Court Involvement Complaint or request for information about proceedings and outcomes of probate/family or juvenile courts	Bias during court proceedings
	Concerns with legal representation
	Delay in court proceedings
	Disagreement with judge's decision
	Other
	Visitation
Behavioral Health Complaint or request for information about access to and delivery of behavioral health services	Emergency department boarding
	Changes or other problems with MassHealth coverage
	Child is not receiving enough services/support for their needs
	Service delivery
	Out-of-home placement not related to DCF
	Other
Physical Health Complaint or request for information about access to and delivery of physical health services	COVID-19
	Access to medication and treatment
	Malpractice
	Insurance & payments
Other Other Complaint or request for information; request not elsewhere classifiable	Discrimination
	Conditions of a physical space where a child lives
	Records requests
	Runaway youth
	Financial assistance
	Housing
	Child treatment
	Mandated reporter training
Other Description of Other Complaint or request for information	Open text

Critical Incidents

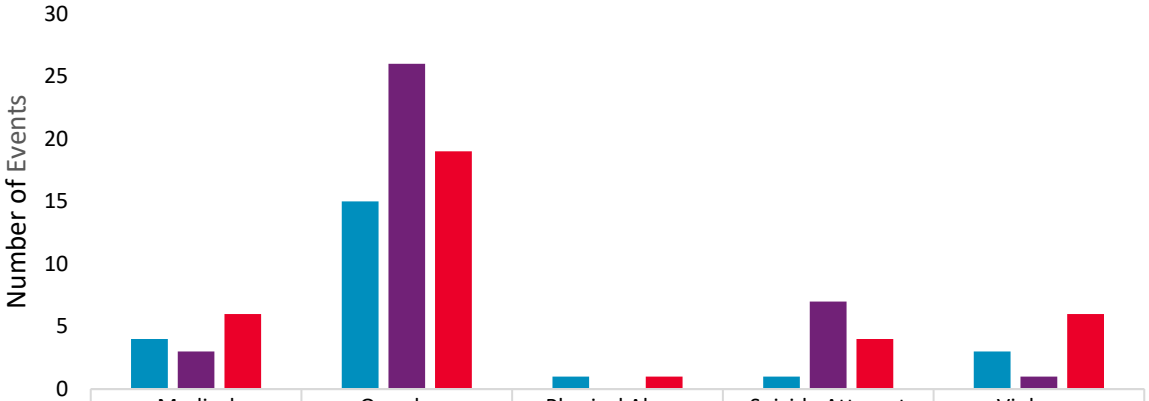
The supplemental data visuals provide complementary data to the information outlined in the Critical Incident Reports section of this report (pg. 40).

Figure 23:
Cause of Fatalities in CIRs (FY22-FY24)



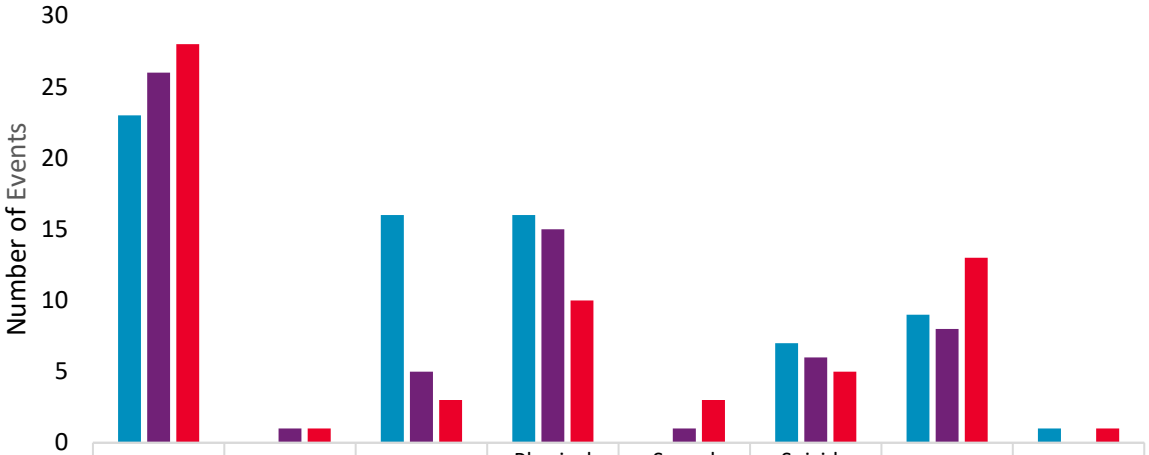
	Injury	Medical	Overdose	Physical Abuse	Suicide	SUID	Violence	Other
FY22	5	41	3	1	5	16	2	8
FY23	10	52	6	1	3	16	4	9
FY24	5	32	1	1	5	17	6	4

Figure 24:
Cause of Near Fatalities in CIRs (FY22-FY24)



