FAMILY VOICES

Insights about prevention services from families and youth directly affected by the Massachusetts Child Welfare system and

A CALL TO PARTNER WITH FAMILIES AND YOUTH WITH LIVED EXPERIENCE FOR PREVENTION SERVICES PLANNING

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Child Welfare Reform Project

MLRI MASSACHUSETTS LAW REFORM INSTITUTE

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About the Massachusetts Law Reform Institute

Founded in 1968, the Massachusetts Law Reform Institute is a statewide nonprofit poverty law and policy center. Its mission is to advance economic, racial, and social justice through a multipronged strategy that includes legal action, policy advocacy, coalition building, community engagement, and public awareness campaigns. MLRI specializes in large-scale initiatives and systemic reforms that address institutional policies that harm low-income people, promote economic fairness and opportunity, and create a path to stability and self-sufficiency for low-income individuals and families. In addition, MLRI serves as the statewide poverty law support center for the Massachusetts civil legal services delivery system, providing substantive expertise to local legal aid programs and also to social service, health care and human service providers, and other community-based organizations that serve low-income people.

MLRI coordinates two statewide legal information websites: **www.masslegalhelp.org** (for individuals and social service providers seeking legal information to assist low-income clients) and **www.masslegalservices.org** (for legal aid lawyers and advocates).

For more information about MLRI, please visit our website at **www.mlri.org** or contact Executive Director Georgia D. Katsoulomitis at GKatsoulomitis@mlri.org.

FAMILY VOICES

Acknowledgments

To the families and youth who shared their experience and insights with us in order to improve the lives of others who would walk in their shoes. This is for you, in the hope that it will be a step towards bringing you, and others with lived experience, to the table as partners in planning the services you need to keep your families safely together, and in planning all child welfare policy affecting families and youth.

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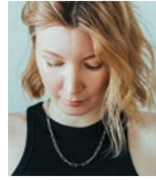
FAMILY VOICES

EVA

JULIA

GRACE


ELIZABETH

TYISHA

DIERDRE

MELANIE

MIRANDA

Families and youth shared essential insights into what services worked for them, both those they received through DCF and those they found outside of DCF. They also talked about the services they needed but did not get. Finally, they shared important information about the impact of the DCF system on the effectiveness of its services.

A. Services

With a few exceptions, parents said that the services that helped them most were those they found on their own rather than those provided through DCF. These included substance use treatment, peer support, primary prevention, domestic violence services, and concrete supports, as described in more detail below.

> *"I feel very fortunate to have been able to get through undoubtedly the darkest part of my life, but I know that I did that only with the help of the community resources I had to fight for."*
>
> *— EVA*

As **Eva**, a parent who successfully achieved recovery from a substance use disorder and regained custody of her children from the foster system, put it:

> *"It's been over a year since my children have been back in my custody. Our life is safe, happy, and healthy, and I now have two years in my own recovery journey. I feel very fortunate to have been able to get through undoubtedly the darkest part of my life, but I know that I did that only with the help of the community resources I had to fight for.*

While most of the effective services parents talked about were those they found on their own, some parents spoke about DCF-provided services that were helpful. They shared their insights into what made them beneficial, and what would improve them.

1. Existing services need improvement

PRACTICAL HELP

Of the contracted services they received through DCF, those that offered practical assistance were the most valuable because they helped parents manage the multiple challenges of their complex lives. These challenges include: poverty, their children's disabilities, being a single parent, balancing a job with the needs of their children, substance use disorders, mental health challenges, or violent partners. Both parent aides (also called parent partners) and intensive in-home services offered practical help. Intensive in-home services also offered counseling and a bond with a reliable caring person.

Grace appreciated the practical assistance of a parent partner who, she described as "super helpful." As a young, single, low-income mother with six children, one of her challenges was the condition of her house. She "had a lot of kids and no access to a washing machine."

> *"The parent partner came in, helped me out with organization, they were able to purchase… storage bins and practical things…they were very helpful.*

The parent partner also helped Grace navigate visitation exchanges with an abusive former partner by picking up and dropping off their child so that Grace didn't have to interact with him.

Elizabeth deeply appreciated the intensive in-home parent skill-based services she received through DCF in which a worker could drive her to appointments, help her get a car and plates, and bring her to visit her daughter and to court. It was not only the practical help that Elizabeth valued but also the relationship of trust that developed with her provider over time.

> *"It's intensive, it's time consuming, but she could come to my house, she could drive me anywhere. As long as I said I needed her to be there, she was there. She was HUGE!...It was kind of like that girlfriend but [a] provider, she was like everything.*

SUFFICIENT DURATION

But helpful services did not last long enough. As Elizabeth said, the intensive in-home services and relationship she so deeply appreciated ended too soon. "We tried to extend that out as long as we could," she said, "but they're only a temporary service."

> *"Once again, short-term implementation for a long-term problem."*
>
> *— GRACE*

Some parents also found counseling provided through DCF to be helpful. Again, the problem was that it didn't last long enough. Grace found that a counselor DCF had put in place could potentially have helped her. The counselor was to "help me create boundaries with my now 18-year-old," The referral was for three months. But, Grace explained:

> *"It took three months for him to just really get to know me, get to know my child, get to understand the dynamics of the household and what we would need. Once we got to that three-month point and what should have happened was now support and implementation, the referral was over. So, you get to that point, and then it falls off. When that happens, DCF doesn't take responsibility for that. It's you, you're not following through....Once again, short-term implementation for a long-term problem.*

CULTURAL COMPETENCE

The Child Welfare League of America defines cultural competence as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms and values the worth of individuals, families, tribes and communities, and protects and preserves the dignity of each."[23]

Parents talked about the necessity of ensuring diversity in group settings, such as parenting groups. More generally, they saw cultural competence in the provision of all services as crucial to their ability to reach and therefore to be effective with parents.

Grace, a first generation American, Afro-Caribbean woman who had been in several of DCF's parenting groups, said it made a big difference when she was referred to a parenting group consisting of racially and ethnically diverse parents. She also felt that cultural competence for parenting group leaders and across the service system was essential. She explained that when parents in the group shared her cultural background, they could relate to her from a background of shared cultural norms. This built understanding and trust. When leaders were diverse, and were culturally competent, they could convey information in a way that was easier for group members to understand. She added:

> *"When service providers could understand my culture, and the lens through which I might view the prevailing child welfare culture, I was better able to trust them.*

The providers, in turn, were better able to help me bridge the gap between my cultural experience and the expectations of the child welfare system.

FAMILY-FRIENDLY

When groups are available at times that don't conflict with parents' schedules, (jobs, appointments for their children's medical, educational, supervision or social needs, or their own medical and other essential needs) it is much easier for parents to participate in them. Grace explained why one of the several DCF parenting groups she was in worked well for her:

> *Part of the reason why I found it super helpful is just because of the way they organize it... It's in the evening, they have child care, they provide meals...Things like that make it easier for parents... to be able to participate and to be able to have supervision for their children while they're getting those necessary skills.*

2. Peer support is essential

Parents spoke compellingly about the power of human connection through peer support as an essential element in effective services; human connection was vital in enabling them to get through the experience of DCF involvement and being separated from their children. But, they said, much more was needed.

Parents did not get peer support services from DCF. Eva, however, took the initiative to create her own Facebook support group for mothers with substance use disorders whose children were in DCF custody. That group became critical for her because for her, as for other parents, losing custody of her children was traumatic:

> *[Losing my kids] literally felt like someone ripped my heart out and then just pulled. [T]here were other women that knew that pain and were trying to get through it the best we could. I just needed to know that I wasn't alone and I just needed to know that eventually it was going to get better..... I think people misjudge how much power there is in just being supportive of one another.*

It occurred to her that DCF had not yet effectively tapped the power of such groups.

> *Millions of people recover every day because of support groups. You know, why are there no various support groups for families that have just lost their kids?*

"[Losing my kids] literally felt like someone ripped my heart out and then just pulled... I think people misjudge how much power there is in just being supportive of one another."

— EVA

Eva said she talked to her DCF worker about how helpful it would be for DCF to offer such a group for free by just making a room available at the DCF office. The worker did not act on the suggestion.

(See also, Eva's discussion of Recovery Coaches in the section of substance use treatment below.)

Dierdre also reflected on the need for human connection. Looking back on her own experience as a human services worker in the 90's, she noted that even more fundamental, at times of desperation, than mental health treatment was human connection at a time of desperation. That had existed when she was a human services provider, but it no longer does.