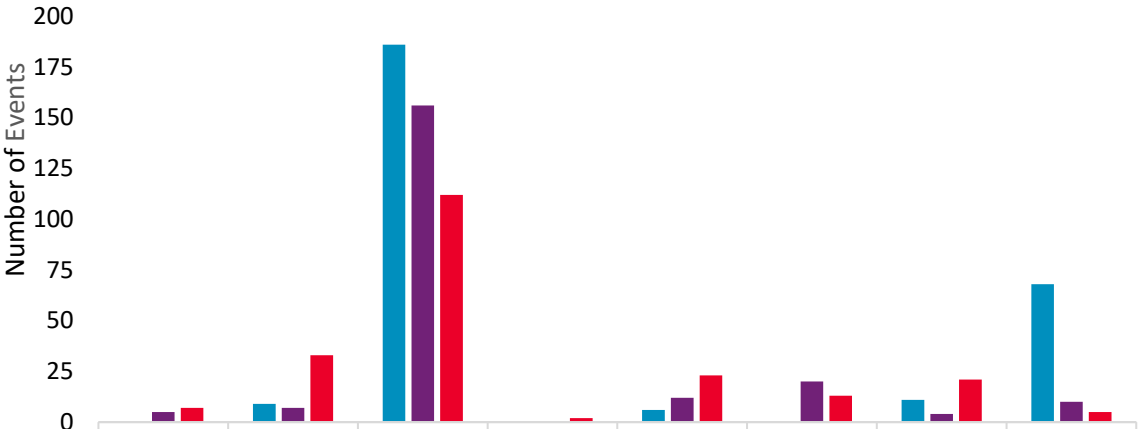
	Medical	Overdose	Physical Abuse	Suicide Attempt	Violence
FY22	4	15	1	1	3
FY23	3	26	0	7	1
FY24	6	19	1	4	6

Figure 25:
Cause of Serious Bodily Injury in CIRs (FY22-FY24)



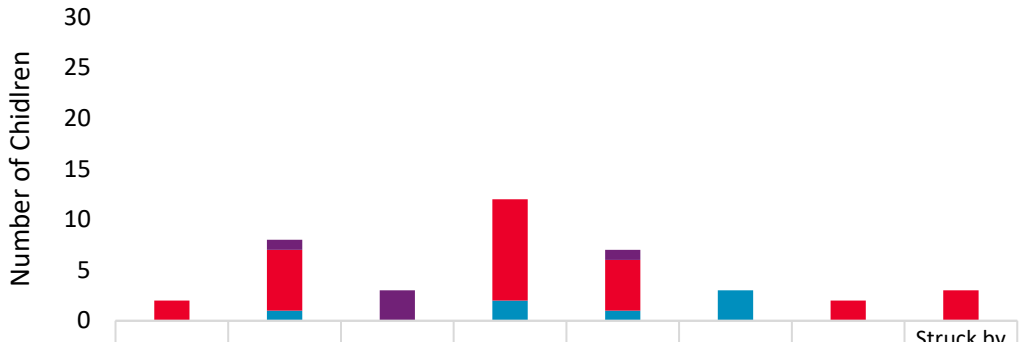
	Injury	Medical	Overdose	Physical Abuse	Sexual Assault	Suicide Attempt	Violence	Other
FY22	23	0	16	16	0	7	9	1
FY23	26	1	5	15	1	6	8	0
FY24	28	1	3	10	3	5	13	1

Figure 26:
Cause of Emotional Injuries in CIRs (FY22-FY24)



	Injury	Medical	Overdose	Physical Abuse	Suicide/ Suicide Attempt	SUID	Violence	Other
FY22	0	9	186	0	6	0	11	68
FY23	5	7	156	0	12	20	4	10
FY24	7	33	112	2	23	13	21	5

Figure 27:
Number of Children Who Sustained Specific Types of Injuries and Injury Outcome



	Bodily Force	Car Crash	Drowning	Fall	Fire/ Burn	Gun/ Projectile	Other	Struck by or Against
Total	2	8	3	12	7	3	2	3
Fatality	0	1	3	0	1	0	0	0
Serious Bodily Injury	2	6	0	10	5	0	2	3
Emotional Injury	0	1	0	2	1	3	0	0

Supported Reports of Abuse and/or Neglect in Specific Out-of-Home Settings

Child Care

Of the 93 supported reports involving 149 children, 99% involved neglect (92), 30% involved physical abuse (28), and 3% involved sexual abuse and/or sexual exploitation (3).

Table 12: Child Care: Outcome Decisions and Incident Concern Categories

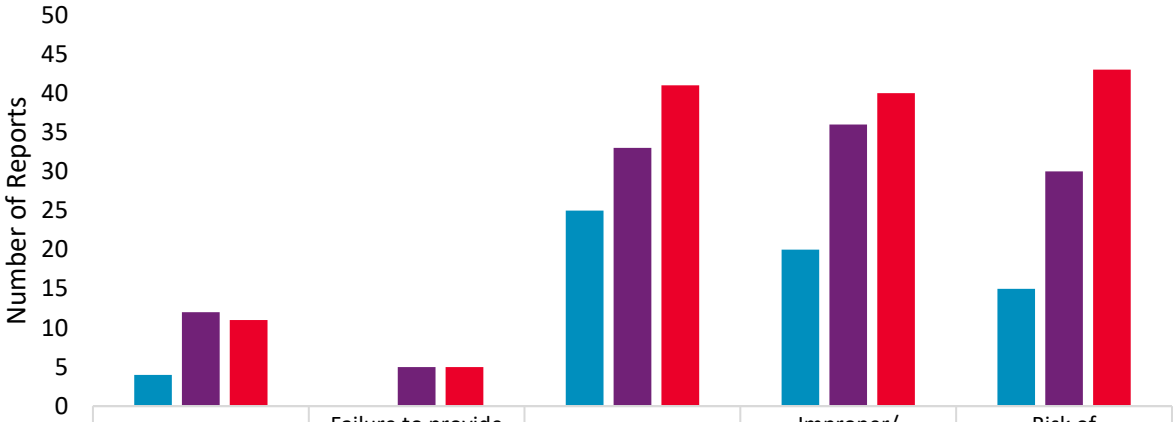
Outcome Decision	Cases	Child Involved	Case %
Neglect	92	148	99%
Physical Injury (Abuse)	28	44	30%
Sexual Abuse/Exploitation	3	5	3%
Boundary Issues	2	2	2%
Failure to Provide for Basic Needs	11	31	12%
Failure to Provide Health/Medical Care	5	5	5%
Improper Behavior Management	41	66	44%
Improper/Inadequate Supervision	40	53	43%
Risk of Emotional/Psychological Harm	43	86	46%