> *There is nowhere to call now ... When I started out in the mid-nineties on the information and referral, I might not have been able to really get direct service to some, but I was at least there to help explore what avenues someone might be able to get to for information and to verify and acknowledge that person's struggle. That alone they thanked me [for]: "just in hearing my pain and hearing my struggle. You might not be able to help me, but you heard me." We don't have that anymore.*

Members of Family Matters 1st, a group of parents and youth who have been involved in the formerly in the DCF system, spoke about the support they had gotten since joining the peer support group they had established, and how much more peer support was needed. A primary reason peer support was needed, they said,

was to help parents deal with being involved with DCF, and for those whose children were in foster care, the trauma of separation. One member recommended that someone be on site to help parents immediately with the trauma of family separation. Group members also explained that even before they are involved with DCF, many parents have trouble trusting community providers as a source of help because so many of them are mandated reporters. Peers can be a trusted source of support that many professionals cannot be.

Members of this group emphasized that peer service providers must be compensated as other service providers are, otherwise they will not be able to afford to do this critical work. They stressed that no degree would give a provider the education they have gained in what it is like to be a parent involved in the DCF system, a child in the foster system, a youth who has aged out of care, a parent in recovery, or one who has found safety from a violent relationship. This experience must be fairly compensated.

In addition, Tatiana, the group's leader, explained why Black and Brown parents who've experienced trauma often need to work with Black and Brown peers or professionals who share similar backgrounds, experience and trauma.

> *"When you grow up in trauma, you have to re-condition your mind by talking to Black and brown people, people in the community that have witnessed the violence in our community. We have lost so many people to gun violence, so many people got raped, [we've seen] our friends going to prison.*

Members of this group, and other individuals we spoke to, strongly urged that peer partners play a more significant role in the way DCF serves families. They also emphasized how large a role peer partners could also play for vulnerable families who are not involved with DCF. They urged exploring varied ways of engaging peer partners to prevent risk to children and DCF involvement.

Recovery coaches are a specialized form of peer support who can also help fill gaps in the substance use treatment system to create a coordinate system of care (See item 4 below). Eva explained that recovery coaches who had experienced losing custody of their children could be a powerful source of support for mothers in recovery from substance use disorders:

> *"One of the most powerful things is seeing other people going through what you're going through and succeeding in getting to the other side. Because in a moment when there's no hope and you're devastated, if there's a little bit of a light or some kind of hope to say 'Hey, listen, … I've been there. You're going to be okay.'*

3. Primary prevention is the priority for families and youth

Members of the group of parents and former foster youth could not have been clearer: for them, prevention services help them address issues that might be putting their children at risk before abuse and neglect allegations are made and before DCF gets involved. Prevention means services available in their communities that do not require contact with mandated reporters.

The services and concrete supports they listed included housing, rental assistance, access to healthy food and help with clothes, help with disabilities, help with racial disparities, tutoring for kids, child care, teen centers, and mentors.

Many in this group were members of Black and brown communities for whom racism and poverty worked together to create harsh adversity for their families. All of the parents we spoke to were struggling with poverty or

lack of access to the resources they needed to parent their children. None were aware of community-based resources for families at risk of child welfare involvement such as Family Resource Centers,[24] or services available through the Children's Behavior Health Initiative.[25] None of the interviewees with substance use disorders were aware of the Franklin County Family Drug Court,[26] where cases involving DCF parents with substance use disorders are handled in a more holistic service-oriented manner.

4. Families need access to comprehensive substance use treatment

What we heard from DCF-involved families and youth was that, in their interactions with DCF, parents experienced punishment, rather than treatment, for their substance use disorders. In addition, all of those we spoke to who received substance use treatment found that treatment outside the DCF system and without help from DCF.

Tyisha, a young mother who had spent time in the foster system as a youth, had watched her mother descend into substance use dependence after an accident when she fell asleep at the wheel while driving to her out-of-state factory job. Her mother then continued using drugs to stay awake and alert at work and, as she experienced more stress, drug use became her coping mechanism. Reflecting back, Tyisha told us, her mother was "going through a lot" at that time, but DCF removed Tyisha and her siblings from mother without helping her with her substance use disorder. "She needed help," Tyisha told us, "and what she got was punishment. It sent her on the worst path."

> *She needed help and what she got was punishment. It sent her on the worst path.*
>
> *— TYISHA*

ACCESS TO RESIDENTIAL TREATMENT

Families stressed the need for residential substance use treatment, particularly family-based residential treatment.

Dierdre is a former human services provider whose three adult children are all in recovery from substance use disorders. "Where I live," she said, "I don't know hardly anyone who's not affected by the opiate epidemic." She offered many hard-won insights into services needed to address substance use disorders. One was that for many, residential treatment is essential. "The bottom line is," she said:

> *"There is no way to get a handle on any of this addiction unless you're inpatient for a minimum of 30 days where you're separated from the people, the drug and everything, where the fog can clear out of your head enough where you can say, wait a minute, I got stinking thinking. Let me correct this. You can't see that in a three-day detox.*

Deirdre also noted that many parents who are struggling with substance use disorders and facing separation from their children are on their own in finding effective substance use treatment or are forced into it through the criminal justice system.

Elizabeth is one such parent. She got the treatment she needed through the criminal justice system. After eight years of DCF involvement, she was arrested for possession of drugs and related charges. At that time, DCF removed her children and placed them in the foster system and Elizabeth was sentenced to a 34-day detox program in a correctional facility. After that, she spent eight months in a residential substance use treatment program.

Elizabeth told us the 34 days she spent in a locked substance use facility, "saved my life." She firmly believed that a short-term treatment program would not have helped her. It hit her, she said, when she was being arrested.

> *"I knew if I was in a seven-day program or a three, four-day program, those, they call them spin cycles. You're in and you're out, you're in and you're out, you're in, you're out. But the fact that I was locked in jail with guys, you know, strip searched, freaking search dogs... and it was weird cause after the second week... I was complying, as anti-government as I am. I was falling into the routine, and I found it very almost weird.... I wanted to stay.*

She appreciated the structure of the locked ward so much, she admitted to us with a grin, that eventually the prison staff said to her "you can't stay here forever .... But I liked the routine and the strictness of it, and I think that's kind of what really helped." Sadly, despite all her years of DCF involvement, Elizabeth had not gotten the structured substance use treatment she needed until she was arrested and entered the criminal justice system.

Eva, who had been struggling with a substance use disorder for a year-and-a-half before her DCF involvement, got herself into a family-based residential substance use treatment center. There she could live with her newborn daughter and get treatment when she found out she was pregnant. As she put it:

> "*I got myself into treatment, I got clean.... If I didn't have [that treatment center], I'm pretty sure that [my daughter] would have been taken by DCF.*

Eva's mother **Julia**, who is a mental health professional as well as a kinship caregiver for one of Eva's children, said that Eva's experience in the family-based residential program "saved her life at that moment."

Eva also pointed out that family-based residential substance use treatment often wasn't available to people who needed it when they needed it:

> "*I've seen [people] be able to get out and have these, safe, secure, stable lives. And it's possible. The biggest thing is there's just not enough of them... [I]f I'm having an emergency right now, what am I supposed to do in the meantime?...The biggest thing is the funding.... they don't have the money for that."*

Later, after Eva relapsed and DCF removed her children and placed them in the foster system, she could not get the help she needed from DCF. Instead, she was left to find the treatment and recovery services she needed on her own. As she reflected, looking back on the journey to reunification with her children:

> "*I was able to reunify with my kids because I fought to get a bed at a family shelter. I learned how to cope with my own abuse and trauma because I researched domestic violence agencies in my area and told my story until someone listened and offered help. I refused to let the lack of support stop me from my main goal, getting my kids back because I have watched many parents die from active drug use before getting the opportunity to reunify with their children, and I knew that couldn't be me.*
>
> *I would like to see DCF helping to access treatment for a struggling parent, so that it does not feel like punishment for their disease. What I experienced was having to fight my disease on my own with no support or guidance while simultaneously experiencing the trauma of having my kids removed from my home because of that disease.*

> ***"I've seen [people] be able to get out [of family based residential substance use programs] and have these, safe, secure, stable lives. And it's possible. The biggest thing is there's just not enough of them... "***
>
> ***— EVA***

ADDRESSING ISSUES UNDERLYING SUBSTANCE USE DISORDERS

The lives of the parents, relatives and former foster youth illustrate a reality about substance use: many issues underlie substance use disorders. Consequently, addressing the issues underlying substance use disorders is fundamental in promoting long-term recovery, and in keeping or reunifying children safely with their families.

Dierdre, the former human services worker who told us that where she lived, she hardly knew anyone who wasn't affected by the opiate epidemic, reflected on the extent to which substance use disorders begin as a form of self-medication for people dealing with the stresses of poverty and other issues:

> "*When you're living within low-income poverty income, you [are] in a state of clinical depression. There's no other way around it. When you don't know if you're*

going to be able to have your lights on, you don't know if you're going to be able to keep that roof over your head, you got nowhere to turn for assistance.

....“Anybody who has addiction issues, you're self-medicating some kind of something. So, most people have dual diagnoses.”

> *“I would like to see DCF helping to access treatment for a struggling parent, so ...it does not feel like punishment for their disease.”*
>
> *— EVA*

Tyisha, whose mother's substance use disorder started after a car accident that occurred when she fell asleep at the wheel driving long hours to her out of state factory job, understood that substance use became her mother's coping mechanism to deal with the stresses of a long commute, long hours at a factory job to support two children, and coping with unrelenting poverty. Tyisha reflected that her mother never got the help she needed for her substance use disorder before or after her children were taken from her.

FILLING THE GAPS FOR A COORDINATED SYSTEM OF CARE

Ensuring coordination of care is essential for effective substance use treatment so people don't experience gaps in treatment as they move from one stage of treatment to the next. Those we spoke with illustrated the gaps and had a number of ideas to close them.

Eva offered some practical suggestions to fill gaps in the delivery of substance use treatment services, including the benefits of recovery coaches for DCF-involved parents with substance use disorders:

> *“I guess my thought was why don't we have recovery coaches that work for DCF that are like, ‘Hey, your kid just got taken. I understand what you're going through. I have a list, here's a packet of information, here's all the local detoxes, here's a hotline that you can call if you feel suicidal, here's a domestic violence hotline to call.’ [T]hey don't offer any of that at all, they could literally just hand someone a packet and [say] ‘here's some information’ and they don't do that. And I don't know why.*

(See also Eva's comments on how recovery coaches serve as an essential source of peer support in item no. 2 on peer support above.)

Eva saw recovery coaches as an efficient way for DCF to utilize services that were already available in the community. She understood that DCF didn't “have the capacity to sit there and go through everything.” She acknowledged, that “they are overwhelmed... as it is.” But, she said, providers other than DCF...

> *“are ...out there that do have that knowledge and do have that ability to make referrals to link services. So, I don't know why DCF isn't utilizing more of that when they are already in the community. It's not like they don't exist. They exist, but they're just not being used.*

> *“You need to be set up, not given a list and [told], ‘good luck contacting these places and making the appointments.’”*
>
> *— DEIRDRE*

Dierdre focused on the need for DCF to make referrals to help get DCF-involved individuals into treatment and aftercare when they were leaving a treatment program.

> *“You need to be set up, not given a list and [told], ‘good luck contacting these places and making the appointments.’*

She also said that people leaving residential facilities need assistance with service coordination both while they're in the residential program and when they leave. Dierdre's daughter-in-law was helped when her parents

sectioned[27] her into a 37-day recovery program. While the program was helpful, its effectiveness was undermined because DCF didn't coordinate this mother's treatment.

> *That whole 37 days, the people she was working with [were] calling her case worker at DCF to talk with [him], and he never responded.*

Now that her daughter-in-law's been back home for a month with her children, Dierdre reported, the case worker "hasn't even been over to see the babies or her yet, we don't know what the game plan is."

5. Families need post-reunification services

Eva was overjoyed to get the first of her children back home, but she painted a haunting picture of his status upon return and the impact of a lack of post-reunification services.

> *[T]he first night that I brought [my child] ...home, I was crying because he refused to let me touch him. He wouldn't speak, he would just scream at the top of his lungs...It was just this terrible screech..., and he just sat in the corner...for the whole night....He fell asleep on the floor. He wouldn't eat...I tried to...change his diaper. It... was impossible.*

She described what happened when she called DCF for help:

> *I told DCF that this was what was going on and they [said], 'Oh, well, he's probably just traumatized...' So, I asked them what kind of services they could provide for me and they [said], 'you're going to have to find something in your area. We don't know.'*

B. System Changes Needed for Service Improvement

Parents provided essential insights into elements of DCF's system that can either undermine or support the effectiveness of any services DCF provides. These are presented below.

"[T]he first night that I brought [my child] ...home, I was crying because he refused to let me touch him ... [DCF said] 'he's probably just traumatized... you're going to have to find something in your area. We don't know.'"

— EVA

1. Service planning needs to better identify necessary services

FAMILY ACTION PLANS

The Family Action plan[28] is supposed to convey three essential pieces of information to parents. These are 1) the risk the Department believes the parents pose to their children, 2) what the parents need to do to address the Department's concerns, and close their case or get their children back home, and 3) what services and supports the Department will provide to help parents accomplish these goals.[29] Too often, though, Family Action Plans lack clear statements of one or more of these elements. This lack of clarity is a significant service delivery flaw that undermines the effectiveness of even the best services.

Grace, for example, told us that her children were removed due to lack of adequate supervision, but that none of the services she received addressed the supervision issue. In addition, although DCF told her she needed to develop her own natural support network, when she did that, DCF would not allow her to use that network to parent her children.

ADEQUATE EXPERTISE, SKILLS AND TRAINING

Parents also described not being able to access the services they needed because the caseworkers who wrote their action plans lacked the necessary expertise

in the relevant issues. Two areas of expertise they spoke about most were substance use and disabilities.

i. Substance use expertise

Eva, who had gained a good deal of knowledge about the stages of recovery through both personal and professional experience, said her DCF worker required her to go to detox when she had just come out of detox. Instead, what Eva needed after detox was immediate out-patient treatment for her mental wellness, and access to an addiction specialist or wellness coach. Being required to enter detox when she had just come out of detox disrupted her treatment and recovery.

ii. Expertise about disabilities

Melanie, a young mother of two boys who has an intellectual disability, spoke with us, together with her attorney, about DCF's failure to adapt services to accommodate her disability, and even to recognize its obligations under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act to provide reasonable accommodations to parents with disabilities.

DCF's own neuropsychological evaluation concluded that Melanie needed to learn through repetition, mastering one task before moving on to another. It also recommended that Melanie would need assistance in providing specialized medical care to her younger son, and specifically recommended that the child's grandmother Sandra, a Certified Nurse Assistant, who lived in the same house as Melanie and the child's father, would be a good resource. Sandra informed DCF she intended to help with the child's medical care.

Nonetheless, DCF refused to let Sandra participate in the trainings with Melanie on how to provide her son's medical care, and would also not let the child's father, who did not have a disability, participate in the trainings. Instead DCF insisted that Melanie learn on her own.[30] In addition, although the neuropsychologist recommended the training be slow and repetitive, DCF's training flooded Melanie with a huge amount of information in the very first session.

Melanie struggled to learn the material. When her lawyer insisted that DCF's failure to accommodate Melanie's disability, or allow supports, violated the Americans with Disabilities Act (ADA), the nurse whom DCF had hired to design the trainings replied that DCF was not required to follow the ADA.

> ***"It was obvious that they were going against my disability. I've never done drugs. I've never gotten into trouble. I've never gone to jail.... I don't have a criminal record. I don't smoke cigarettes. I don't do [any] of that stuff....And I would die for my kids. I love my [children] they're my everything."***
>
> ***— MELANIE***

Melanie knew that she was being discriminated against because of her disability:

> *"It was obvious that they were going against my disability. I knew, I'm like, "you guys don't have anything else on me. I just have a disability. I've never done drugs. I've never gotten into trouble. I've never gone to jail.... I don't have a criminal record. I don't smoke cigarettes. I don't do [any] of that stuff."*

DCF's inability to accommodate this parent's disability meant they were unable to recognize and build upon her many parenting strengths. Her lawyer told us:

> *"every practitioner, including DCF's own social workers, talks about how committed and organized and diligent she is and [how] she just follows through with everything, and just tries her very hardest every day to do what's being asked of her.*

Melanie added:

> *"And I would die for my kids. I love my [children]. They're my everything.*

2. Families need guidance about the Department's expectations

It is crucial to parents that they understand clearly why DCF is involved with their family, how the DCF process works, and what is expected of them at each stage.

Grace, who had grown up in what she described as "a Caribbean cultural bubble," emphasized how little she understood of DCF's expectations from the start. She explained how disadvantaged she was by this lack of understanding throughout her involvement with the Department.

> *"She had her son taken. She still doesn't know why."*
> *— GRACE*

After DCF removed her children, when a DCF caseworker came for a home visit, the worker had asked in the middle of a routine visit: "could I see your home? Do you mind walking me through your home?" Grace explained:

> *So, I'm thinking of the situation from a normal circumstance. And what I mean by that is, any of us, right, if a person comes to our house and asks us for a tour of our home... At any given time, there might be a room that we might not let them into, right? So even if you point to a room, you're not going to invite what is essentially a stranger into your bedroom, or certain rooms.*

Based on that expectation, she had given the worker a tour of her apartment, pointing out her bedroom, and the bedroom of her oldest daughter who was off in boarding school, without opening those doors.

She learned of DCF's expectation when the caseworker reported her actions in court, indicating to the judge who was considering returning one of her children to her custody that Grace must have had something to hide. Reflecting back, she said.