Consistent with prior fiscal years, nearly all supported reports in child care involved **neglect**. Major themes in FY24 relate to risk of emotional/psychological harm, improper behavior management, and inadequate or improper supervision. Risk of emotional/psychological harm often occurred in the context of improper behavior management or improper/inadequate supervision. Inadequate supervision reports mostly resulted in physical injuries or failure to provide basic needs and sometimes related to improper behavior management, such as exclusionary practices. In cases involving inadequate supervision, staff left a child or children alone for extended periods, left a child with an unapproved caretaker, or did not notice a child left a facility unattended. Failure to provide basic needs also occurred from a child accessing a harmful substance, such as an allergen or a vape pen. Risk of psychological harm related to caregiver substance use, domestic violence, and conditions of the facility. Improper behavior management involved yanking, grabbing, pinching, threatening, and vulgar language.

Supported **physical abuse** reports related to the childcare provider or employee's inappropriate response to a child's behaviors or inappropriate attempt to modify a child's behaviors that resulted in injury, including corporal punishment. These cases often included grabbing, slapping, hitting, pushing, or force-feeding a child.

Supported **sexual abuse** reports in FY24 occurred only in center-based childcare settings and involved a child being sexually abused by a provider or provider's family member and child pornography.

Figure 28:
Nature of Supported Reports of Neglect in Child Care



	Failure to provide for basic needs	Failure to provide health/medical care	Improper behavior management	Improper/ inadequate supervision	Risk of emotional/psychological harm
FY22	4	0	25	20	15
FY23	12	5	33	36	30
FY24	11	5	41	40	43

Data Note: The OCA may identify more than one incident concern per supported report; sums will not equal total.

Congregate Care

Of the 145 supported reports of abuse and/or neglect in congregate care in FY24 involving 198 children, the majority came from residential schools (79, 55%), followed by group homes (41, 28%) and secure facilities run by DYS (25, 17%).[99]

Table 13: Type of Congregate Care Involved in Supported Reports of Abuse and/or Neglect

Congregate Care Setting	Cases	Child Involved	Percent of Cases
Group Home	41	57	28%
Residential School	79	109	73%
Secure Facility	25	32	17%
Grand Total	**145**	**198**	**100%**

Of the 41 supported reports involving 57 children from group homes, 93% involved neglect (38), 27% involved physical abuse (11), and 10% involved sexual abuse and/or sexual exploitation (4).[100]

Of the 79 supported reports involving 111 children in a residential school, 99% involved neglect (110), 18% involved physical abuse (20), and 3% involved sexual abuse and/or sexual exploitation (3).

Of the 25 supported reports involving 43 children in a secure facility run by DYS, 93% involved neglect (40), 30% involved physical abuse (13), and none involved sexual abuse and/or sexual exploitation.

In FY24, incidents resulting in supported reports of **neglect** mostly involved situations in which inappropriate or inadequate supervision or boundary issues resulted in youth running away from the program, engaging in consensual or coercive sexual contact with one another, and/or using illicit substances. Incidents resulting in supported reports of neglect also include boundary issues such as staff communicating with children on social media, allowing children to use a staff member's cell phone, providing children illicit substances, and failure to report elopement. Improper behavior management relates to 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). Failure to provide basic needs mostly occurred in residential schools and involved neglecting a child's hygiene or medication needs or exposing a child to violence.

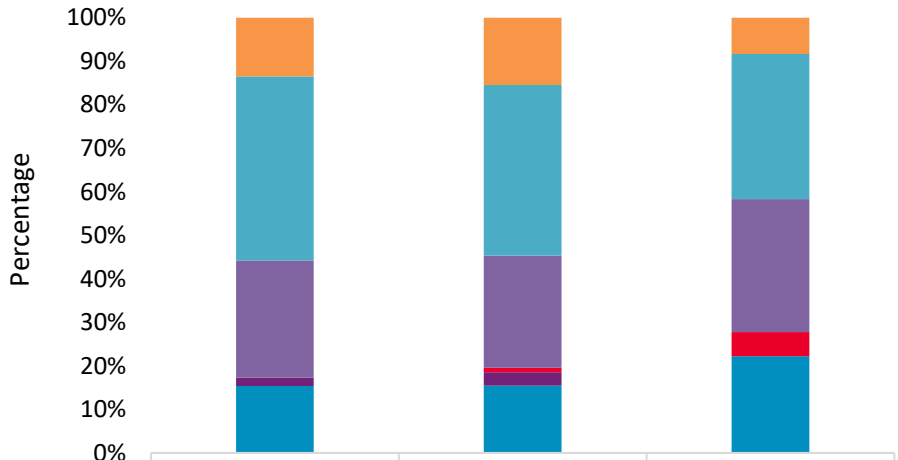
Supported reports of **physical abuse** include injuries to the child due to a staff person's negligent behavior or inappropriate response to the child's behavior such as pushing, choking, slapping, and unapproved or incorrectly performed restraints and escorts.