> *So fast forward all these years later, and I'm having a conversation with my husband [who had been a foster parent] and he says to me, 'Oh yeah in foster parent training, they teach us that...you have to allow DCF to have full access or disclosure to your space" and .... I didn't know that...So that puts such a huge question mark in my mind: if foster parents and prospective foster parents are given extensive training for them to understand the expectations of the department once children have been...removed...why [aren't] the parents?*

Grace also provided insight into the challenges that recent immigrants experience in understanding DCF's expectations or even understanding the reasons for DCF's involvement in their lives. In her parenting group, she said, there was a Muslim woman from East Africa. "She had her son taken," Grace told us, "She still doesn't know why."

3. Youth need greater educational stability and less trauma in the foster system. Youth aging out of the foster system need greater access to services and supports to transition to adulthood, whether from DCF or from outside of DCF, in order to prevent intergenerational child welfare involvement.

All five of the individuals we spoke with who had been in the foster system saw education as the path to a better life. But all encountered significant obstacles to attaining an education while in the foster system. All also experienced significant abuse or trauma in the foster system.[31] Although none of the individuals we spoke with found permanent families when they left the foster system, none availed themselves

of educational, life-skills building and other services for they may have been eligible through DCF to help prepare them for adulthood.[32]

> *"I made it my mission to get as far away from DCF as possible."*
> *— TYISHA*

Tyisha, who remembers DCF tearing her away from her own mother, had a traumatic experience in foster care and described her foster placement as a "detention center in the middle of the woods," made it "her mission" to get as far away from DCF as possible. At 17, she was pregnant and homeless, yet when the opportunity came, Tyisha signed out of DCF care as soon as she could, foregoing any services that might have been available to her through DCF. Instead, she found what she needed on her own.

Although she had the power to end her connection with DCF at age 18, Tyisha was "terrified" that because she was young and homeless, DCF would take her baby. After she had her son at age 18, she accessed educational programs through one of two homeless shelters they spent time in. These programs gave her the chance to work towards her GED and then gain work experience that set her on a path for long-term employment. This long-term job also gave her a "work family." From this foundation of stability, she found permanent housing and began therapy. She was able to give her child the stable childhood that she herself had not experienced, but with no help from DCF's program for services for transition age youth.

> *"We get a little bit of hope [in foster care] and we take that with us until it dims, and then eventually we find something else to hold onto and... we take that with us."*
> *— MIRANDA*

Miranda too had a traumatic experience in the foster system. During their time in the foster system, she and her siblings were returned to their mother three times, each time returning either to DCF or to live with family members. As she described it, she lived in "an unreasonable amount of homes."

Both Miranda's sister and brother were abused in the foster system. Her brother "doesn't talk about it, but eventually he ended up in jail," moving from the juvenile to the adult system without legal representation, and her sister developed an alcohol problem.

Despite being recognized as bright, Miranda had a hard time progressing in school. "Every time I was doing well," she told us, "they removed me," and she had to start again in a new school.

> *"We get a little bit of hope [in foster care] and we take that with us until it dims, and then eventually we find something else to hold onto and then we take that with us.*

Miranda attempted suicide three times while in the foster system. After the first two attempts, she had no one to talk to and DCF put her back in the same home. Then at age 15, she made her third suicide attempt after she got pregnant. She was going to try to have an abortion, but then she lost the baby. Although DCF knew about the miscarriage, she says no one ever asked her about it.

Although she asked to remain in DCF's custody beyond age 18, in order to receive services and access to educational opportunities, DCF denied her request because she hadn't finished high school and did not want to enter DCF's job training program. Instead, she wanted to get her GED.

Miranda eventually did get her GED on her own at age 33. She is now the mother of a six-year-old boy and works as a parent organizer. The education she got on her own has been key to her success.

4. DCF should draw on the strengths of extended family

Extended family members and members of parents' extended support networks can build additional safety and skill around a family unit that can last beyond the time that DCF is involved in their lives.

Parents talked about the extent to which they used family and community support systems that were in place prior to DCF's involvement or which they built while involved with DCF. They also shared their frustrations with DCF's not allowing them to fully use these natural supports.

Dierdre noted an instance in which DCF did recognize the importance of a family network. She described how having all the grandparents mobilized in support of her son and daughter-in-law changed an initial meeting with a DCF investigator when DCF received a report that her son and daughter-in-law were using drugs. When the DCF investigator saw both sets of grandparents ready to help their kids and grandchildren, the investigator's response was "Wow, if you all weren't here, this would have a very different outcome."

> ***"There was a story told about me that was just so egregious that the woman still holds on to it to this day....That created that chasm where I was not able to interact with the foster parents."***
>
> ***— GRACE***

Based on her experience as the mother of two sons with substance use disorders who had lost custody of their children to DCF, and as a human service provider, she strongly believed that DCF needed to draw upon the resources of the extended family when possible. She talked about how therapy to work with the whole family was needed in dealing with families affected by substance use, but had not been available to her family to assess the capacity of extended family to support the nuclear family that was in crisis. Family Systems Therapy, she said is helpful in

> *identifying what a family needs, what a family's weaknesses are, a whole fam[ily].... When you've got a family with DCF, where's one of these kinds of evaluations to look at the family as a whole? ...The whole family system is affected by addiction.*

Eva had natural support from her mother Julia, a well-respected mental health professional who served as the guardian for one of her four children. But Julia, who also spoke with us, was beside herself with frustration and anguish at her inability to get anyone at DCF to respond to her concerns that the residential facility they had placed her grandson with autism in was unsuited for his needs.

> *I called them and said, "that's outrageous. You know, [this child] has autism [and] doesn't belong in a program for kids with emotional disturbances. I know them well, those settings... and that's not the right place. I called DCF's ombudsman. I called their supervisor ... nothing.*

Even Julia, with all her professional expertise and standing, was unable to persuade DCF to find an appropriate placement for this child with autism.

Grace's caseworker told her "We need you to beef up your natural support network." Grace did this on her own by finding friends through her children's school including one who became both a temporary foster parent for two of her children and the educational advocate for another.[33] She expressed her frustration that once she had found an educational advocate for her daughter as required, DCF would not "give me custody back of my child so that [the education advocate I found for her] can be a genuine natural support to me."

Moreover, allowing parents with disabilities to use their natural supports, including family members, to help them accomplish tasks that their disabilities impede

them from performing, is required as a reasonable accommodation under the Americans with Disabilities Act. Melanie's experience, described in the section on expertise needed in service planning above, illustrates that DCF needs to make more progress in this area.

5. DCF needs to build on parental strengths to promote reunification

When DCF removes children from their parents and puts them in the foster system, that removal is supposed to be temporary. The goal for the child is usually reunification with their parents at the time of removal. DCF's duty under state and federal law is to make reasonable efforts to provide services to the child's family to address the issues that prompted the removal so that the child can be reunified with their family.[34] **Most parents do not stop being parents while their children are in the foster system. Encouraging, strengthening and building on those parenting strengths and instincts is crucial to the Department's required reunification efforts. Sadly, parents reported instances where their efforts to maintain their relationships with their children, and ensure the safety and well-being of their children in the foster system were ignored or impeded.**

Grace was deeply concerned about the safety and well-being of her two youngest children throughout the time they were in the foster system. She watched with growing concern as one of her sons deteriorated in his foster home, acting out as a result of his anger at being separated from his mother. She also learned that their foster mother had left both children in the care of a teenager when she went out of the country. Grace was never able to get DCF to address her concerns.

When her two sons were eventually moved to a pre-adoptive foster home, Grace was not allowed to speak with their foster mother. She was aware that her children's foster mother viewed her as a terrible person and mother, a view Grace knew did not reflect the reality of who she was. However, there was nothing she could do to address the misconception created by what DCF had told the foster parents. Once this foster parent formed this negative view of Grace, she would not permit Grace to contact her.

> *"There was a story told about me that was just so egregious that the woman still holds on to it to this day....That created that chasm where I was not able to interact with the foster parents."*

Eva was very concerned that her child with autism was placed in a residential facility that was not appropriate for children with autism, and that she was unable to receive information about him or his care in that facility.

> *"So, they put him in a facility, which was awful. ...and I didn't really get much information. The only time that I was really allowed to have any contact was with his case manager who basically was just able to tell me that .... he was okay. But I mean, there's no reason that a four-year-old little boy with autism should be on a psych unit.*

> ***"I didn't see [my daughter] until [two months after the children were removed], and I didn't see [my son] until after that. I couldn't even call [my son] on the phone. I wasn't even allowed to talk to him. They didn't even let me know where either of them was at the time either."***
>
> ***— ELIZABETH***

When Elizabeth's children were removed from her home and separated from each other, she was not informed of their placements.

> *"I didn't see [my daughter] until [two months after the children were removed], and I didn't see [my son] until after that. I couldn't even call [my son] on the phone. I wasn't even allowed to talk to him. They didn't even let me know where either of them was at the time either.*

Once she was allowed to see her daughter, Elizabeth became deeply concerned about her child's health and well-being. At visits, her daughter had physical injuries and would cry. Elizabeth was concerned that her daughter with multiple disabilities was in a residential placement not appropriate for her needs.

RECOMMENDATIONS

1. Partner with families and youth in making service planning policy

- Partner with families and youth in planning prevention services and other child welfare policy in which they have a stake and for which their direct experience gives them expertise.
- Establish a Stakeholder's Committee on Prevention Services for Families to engage broad public input, including families and youth with lived experience in the Massachusetts child welfare system and representing the diversity of the communities most impacted by inequities in that system.
- Include representation of the following groups:
  - Parents of children currently in the DCF caseload
  - Parents of children in the DCF foster system
  - Current or former foster youth
  - Kinship caregivers of children currently or formerly in DCF caseload
  - Individuals of color, LGBTQ individuals, and individuals with disabilities

Implementation Pathways:

- **Massachusetts has the opportunity this year — with two major prevention services planning initiatives now underway[35] — to partner with families and youth with lived experience in the policy planning process. But it must act now.**
- **Follow the lead of states that have engaged in effective public Family First planning process that include families and youth** — Although Massachusetts has recently submitted[36] its Family First prevention plan without public input,[37] it is not too late for the Commonwealth to follow the lead of other states that have had robust Family First public planning teams with strong representation of directly impacted families and youth. These teams can be involved in further planning and implementation of the Commonwealth's prevention plan.

  See examples described in the Family First prevention plans of Colorado,[38] pp 36-38, Connecticut,[39] pp. 4-8, and California,[40] pp. 16-17
- **Useful resources** for integrating Families and Youth in child welfare policy planning include:
  - Strategies for Authentic Integration of Family and Youth Voice in Child Welfare[41] (and sources cited)
  - Strategic Planning in Child Welfare: Strategies for Meaningful Stakeholder Engagement[42]
  - Children's Bureau Information Memo 19-03, Engaging, empowering and utilizing family and youth voice in all aspects of child welfare to drive case planning and system improvement[43]

2. Prioritize Primary Prevention.

- **Fund and provide primary prevention services to build a public health approach to child welfare.**[44]
- Deliver primary prevention services through Family Resource Centers, Family Drug Courts, Children's Behavioral Health Initiative services, and other community-based organizations, if families know and trust them. Ensure families know about and are able to access these resources.
  - The less DCF is associated with these organizations, and the fewer mandated reporters staff them, the more families will seek them out
- **Fund, create, consistently update, and make widely accessible a resource guide** featuring:
  - Community-based organizations, such as community health centers, schools, community-based domestic violence and sexual assault programs, recreational centers, and child care providers
  - How to access concrete resources including housing, help with accessing cash assistance, SNAP or other government benefits, child care, health care, access to healthy food, tutoring for children, teen centers and other immediate and essential needs.[45]
- **Train mandated reporters to refer families struggling with poverty to community-based primary prevention resources** when the issue is poverty rather than child abuse and neglect.

Implementation Pathways:

- **Funding – Include *"Community Pathways"* in Family First prevention plans.**
  - A substantial number of states have included "Community Pathways" in their prevention plans to bring in federal funding so **families could get primary prevention services in their communities without coming into the child welfare system.**

    See examples described in the Family First prevention plans of Connecticut,[46] pp. 8 and 21-31 and California,[47] p. 22
- **Primary prevention services through Family Resource Centers** – Family Resource Centers in Massachusetts provide some primary prevention resources and Massachusetts may be looking at expanding this option. This is a promising start.
  - Issues to consider include: how to deliver primary prevention without involving mandated reporters, how to use and fund peer support, how to tap federal funding Family First or other funding through use of community pathways or other innovations.
- **Mandated reporters** – The Office of the Child Advocate is now working with a consultant to design an evidence-based mandated reporter training program on a pilot basis in Massachusetts at this time. Data should be collected, shared publicly and evaluated to measure:
  - Whether this training reduces reporting of poverty and increases referrals in those cases to primary prevention resources in cases in which poverty rather than abuse or neglect is the issue
  - Whether the training reduces current rates of racial disproportionality in mandated reporting.[48]

Give meaningful consideration to the following 11 recommendations from directly impacted families that are presented in this report along with the recommendations of other directly impacted persons who are included as partners in prevention service policy planning:

3. Improve services to prevent removal and reunify children with their families.

- Ensure that services:
  - Address families' practical needs,
  - Are of sufficient duration to achieve intended results,[49]
  - Are family-friendly and don't conflict with families' other logistical demands,
  - Respect and take into consideration a family's cultural values and traditions
  - Respond and address any trauma experienced and residual effects, and
  - Have a proven record of effectiveness with communities of color, LGBTQ individuals and individuals with disabilities.

Implementation Pathways:

- **Funding for both reunification and pre-removal services** – Family First provides open-ended funding for services to prevent foster care and enhances capped funding for reunification services.[50] While they have different funding sources, services to prevent removal and to reunify families are very similar and the insights from families apply to both.
- **Sufficient duration** – FFPSA funds services for up to 12 months, and allows extensions for longer in some instances.[51] Typically, in Massachusetts services are provided for three months and can be extended for an additional three to six months. The longer time frames that Family First allows will enable services to last long enough for parents to develop sustained relationships with providers and to achieve the intended results.
- **Proven record of effectiveness with communities of color** - Some, but not all, of the evidence-based programs fundable under the FFPSA have been shown to be effective with families of color.[52] In addition, guidance from the Administration for Children and Families allows states to make eligible adaptations of approved programs to evidence-based programs, including adaptations to meet the cultural needs of specific populations.[53]

4. Provide peer support as both a primary prevention strategy and for families involved with DCF.

- **Peer support is needed** not only to help families deal with the issues that present a risk of abuse and neglect, but also to help families and youth cope with the child welfare system itself and the trauma of family separation.

- Families need peer supporters provided by individuals with lived experience in the DCF system
- Peer supporters should be paid a fair wage for their time
- Peer supporters should not be mandated reporters
- Peer supporters should be available to:
  - Help parents and youth understand and navigate the DCF system
  - Deal with the trauma of family separation and removal of children into the foster system
  - Provide recovery coaching for individuals with substance use disorders
  - Provide coaching and counseling in other areas of need
  - Provide peer support for:
    - Parents with disabilities
    - LGBTQ parents and youth
    - Parents living in poverty
    - Youth aging out of the foster system
  - Provide needed human connection at a crucial time

Implementation pathways:

- **Peer Support Guide Written for and by directly impacted families** - A peer support model worthy of review and consideration was developed by RISE in New York City. See, Someone to Turn To: A Vision for Creating Networks of Parent Peer Care.[54]

5. Address families' concrete needs.

- Make appropriate referrals using comprehensive, updated resource guides (described in Recommendation no. 2 above), and follow up to ensure that parents are able to access these services. Treat the provision of this assistance as an opportunity for human connection and retain responsibility for ensuring the client successfully accesses the service. Post user-friendly, regularly updated, versions of these resource guides on DCF's website in the languages DCF-involved families speak.

Implementation pathways:

- **Resource:** See, System Transformation to Support Child and Family Well-Being: The Central Role of Economic and Concrete Supports[55] for a detailed description of a public health approach to child welfare, the role of concrete supports, and a policy pathway.

6. Provide comprehensive substance use treatment for DCF-involved parents.

- Ensure priority access to residential substance use treatment[56] for DCF-involved families[57]
- Provide treatment that addresses issues underlying substance use disorders and dual diagnoses[58]
- Fill the gaps in the substance use treatment continuum so parents and youth don't experience gaps in recovery
  - Recovery coaches in particular provide effective coordination and draw on available community resources while also providing needed peer support and human connection

Implementation Pathways:

- **Funding:**
  - Family First funds evidence-based substance use treatment services for parents of children who are candidates for foster care. This funding is only available if there is not already another public or private source of funding, such as private insurance or Medicaid, for those services.[59] Either way, these are federally funded services that are needed by a large number of DCF-involved parents.
  - Family First also funds much needed family-based residential substance use treatment for parents and for their children who are in the custody of DCF.[60] Massachusetts should explore the use of Family First funds to increase the availability of much needed family-based residential care.
- Resources in Massachusetts that can be more effectively mobilized for integrated and coordinated substance use treatment include recovery coaches, case coordinators, wrap around care, and the Plan of Safe Care [61] federally mandated for families of substance exposed newborns.

7. Provide post-reunification services.

- Services for families once a child returns home from the foster system should be sufficient to stabilize the family and prevent re-entry into the foster system, and include:
  - Services to address the trauma of family separation from their families, multiple placements in foster care, or any abuse or neglect while in the foster system.
  - Services to help children adjust to living with their parents after an extended separation.
  - Continuing, for a time post-reunification, some services that were effective prior to reunification.
  - Concrete supports that reunified families may be eligible for (such as child care and housing vouchers), and referrals to others they may need.