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.

[99] Interpret with caution. Higher volume of reporting can indicate strong reporting protocols.
[100] Some cases involve more than one outcome decision; sums will not equal 100%.

Figure 29:

Nature of Supported Reports of Neglect in Congregate Care by Setting



	Group Home (41)	Residential School (109)	Secure Facility (32)
Risk of emotional/psychological harm	7	15	3
Improper/ inadequate supervision	22	38	12
Improper behavior management	14	25	11
Failure to provide health/medical care	0	1	2
Failure to provide for basic needs	1	3	0
Boundary Issues	8	15	8

Data Note: The OCA may identify more than one incident concern per supported report; sums will not equal totals for each setting.

Foster Care

Of the 84 supported reports of abuse and/or neglect in foster care received in FY24, 94% involved neglect, 17% involved physical abuse, and 13% involved sexual abuse and/or sexual exploitation.[101]

The number and type of neglect varied by foster care setting.[102] 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.[103]

Table 14: Type of Foster Care Involved in Supported Reports of Abuse and/or Neglect

Type of Foster Care	Cases	Child Involved	Percent of Cases
CFC	10	11	12%
Kinship	27	40	32%
Unrelated/Unrestricted/Pre-Adoptive	47	81	56%
Grand Total	**84**	**132**	**100%**

[101] Some cases involve more than one type of abuse and/or neglect; sums will not equal 84.
[102] For definitions of the types of foster care settings, see Appendix E: Glossary of Terms.
[103] For definitions of the types of foster care settings, see Appendix E: Glossary of Terms.

Comprehensive Foster Care

In FY24, the OCA received 10 supported reports from comprehensive foster care involving 11 children. This is substantially fewer than what was received in FY23. These reports involved supported allegations of neglect in 80% of cases, physical abuse in 40% of cases, and sexual abuse in 20% of cases.

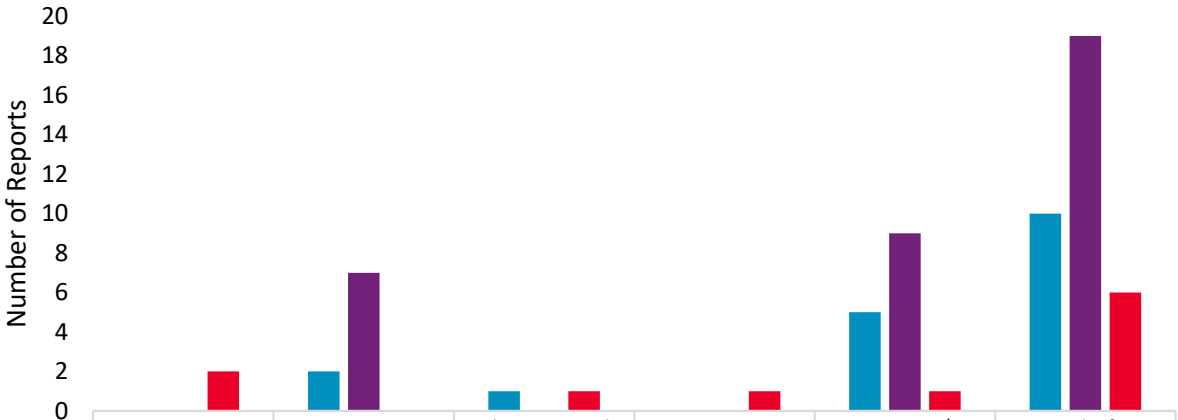
Table 15: Supported Reports of Abuse and/or Neglect in Comprehensive Foster Care, FY22-FY24

Fiscal Year	FY22	FY23	FY24
Supported Reports	12	22	10
Number of Children	20	40	11
Total Number of Children Served	1,081	962	992

Incidents of **neglect** included concerns about a foster parent's boundaries, failure to seek necessary medical treatment, substance use, and lack of gender-affirming support. Supported reports 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 the foster parent.

Figure 30:

Nature of Supported Reports of Neglect in Comprehensive Foster Care



	Boundary Issues	Failure to provide for basic needs	Failure to provide health/medical care	Improper behavior management	Improper/ inadequate supervision	Risk of emotional/psychological harm
FY22		2	1	0	5	10
FY23		7	0	0	9	19
FY24	2	0	1	1	1	6

Data Note: The OCA may identify more than one incident concern per supported report; sums will not equal total.