Implementation Pathways:

- **Funding:** Massachusetts can write its Family First plan so as to be eligible for uncapped federal reimbursement for post-reunification services. The Family First Act funds services for "candidates for foster care" — children who are at risk of entering foster care — and thus title IV-E funding under the Family First funding may potentially cover post-reunification services.[62] In addition, the Family First Act permits the use of Title IV-B funding for time-limited, post-reunification services.[63]

8. Write clear Family Action Plans; engage families and youth in the development of their own plans.

- Provide on time, regularly updated, Family Action plans, that have been jointly developed by parents, youth and caseworkers, that clearly identify:
  - The risk that each parent presents to the child/ren
  - The changes expected of the parent/s
  - The services DCF will provide to help achieve those changes
- DCF caseworkers need to ensure parents can access the services set out in their Action Plans.

Implementation Pathways:

- **Clear Family Action plans:** The elements of a clear Family Action plan proposed above are the essential elements of the "clinical formulation" which is the foundation of a Family Action plan, according to DCF.[64]
- **Family engagement in Family Action plans:** Just as DCF needs to partner with families in making policy, on the individual case level it needs to partner with families[65] and youth[66] in developing individual plans to strengthen their families, valuing their expertise about what their families need and how to achieve those needs.[67]

9. Ensure DCF caseworkers have the necessary skill, expertise and training for service planning, or have access to that expertise[68] particularly with respect to substance use disorders and disabilities[69]

- **DCF workers planning services need expertise, skill, and training – or access to expertise – about the following, in order to plan services:**
  - Substance Use Disorders – sufficient expertise and skill to know:
  - The stage of recovery the individual is in,

- What treatment is appropriate for that stage of recovery,
- What treatment resources are available in their community for that treatment, and
- How to ensure the individual can access that treatment.

▶ **Disabilities** – sufficient expertise and skill to:

- Identify the individual's disability or the diagnostic tools to identify the disability (particularly for intellectual disabilities),[70]
- Provide reasonable accommodations for that disability including allowing the use of family supports, and
- Acknowledge and meet the requirements of federal law: the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.[71]

▶ **Other areas** in which services planners and providers need sufficient expertise and skill:

- Working with LGBTQ youth and parents[72]
- Mental health issues
- Understanding poverty
- Understanding and combating racism in the lives of their clients and in their own practice

Implementation Pathways:

▶ DCF has added internal staff that can provide consultations and training for workers needing additional information and skill in service planning for parents and youth with disabilities. This staff includes a DCF Statewide Mental Health Director and Mental Health Specialists for each region. The Department has also hired a Director of Disability Services. Apparently, she will be hiring two staff to work with her, and that her office will follow a model similar to that of the Statewide Mental Health Director.

▶ DCF workers doing case planning should be required to consult with this internal staff. This internal staff should also be available to consult with families. This would provide needed resources and expertise in case planning for services involving families and youth with disabilities. These specialists could also train staff on working with parents with disabilities.

10. Provide guidance and transparency about the agency's expectations.

▶ Provide client educational programs and materials in the languages that clients speak that explain how the DCF process works at each stage, and/or ensure that DCF caseworkers are trained to explain the process to clients and are accountable for doing so.

- For services that DCF cannot provide, make appropriate referrals and follow up to ensure that parents are able to access these services. Treat the provision of this assistance as an opportunity for human connection and retain responsibility for ensuring the client successfully accesses the service.

- Peer partners can also support families and youth in navigating the DCF system, while providing needed human connection.[73]

11. Provide educational stability, reduce trauma, eliminate abuse of youth while they are in the foster system, and ensure youth aging out of the foster system can access the support and services they need, to prevent intergenerational child welfare involvement.

- **Addressing educational barriers, reducing trauma and eliminating abuse for youth in the foster system** are essential elements of DCF's obligations to protect youth and promote their well-being. In addition, doing so will increase the likelihood that youth aging out of the foster system will choose to sustain a connection with DCF after 18 so they can avail themselves of the services they may need for a successful transition to adulthood and for avoiding involvement with DCF as parents themselves.

- **Trauma is too frequent for children and youth in the foster system, and it is unacceptable that any youth should be abused in the state's custody.**[74] We recommend the establishment of an independent, non-governmental, community-based organization, to be designated by an independent panel of current and former foster youth to establish a hotline for foster youth to call when they are experiencing abuse in the foster system.

- **Eliminate direct barriers to schooling, as well as the abuse and trauma in the foster system, which undermine children's ability to learn.**[75] This will also help ensure that youth who age out will consider using transitional services available to youth aged 18-23 which include educational, life-skills building and other services they are eligible for. These services can help to mitigate some of the negative outcomes that youth aging out of the foster system otherwise encounter,[76] and reduce the chances they will be involved in the DCF system as parents.

- **Reduce barriers for aging out youth who wish to access transitional services through DCF.**
  - While there are federal eligibility requirements for keeping a DCF case open for purposes of accessing transitional supports, DCF should ensure as much flexibility and support as possible to youth in meeting those requirements so they can access needed services.[77]

- **Ensure access to transitional services and supports that don't require DCF involvement using models of resource navigation**, to help connect transition age youth to the resources they need to move towards healthy independence:[78]
  - Some resource navigation models include peer resource navigation which connect aging out youth to peers with lived experience whom they may trust
  - Needed resources that navigators can connect youth to include employment and educational supports that youth are eligible for because they were in the foster system whether or not have an open DCF case. Youth need information about these services and supports.
  - Youth need to be connected to the supports and benefits they are eligible for as adults. These include: Medicaid, SNAP employment and training benefits, WIC, youth job programs.

- Increase financial security for youth leaving the foster system by allowing them to retain their social security benefits while they're in the foster system.
  - Preserve social security benefits of children in the foster system for their own benefit while they're in the foster so they have a nest egg as they begin their independent lives. Currently in Massachusetts, children are having their Social Security benefits – including SSI for disabled children and Title II Dependent/Survivor's benefits on a parent's wage record – taken from them to offset the state's financial obligation to provide foster care to them
  - Youth aging out of the foster system, including youth with disabilities who have lost their SSI benefits, desperately need these funds as they start to build their independent lives.[79]

Implementation Pathways:

- **Funding:** Services for youth in the foster system are funded through the Chafee Foster Care Independence Program which is enhanced through the FFPSA.[80] The FFPSA also funds prevention services for pregnant and parenting teens. In addition, those former foster youth who leave the DCF system and become young parents are potentially eligible for FFPSA-funded prevention services, if they become involved with DCF as young parents. Family First planning must include the needs of youth in the foster system and they must be at the prevention services planning table.
- **Resources:**
  - **Resource navigation models.** Former foster youth are eligible for a number of programs by virtue of having been in the foster system even if they don't remain connected to DCF, and they are also eligible for various benefits. However, they need to be connected to these programs. An example of a successful resource navigation model is ifoster[81] which connects youth aging out of foster system in all states to the local resources they need to move towards independence. Ifoster also has a peer navigation system.
  - **Education coordinators at DCF.** DCF has an Education Manager and recently hired a Regional Education Coordinator who will report to him. The Regional Coordinators are able to train and to provide consultations on education issues, both to DCF staff and to families. This resource may be helpful in addressing the educational needs of youth in the foster system.
- **Ongoing challenges:** None of these services will address the fundamental problems of disruptions to educational progress due to school moves resulting from too many foster care placement moves,[82] and trauma in the foster system which undermines children's readiness to learn. Massachusetts must reduce those serious problems as well as the very high numbers of youth aging out of its foster system without permanent families,[83] all of which are a foundation for a stable adulthood.

12. Engage extended family and community networks

- Engage extended family not only as a placement option, but as a support to the family unit.

Implementation pathways:

- Explore more effective and uniform use of family team meetings, referrals for types of family systems therapy, and other means of using, encouraging and allowing families to rely on their extended family and community support systems as a part of DCF's mission of keeping children safely with their families whenever possible.[84]
  - See, Resources on the Protective Factors Approaches in Child Welfare[85] – this is an approach that child welfare agencies take to consider conditions or attributes of individuals, families, communities, and the larger society that mitigate risk and promote the healthy development and well-being of children, youth, and families. It emphasizes positive relationships with extended family.[86]

13. Build on parenting strengths to promote reunification

- Develop a policy on engagement of parents while their children are in the foster system to promote safe, prompt, and lasting reunification. Such a policy would ensure that, in the absence of documented health or safety reasons, parents can:
  - Contact their children immediately upon their removal and placement and remain in contact frequently throughout placement,
  - Have meaningful in-person parenting time with their children,
  - Remain informed about their children's educational progress,
  - Communicate and partner with their children's foster parents about their children, and
  - Have their concerns about their children's safety and well-being in the foster system addressed.