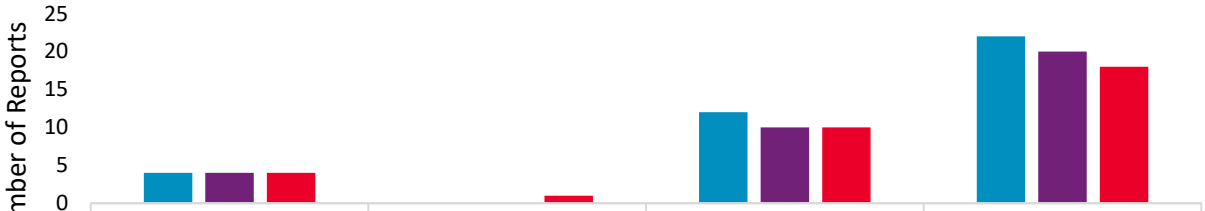
Kinship Foster Care

In FY24, the OCA received 27 supported reports involving 40 children from kinship foster care. Neglect was involved in 100% of cases, and physical abuse in 7% of cases. There were no cases of sexual abuse or exploitation.

Table 16: Supported Reports of Abuse and/or Neglect in Kinship Foster Care, FY22-FY24			
Fiscal Year	**FY22**	**FY23**	**FY24**
Supported Reports	34	24	27
Number of Children	67	37	40
Total Number of Children Served	3,169	3,001	2,923

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 reports of **physical abuse** were the result of the foster parent's use of inappropriate physical discipline.

Figure 31:
Nature of Supported Reports of Neglect in Kinship Foster Care



	Failure to provide for basic needs	Failure to provide health/medical care	Improper/ inadequate supervision	Risk of emotional/psychological harm
FY22	4	0	12	22
FY23	4	0	10	20
FY24	4	1	10	18

The OCA may identify more than one incident concern per supported report; sums will not equal total.

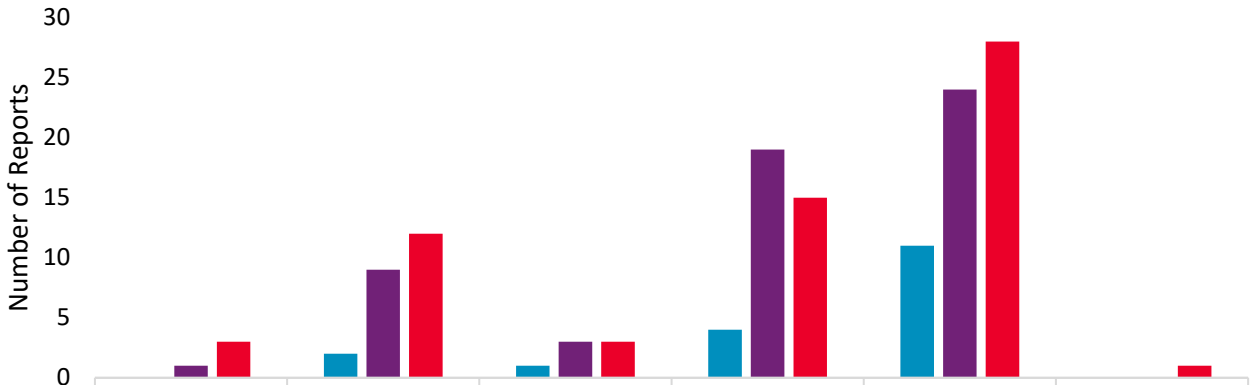
Unrelated/Unrestricted/Pre-Adoptive Foster Care

In FY24, the OCA received 47 supported reports from unrelated foster care involving 81 children. Cases involved supported allegations of neglect in 95% of cases, physical abuse in 11%, and sexual abuse or human trafficking in 12%.

Table 17: Supported Reports of Abuse and/or Neglect in Unrelated or Unrestricted Foster Care, FY22-FY24			
Fiscal Year	**FY22**	**FY23**	**FY24**
Supported Reports	12	37	47
Number of Children	23	64	81
Total Number of Children Served	2,387	2,204	1,923

Incidents of **neglect** included foster parent substance use, domestic violence between foster parents, a foster parent's suicide attempt, foster parent's mental health, inappropriate contact with a child's natural family, educational and medical neglect, and inadequate supervision resulting in harm. **Physical abuse** reports related to a foster parent's inappropriate discipline practices and coercion to fight with siblings. **Sexual abuse** reports related to inappropriate physical touch and sexual contact with a foster parent or foster sibling.

Figure 32:
Nature of Supported Reports of Neglect in DCF Unrestricted/Unrelated Foster Care



	Educational	Failure to provide for basic needs	Failure to provide health/medical care	Improper/ inadequate supervision	Risk of emotional/psychological harm	Improper behavior management
FY22	0	2	1	4	11	0
FY23	1	9	3	19	24	0
FY24	3	12	3	15	28	1

Data Note: The OCA may identify more than one incident concern per supported report; sums will not equal total.

Appendix D: Acronyms

State Agencies

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

DTA Department of Transitional Assistance

DYS Department of Youth Services

EEC Department of Early Education and Care

EOHHS Executive Office of Health and Human Services

EOHLC Executive Office of Housing and Living Communities

EOTSS Executive Office of Technology Services and Security

MassHealth Massachusetts Medicaid Program

OCA Office of the Child Advocate

Other Acronyms Appearing in the Report

ACRT/RCRT: Area or Regional Clinical Review Team

ASD Autism Spectrum Disorder

CQI Continuous Quality Improvement

CRA Child Requiring Assistance System

CCWT Center on Child Wellbeing & Trauma

CFC Comprehensive Foster Care

CFR Child Fatality Review

CIR Critical Incident Report

CJRA Criminal Justice Reform Act

CSAP Child Sexual Abuse Prevention

CTTF Childhood Trauma Task Force

DWG Child Welfare Data Work Group

EI Emotional Injury

IEP Individualized Education Program

F Fatality

FCR Foster Care Reviews

FRCs Family Resource Centers

FY Fiscal Year

HSSP Housing Stability and Support Program

ICPC Interstate Compact on the Placement of Children

JJPAD Juvenile Justice Policy and Data

LEP Limited English Proficiency

MRC Mandated Reporter Commission

NF Near Fatality

PSB Problematic Sexual Behaviors

SCFRT State Child Fatality Review Team

SBI Serious Bodily Injury

SUD Substance Use Disorder

SUID Sudden Unexpected Infant Death

TAY Transition Age Youth

TIOA Trauma-Informed Organizational Assessment

Appendix E: Glossary of Terms

Abuse and/or neglect: In relation to the Complaint Line, this refers to DCF's response to a report of abuse and/or neglect; maltreatment of a child at home or in an out-of-home setting.

Boundary issues: Relates to a supported report of neglect in an out-of-home setting. The provider violates physical and/or emotional boundaries with a child.

Care and/or custody of child: In relation to OCA case review findings, this refers to a concern that DCF left the child in the care and/or custody of a parent or caregiver or removed the child from the care and/or custody of a parent or caregiver.

Child care: For the purposes of this report, child care references center-based, independent home-based, and provider-affiliated home-based programs.

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 with whom the family or child has a strong bond and who is significant in their life. This was incorporated by DCF into kinship foster care in FY24.

Child welfare: In relation to the Complaint Line, this refers 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.

Clinical formulation: DCF is not holistically assessing the family based on all available information to create a realistic plan of required changes that will promote a child's safety, permanency, and well-being. Clinical formulation requires a thorough review of DCF's history with the family.

Collateral contact: In relation to OCA case review findings, this refers to a determination that the risk posed to the child was not fully assessed because the DCF case management team did not contact professionals and/or natural supports or did not ask questions that elicited information necessary to inform clinical formulation. 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.

Comprehensive foster care: Foster homes that offer more intense therapeutic care and supports for children with more complex needs. This service is only provided by licensed foster care agencies in accordance with the licensing requirements of EEC and DCF.

Congregate care: 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.

COVID-19: In relation to the Complaint Line, this refers to concerns arising from a lack of adherence to COVID-19 protocols.

Critical incident report: State agencies providing services to children or youth must notify the OCA if a child suffers a fatality, near fatality, serious bodily injury, or emotional injury. These notifications are referred to as critical incident reports.

DCF case management: In relation to the Complaint Line, this refers to DCF's response to a report of abuse and/or neglect; removal of a child; service coordination or case oversight; frequent changes in social workers.

DCF personnel: In relation to the Complaint Line, this refers to 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.

DCF specialist consultation: In relation to case review findings, this refers to 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.

Delayed or no health care: Relates to a supported report of neglect in an out-of-home setting. The provider failed to ensure the child has proper and timely physical, dental, or behavioral health care.

Diversion: Any program that allows a youth who commits an offense to be directed away from more formal juvenile justice system involvement. Diversion is considered an alternative response to arrest and/or prosecution in juvenile court.

Dually involved youth: Youth who are involved with the child protection system who also become involved with the juvenile justice system.

Education: The OCA uses this term in two ways:

- In relation to an allegation of neglect, this refers to a failure to provide the child with proper educational opportunities.
- In relation to the Complaint Line, this refers to concerns or requests for information related to bullying, an Individualized Education Plan (IEP) for a child, and/or special education.

Emotional injury: An emotional injury occurs when a child is known to witness the fatality or life-threatening incident of an individual related to an unexpected medical event, overdose, violent act, or suicide.

Experiences: In terms of a critical incident, this is used to capture the multitude of outcomes and characteristics that can occur from one single event, leading to a critical incident report. For example, one critical incident report can involve two children—one who died, and one who experienced a serious bodily injury and witnessed the death of the other child. This would be captured as one report involving two children and three experiences.

Failure to meet basic needs: Relates to a supported report of neglect in an out-of-home setting. The provider did not meet the child's needs for food, shelter, and clothing. This also includes situations where there are safety concerns regarding the physical environment where services are provided.

Fatality: In terms of a critical incident, fatality occurs when a child between birth to 24 years old dies.

Foster Care Review safety alert: Safety alerts are generated by Foster Care Reviewers at the end of a Foster Care Review if an immediate safety concern is identified for the child/youth. The safety alert is immediately sent to the DCF area office responsible for the case. The area director must document a response to the safety alert within one working day.

Foster Care Review: A Foster Care Review panel convenes every six months for every child in out-of-home placement to provide oversight and ensure that every child and youth under the state's custody has a permanency plan, which defines a safe and permanent home. The implementation of a Foster Care Review process is a federal requirement.[104]

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, DCF places the most children in foster care, however DYS can also place children in foster care.

Secure facility: A DYS or provider facility characterized by locked entrances and exits and other physically restrictive construction that typically includes locked bedrooms as well as procedures that are intended to prevent a client from departing without the approval of the Department.