Implementation Pathways:

- **Parent-foster parent communication and partnership:** Many states have incorporated into their foster parent recruitment plans the requirement that foster parents be able to partner effectively with birth parents to cooperatively parent children and promote reunification. Building this partnership in Massachusetts would promote the implementation of all the elements of recommendations number 13.
- **Resources:**
  - See Resources sheet on different forms of shared parenting and co- parenting at https://www.childwelfare.gov/topics/supporting/support-services/familycare/[87]

- See Partnering with Birth Parents to Promote Reunification, Child Welfare Information Gateway and Children's Bureau, (2019) at https://www.childwelfare.gov/pubPDFs/factsheets_families_partnerships.pdf[88]
- See resources available on the website of the Birth and Foster Parent Partnership (BFPP), Children's Trust Fund Alliance (2020) https://ctfalliance.org/partnering-with-parents/bfpp/[89]

CONCLUSION

Families and youth who have been directly affected by the child welfare system have been absent for far too long in partnering with policy makers to plan the services needed to keep and return their children home with them.

It is time to put action behind the widely recognized principle of family engagement in child welfare practice, by partnering with families and youth in planning prevention services policy. And we must do so now when the Commonwealth is engaged in an unprecedented level of planning of prevention services.

As Tatiana, the leader of Family Matters 1st, said:

> ***"We need to have a seat at the table. Include our voice. We have a long list, we have it ready."***

APPENDIX A

WHAT IS THE FAMILY FIRST PREVENTION SERVICES ACT?

The Family First Prevention Services Act (the Family First Act or FFPSA), enacted by Congress on a bi-partisan basis, and signed into law on February 9, 2018, fundamentally restructures the way child welfare is financed in the United States. ***For the first time ever, it makes available to the states federal funding, on an open-ended entitlement basis,[90] to provide services to keep children safely at home and out of foster care.***

This funding does not cover all needed services and comes with significant requirements and limitations. Understanding these is essential to planning how states can most effectively use the FFPSA to fund services to keep children safely with their families.

- **The Family First Act provides open-ended federal funding to reimburse states for services to keep children safely at home.**

  Before the Family First Act, open-ended Title IV-E federal funding was available only to fund the costs of placing children in the foster system.

  Under the Family First Act, for children whom the child welfare agency designates as at risk of entering foster care ("candidates for foster care"), the federal government reimburses states approximately 50% of the costs of evidence-based,[91] trauma-informed services that the state provides to keep those children safely at home.

- Services eligible for federal reimbursement under Family First Act include:
  - Parent skill-based services[92]
  - Substance use treatment services, and
  - Mental health treatment services.

- Services must be:
  - "Evidence-based" meaning they are approved by the Title IV-E Prevention Services Clearinghouse, and[93]
  - Trauma informed

- Funding maximum: 12 months of a particular service, but can be extended.[94]

- Includes funding for reunification services for an unlimited time while a child is in the foster system and for 15 months of post-reunification services.[95]

- Provides funding to place children safely with a parent for up to 12 months in a licensed, family-based residential substance use treatment program.[96]

- The agencies that provide such services (Department of Children and Families for parent skill-based services, Department of Public Health for substance use services and Department of Mental Health for mental health services) must coordinate the delivery of these services.
- In order to be eligible for federal reimbursement, the state must submit a "Family First prevention plan"[97] to the federal Children's Bureau in which it sets out the evidence-based services for which it plans to seek federal reimbursement, and other elements of its comprehensive five-year plan.

APPENDIX B

PROFILES

EVA

JULIA

GRACE

ELIZABETH

TYISHA

DIERDRE

MELANIE

MIRANDA

EVA AND JULIA

Click on the names above to read more about Eva on pg. 1 and Julia on pg. 6

DCF entered Eva's life when she was struggling to maintain her substance use recovery while caring for her four children. A few months later, she let her DCF worker know she was struggling with maintaining her recovery and asked for any services DCF could offer to help with her four children. DCF provided no services.

Several months after that, Eva relapsed. While she was still in the emergency room, DCF went to her home and removed her children.

She immediately entered a detox program for three days and when she came home, reality set in. "Their diapers still filled the trash can, and their cups were still in the sink," Eva recalled. "There are no words for the trauma of losing your children," Eva told us, "just an emptiness and sadness that never goes away."

DCF's Family Action Plan, the plan for services to address her issues so that her children could return home, gave Eva minimal guidance and support. She was not given any treatment referrals nor helped into any kind of therapy. Eva, who has years of experience in recovery, said the Family Action Plan did not accurately identify the level of care that was appropriate for what she needed at the time. It said she needed to go to detox, which she had just come out of.

Eva also had the support of her mother Julia, a well-respected mental health professional who stepped in to serve as guardian for one of Eva's children. Both Eva and Julia were terribly concerned, however, about the facility Eva's son with autism had been placed in. Julia brought all her mental health expertise and professional resources to bear in her efforts to get her grandson into an appropriate placement and was beside herself with frustration and concern with her inability to get DCF to respond to her.

Ultimately, Eva got her children back home, but like many other parents, Eva told us that the services that helped her were those that she found on her own rather than services that DCF provided or referred her to.

Looking back on her experience with DCF, Eva reflected:

> *"It's been over a year since my children have been back in my custody. Our life is safe, happy and healthy and I now have two years in my own recovery journey. I feel very fortunate to have been able to get through undoubtedly the darkest part of my life, but I know that I did that only with the help of the community resources I had to fight for. I was able to reunify with my kids because I fought to get a bed at a family shelter. I learned how to cope with my own abuse and trauma because I researched domestic violence agencies in my area and told my story until someone listened and offered help. I refused to let the lack of support stop me from my main goal, getting my kids back, because I have watched many parents die from active drug use, before getting the opportunity to reunify with their children, and I knew that couldn't be me.*[98]

GRACE

Click on the name above to read more about Grace on pg. 1

Grace is a low-income, single mother of six. She had her youngest child at age 15. Grace had been involved with DCF for 13 years when the department removed her four youngest children from her home and placed them in foster care on the grounds of inadequate supervision. At that time, she was relying on public transportation to get to work because she could not afford a car. As a result, she was often unable to be home when her children returned from school.

During the many years Grace was involved with DCF, both before and after her children were removed, DCF provided a number of services designed to improve her parenting. Grace provided many insights into what was helpful and why and what would have made services more helpful. As a first generation American, Afro-Caribbean parent, she provided insights into cultural competence in service delivery as well as the challenges immigrants faced in understanding DCF's expectations. Of the many services she received over the years, however, none of them addressed the issue of supervision, the issue for which DCF had removed her children.

In order to address the supervision issues, Grace's DCF caseworker told her she needed to "beef up [her] natural support network." Grace was proactive in taking on this task, finding friends through her children's' school including one who became both a temporary foster parent for two of her children and the educational advocate for another of her children.[99] However, even once she assembled a strong support network, DCF did not return custody to her. It appeared that the pre-adoptive parents with whom her two youngest sons had been placed very much wanted to adopt those two boys and DCF supported that plan. Ultimately, it was the insistence of the older of these two children that he return home which eventually led his upper middle-class white foster parents to abandon their plans to adopt him. This is turn resulted in DCF's deciding to send him home to Grace. The younger of the two brothers has not been as clear that he wished to return home, and DCF continues to oppose reunification.

Her oldest child in the foster system aged out without a permanent family and her second oldest was placed in the custody of his father.

ELIZABETH

Click on the name above to read more about Elizabeth on pg. 2

Elizabeth, a single, low-income mother of two children with disabilities, had received eight years of services from DCF when she was arrested for possession of drugs and related charges. At that time DCF removed her children and placed them in foster care.

She found the structure she needed for recovery in a 34-day detox program in a correctional facility. After that she spent eight months in a residential substance use treatment program. Following the residential substance use program, she received intensive in-home services through DCF, which she spoke very highly of. The problem was that service didn't last long enough.

Elizabeth believes that DCF's removal of her children was warranted and that she "deserved to have them removed from my chaos."

Although several relatives stepped up as placements for the children, DCF instead separated the children from each other, placing one with a foster family and the other in a group home. Elizabeth did not learn that her children had been separated from each other until her first court hearing. She was not able to see either child for a long time after they were placed in foster care.

Elizabeth had serious concerns about her younger child at the group care facility. The child would cry when she visited and had injuries, but was non-verbal and unable to report abuse.

Her older child was returned to her care approximately three months after Elizabeth completed the residential substance use treatment program. Her younger child is still in the group care facility.

DEIRDRE

Click on the name above to read more about Dierdre on pg. 3

Deirdre is the mother of four adult children. She is a former human services worker and a low-income individual. Two of her adult children have been dealing with opioid use disorders. The children of her oldest son were removed by the state and placed in the foster system. Her second oldest son, who did not himself have a substance use disorder, sought DCF assistance due to his wife's alcohol use. Their two children were placed in the foster system. Deirdre's daughter-in-law was in and out of detox programs for a year before her family sectioned her.[100] She still continues to drink. This son and his wife have separated and the Court has returned custody of this son's children to him.