Healthcare: The OCA uses this term in two ways:

- In relation to an allegation of neglect, this refers to a caregiver and/or staff failing to provide the child with appropriate physical or behavioral health care.
- In relation to the Complaint Line, this refers to MassHealth coverage; extended stays in emergency rooms for behavioral health reasons; children not receiving services and support for their healthcare needs.

[104] United States Social Security Act, 42 USC 675 Sec 475 (5) (B).

Improper behavior management: In relation to an allegation of neglect, this refers to a caregiver and/or staff who do not respond properly to a child who is exhibiting problematic and/or concerning behaviors.

Improper/inadequate supervision: In relation an allegation of neglect, this refers to a caregiver and/or staff who engage in behaviors, activities, or actions that prevent them from being able to properly supervise the child, such as not conducting bed check properly, sleeping while working, etc.

Inadequate education: Relates to a supported report of neglect in an out-of-home setting. Failure to assure the child has proper educational opportunities.

Inconsistent home visits: In relation to case review findings, this refers to 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: In relation to case review findings, this refers to 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.

Independent living: A wide range of residential options that afford youth to live on their own and still access resources.

Injury: In terms of a critical incident, injury relates to non-medical physical harm that is unintentional. Injuries can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Interagency collaboration: In relation to case review findings, this refers to a child having additional agency involvement (DDS, DMH, DYS) and no documentation in the record that DCF is collaborating on an ongoing basis with the agency.

Interviewing/engaging children: In relation to case review findings, this refers to 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.

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.

Lack of father engagement: In relation to case review findings, this refers to a determination that one or more of the following occurred: The father was not assessed as part of a family assessment and action plan; the father was not contacted as part of ongoing case management; or the father was not visited or contacted monthly, and a reasonable explanation is not documented in the case record to support why these actions did not occur.

Language access: Services that agencies use to bridge the communication barrier with individuals who cannot speak, understand, read, or write English fluently to provide limited-English-proficient individuals with the same services as English-speaking individuals.

Legal: In relation to the Complaint Line, this refers to concerns about a court-appointed attorney; delays in court proceedings.

Limited English proficiency: Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English have limited English proficiency.

Medical: In terms of a critical incident, a medical event relates to a non-injury health event, such as a heart attack. Medical events can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Home: Where a child was living before agency involvement. This may be with biological parents, kin, or other caregivers.

Nature: The characteristic of the events involved in a critical incident. These can be related to an unintentional injury, suicide or suicide attempt, overdose, SUID, physical abuse, violence, a medical event, or something else not otherwise classifiable.

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.

Other concern: In relation to case review findings, this refers to the OCA's identification of 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).

Other: In relation to the Complaint Line, this refers to child support and other concerns not elsewhere classifiable.

Outcome decision: In relation to case review findings, this refers to an 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 and/or neglect, with a finding on the alleged perpetrator, or with a categorization of a case as either emergency or nonemergency.

Outcome: Whether or not a child died, nearly died, was seriously physically injured, or suffered an emotional injury. Used to describe critical incident reports.

Out-of-home setting: A facility that provides care to children when they are removed from their home due to abuse and/or neglect, juvenile justice involvement, mental/physical health needs,

or for child care. Settings include congregate care, like residential schools and group homes, childcare facilities, detention centers, foster care, hospitals, and more.

Overdose: In terms of a critical incident, overdose relates to an excessive and dangerous dose of a drug. Overdoses can result in fatality, near fatality, or serious bodily injury. If they are witnessed, they can result in an emotional injury.

Payments/voucher: In relation to the Complaint Line, this refers to assistance with childcare tuition and eligibility for guardianship subsidy.

Permanency planning: A formalized strategy or set of actions designed to ensure the long-term stability, well-being, and security of a child who is involved in the child welfare protection system, typically due to circumstances such as abuse, neglect, or family disruption. The primary goal of a permanency plan is to provide a safe and permanent living arrangement for the child, focusing on their best interests and overall welfare.

In relation to case review findings, this refers to at least one of the following areas: 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.

Physical abuse: In terms of a critical incident, physical abuse relates to an intentional act that causes injury or physical suffering and is perpetrated by a caregiver. Physical abuse can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

Placement/permanency: In relation to the Complaint Line, this refers to length of stay in out-of-home placement; delays in reunification; foster care placement and/or denial of placement with kin; concern for the well-being of a child in foster care or congregate care.

Plans of safe care: A document created jointly by a pregnant or parenting person and their provider. This document helps pregnant people with active substance use disorder or in recovery think about what services or supports they might find useful, to record their preparations to parent, and to organize the care and services they are receiving. A plan of safe care can be any family service plan that covers both the parents' behavioral health/recovery services (including addiction and mental health supports) and family or child-focused services (such as referral to Early Intervention and prenatal care appointments).

Premature case closing: In relation to case review findings, this refers to a determination that a DCF case was closed with one or more of the following conditions: the protective concerns that led to the family's involvement were not 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 after the critical incident without appropriate services/supports in place.

Pretrial detention: Occurs when a judge has placed a youth in DYS before their trial. This occurs after a youth has been arrested and arraigned. Detention stays can last from a couple of hours to weeks or months depending on a variety of factors.

Public schools: Schools that are funded and supported by the Department of Elementary and Secondary Education.

Risk of emotional/psychological harm: In relation to an allegation of neglect, this refers to a caregiver and/or staff allowing children to be exposed to behaviors, activities, or actions that pose a risk of harming a child's emotional or psychological state.

Safety planning: In relation to case review findings, this refers to 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.

Secure facility: Run by DYS, secure facilities are staff-secured or locked facilities where education and other services are provided on site to children who are held pretrial or because they have been committed to DYS post-adjudication.

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."[105]

Sex assigned at birth: The determination about sex that parents and doctors make upon birth of the child based on perceived biological characteristics, such as external reproductive organs. While these data are presented in binary, the OCA acknowledges that 1.7% of the population is intersex or has sexual or reproductive variations and 5.3% of youth in Massachusetts identify as trans. While the OCA also gathers information about people's gender identity, numbers are low and excluded from stratifications to prevent potential identification.

Sexual assault: In terms of a critical incident, sexual assault results in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

Social determinants of health (SDOH): Nonmedical factors that influence health, well-being, and quality of life. They include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. SDOH are important because addressing them can improve health and reduce disparities in health.[106]

[105] Office of the Child Advocate statute M.G.L. c. 18C § 5.

[106] *Social Determinants of Health*. Social Determinants of Health - Healthy People 2030. (n.d.). https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

State care and/or custody: A state agency, such as DCF or DYS, has obtained temporary or permanent legal custody of a child. Children in state custody may stay in their home or be placed out-of-home.

Suicide: In terms of a critical incident, suicide relates to someone taking or attempting to take their own life. A suicide and a suicide attempt can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

SUID: Sudden unexpected infant death is the unanticipated death of an infant under the age of 1 year that occurs without warning where a cause is not immediately known before investigation. These deaths occur primarily during sleep.

Summons: A formal notification issued by the court to a youth outlining the alleged offense and ordering them to appear in court.

Supported report and/or allegation of abuse and/or neglect: 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 best to 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 is categorized as requiring either an immediate emergency response or a nonemergency response. For information about DCF's intake and response to allegations of abuse and/or neglect, refer to the DCF Protective Intake Policy.

Trans: Denoting or relating to a person whose gender identity does not correspond with the sex registered for them at birth; transgender.

Unrelated foster care: An individual(s) who has been licensed by DCF as a partnership resource to provide foster/pre-adoptive care for a child, usually not previously known to the individual(s). Formerly called unrestricted foster care.

Violence: In terms of a critical incident, violence relates to an intentional act that causes injury or physical suffering that is not sexual in nature and is not perpetrated by a caregiver. Violence can result in fatality, near fatality, or serious bodily injury. If witnessed, it can result in an emotional injury.

Visitation: In relation to the Complaint Line, this refers to concerns about the frequency of visits with children in DCF custody; concerns about interactions between a child and parent during DCF supervised visits.

Voluntary placement agreement (VPA): A young adult open with DCF prior to turning 18 may sign a VPA at age 18 and remain open with the Department. Young adults who decline a VPA at age 18 may later request services by returning and signing a VPA prior to turning 23.

Appendix F: Complaint Line Poster

About the Office of the Child Advocate

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.[107] 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. 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.
- Ensuring that state service agencies are trauma-informed.
- Promoting child and family well-being.

In FY24, the OCA incorporated the Center on Child Wellbeing & Trauma (CCWT) directly into the OCA. The Center was originally launched as a project housed at the For Health Consulting Division of UMass Chan Medical School to provide vital support and training to child-serving organizations and state agencies across the Commonwealth to become trauma-informed and responsive through information sharing, trainings, communities of practice, technical assistance, and coaching. The Center uses the Framework for Trauma-Informed and Responsive Organizations, developed by the OCA-led CTTF.

[107] Office of the Child Advocate statute. M.G.L. c. 18C.

Staff List in Fiscal Year 2024

Maria Mossaides, Executive Director

Operations & Legal Counsel

- Crissy Goldman, Division Chief—Legal
- Daniel Arnold, Division Chief—Finance and Administration
- Jean Clements, Office Manager
- Sandy Merida, Fiscal Coordinator
- Samantha Morton, Senior Legal Counsel

Quality Assurance

- Christine Palladino Downs, Division Chief
- Bekah Thomas, Senior Policy Manager
- Dana DeShiro, Quality Assurance Manager
- Renee Franzis, Quality Assurance Manager
- Karen Blake-Robinson, Clinical Specialist
- Nicole Thornhill, Clinical Specialist
- Yosstina Saadallah, Clinical Specialist
- Meg Crowley, Child Fatality Review Coordinator
- Jess Seabrook, Data Analyst

Policy & Implementation

- Melissa Threadgill, Division Chief
- Kristine Polizzano, Senior Policy & Implementation Manager
- Daisy Perez, Senior Policy & Implementation Manager
- Ari Fertig, Legislative & Communications Director
- Alix Riviere, Senior Research & Policy Analyst
- Morgan Byrnes, Policy & Research Analyst
- Arianna Turner, Project & External Affairs Coordinator

Center on Child Wellbeing & Trauma

- Audrey Smolkin, Division Chief
- Melinda Kneeland, Deputy Director
- Joy Cohen, Deputy Director
- Vandolyn Esparza, Technical Assistance Manager
- Juan Rojas, Technical Assistance Specialist I
- Kendall Harcourt, Technical Assistance Specialist I
- Kelly Macomber, Technical Assistance Specialist II
- Jonathan Eyberse, Project Coordinator

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 02102

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

Contact
Childadvocate@mass.gov