Deirdre brought her personal and her professional experience as a human services provider together to reflect on the service needs of low-income families involved with the child welfare system, particularly those struggling with substance use disorders. "Where I live," she said, "I don't know hardly anyone who's not affected by the opiate epidemic."

She emphasized the need for human connection in responding to the needs of people struggling with poverty, depression, and substance use disorders, often at the same time. She also pointed out gaps in the substance use treatment and referral system.

Deirdre emphasized the need for DCF to work with extended family to support parents struggling with substance use disorders and other issues. When DCF showed up to investigate the home of her second oldest son and his wife, both Deirdre and her son's father, along with her daughter-in-law's parents, were there to meet the investigator and to show that they were ready to support the family. This made a difference in the way the case proceeded.

TYISHA

Click on the name above to read more about Tyisha on pg. 5

Tyisha is a young mother. She was a youth in foster care from ages 14 to 18. As a child she saw her mother become dependent on cocaine after an accident that happened when she fell asleep at the wheel while driving to her out-of-state factory job. Her mother continued using drugs to stay awake and alert at work, however, as she experienced more stress, drug use became her coping mechanism.

At the time of the accident, Tyisha's mom had no idea that she was pregnant with twins. The twins were born early and required a great deal of care. Sometime later, Tyisha would be the main support for her mom and siblings. Tyisha and her family eventually secured stable housing after being in a family shelter for a short time. Tyisha's mom, now with three children, struggled to make ends meet and continued to rely on drugs to be functional enough to care for her family. Eventually DCF got involved.

Tyisha remembers her mother struggling with two police officers and two social workers to prevent them from taking Tyisha and her siblings from her. Tyisha was traumatized, confused, and angry when she was taken to the DCF office. Rather than getting an explanation for her removal, she was bombarded with questions by a social worker. Feeling powerless and as if her personal agency had been stripped, she became agitated, aggressive, and noncompliant.

She was soon labeled a problem child and moved into a congregate placement which she described as a "detention center in the middle of the woods." Eventually, she ran away from that facility and remained out of DCF's control until she reconnected

with her family. Her extended family members were ready and willing to provide help and support by taking in Tyisha and her siblings, but their family's application to serve as a foster placement for Tyisha and her siblings was denied. Tyisha desperately wanted to feel safe and be with people she knew, and demanded she be allowed to stay with an aunt. Tyisha was able to have a temporary placement with her aunt, but her siblings would be separated from her and remained in foster care.

Tyisha's aunt had four children and was going through a divorce. She would eventually lose her home and the entire family became homeless and forced to live in overcrowded situations with extended family until her aunt could find stable housing. At 17, Tyisha left the care of her aunt and tried to fend for herself while still legally under DCF's care but receiving no resources or support. At that time, she took the direction of her life into her own hands.

Reflecting on what could have prevented her separation from her mother, Tyisha believed that if her mother had received better support to address her depression and substance use disorder, she would have been able to remain clean and reunify with her children. Her mother was "going through a lot," Tyisha told us. "She needed help," Tyisha reflected, "and what she got was punishment. It sent her on the worst path."

As a young mother herself, Tyisha made it "her mission" to avoid DCF and to find the services and supports she needed from other social service agencies. After she gave birth to her son at eighteen, they lived in a homeless shelter through which she learned of a two-year shelter program

for single mothers that offered case managers and workshops on budgeting and parenting. While in this shelter program, Tyisha started to work towards her GED and regularly attended classes at a program designed to create educational stability for low-income women. This provided one of the first educational experiences where Tyisha felt supported and empowered. Every time she got a high score on a practice test, the staff would ask, “why didn’t you go to school?” They always reminded her that no matter what she had been through, she could get her GED and that she had the potential to do more. The first time she took the GED, she passed with flying colors.

Tyisha found her first apartment while her son was still young, and finally felt she had a home. She stayed there for the next 11 years. After being introduced to local community-building work through a work-study program, she built relationships and advanced her own skills. She worked her way to becoming the office manager of a social justice non-profit organization, where she remained for the next 15 years. This job provided her stability and a feeling of family, allowing her to grow both as a professional and as a person.

With this support, Tyisha was able to seek the help of a therapist to deal with the trauma she had experienced as a child. It was only after Tyisha was grounded and supported that she took time to process all the things she had experienced. No longer in fight or flight mode, and knowing that her son was safe, she could take time to for herself to heal.

Although Tyisha had created both home and work families of her own, she still sought out the family that was torn away from her. With the help of her therapist, at thirty-five years old, she discovered her sister on Facebook and took the opportunity to write her a letter. Although she has not heard back, she still hopes to one day be a part of her siblings’ lives again. She also reconnected with her parents. Despite her anger at her father for abandoning them, Tyisha ensured that her son had a relationship with his grandfather and his grandmother. Her mom was one of the most consistent and reliable parts of her circle of support.

Tyisha sometimes wonders what her life would have been like if she and her mom did get real support. If there were more efforts made to keep her family together, what difference that would have made in all of their lives.

MELANIE

Click on the name above to read more about Melanie on pg. 9

Melanie, a 27-year-old mother of two boys, ages six and two, has an intellectual disability. Her younger child was born with a rare genetic disorder and has pervasive problems. One night, several months after his birth, Melanie and her husband brought him to the hospital due to his uncontrolled vomiting. The hospital diagnosed the child with a serious secondary condition which required that a portal be placed in his stomach attached to tubes for his food and medication. When the child was ready to leave the hospital, hospital staff concluded that due to her disability, Melanie would not be able to follow the medical procedures her child needed and filed a G.L. c. 119, § 51A complaint of abuse or neglect against Melanie.

DCF removed her younger child from Melanie's home and placed him in a specialized medical foster home with other ill children. They had no concerns about her care of the older child and left him with Melanie and her husband.

The medical foster mother did not want Melanie in her home and so Melanie was allowed to visit her child only in the hospital when he was undergoing unpleasant medical procedures.

DCF arranged for a neuropsychological evaluation of Melanie to identify the nature of her disability and, given her learning disability, how she could best be trained to care for her younger child. The neuropsychologists recommended that Melanie needed to learn through repetition, mastering one task before moving on to another. They also recommended that Melanie would need assistance with her child's medical care, and specifically recommended that Melanie's mother-in-law Sandra,

a Certified Nurse Assistant who lived in the same house as Melanie and her husband, would be a good resource. Sandra informed DCF she intended to help with the child's medical care.

Despite the recommendations set forth in the neuropsychological evaluation about how to best address the learning needs of the mother, DCF failed to design a medical training program to accommodate those identified needs.

DCF also refused to let Sandra participate in the trainings with Melanie and also would not let Melanie's husband, who did not have a disability, participate in the trainings, instead insisting that Melanie learn on her own. Melanie struggled to learn the material. When her lawyer insisted that DCF's failure to accommodate her disability, or allow supports, violated the Americans with Disabilities Act (ADA), the nurse whom DCF had hired to design the trainings replied that DCF was not required to follow the ADA.[101]

At the time of the interview, Melanie was hoping that Sandra would become her younger child's guardian. If that happened, her child would have the benefit of living with kin, would see his mother, father and brother in his own home, more frequently, under more pleasant and natural circumstances and Melanie would be in a better position to learn how to care for her child, with expert assistance constantly on site so that she would have a chance of eventually regaining custody of him.

MIRANDA

Click on the name above to read more about Miranda on pg. 11

Miranda was a youth in the foster system from age nine, when her parents developed substance use disorders, to age 17 when she left the system and aged out without a permanent family.

During their time in foster system, Miranda and her siblings were returned to their mother three times, but each time they were soon removed again either to DCF custody or to family placements. During her time in the foster system, Miranda lived in an "unreasonable amount of homes."

Both her sister and brother were abused in foster care. She said her brother "doesn't talk about it, but after a truancy and a fight in school, he ended up in jail," moving from the juvenile to the adult system due to a lack of legal representation. "That's how it started. He never had a chance. He needed therapy, not jail." Miranda reflected. Her sister developed an alcohol problem.

Despite being recognized as bright, Miranda had a hard time progressing in school. "Every time I was doing well [in a school], they removed me," she told us, and she had to start again in a new school. "We get a little bit of hope [in foster care]" she told us, "and we take that with us until it dims, and then eventually we find something else to hold onto and then we take that with us."

At 14, she got into a fight at school and ended up in the juvenile justice system, and "that's when everything took a turn for the worst," she said. She was sent to an after-school program which she described as "really abusive." She never made it past ninth grade. Instead, she said, she "just defected."

Miranda had a disability, ADHD, but she says DCF never wanted to give her therapy, just medication. She attempted suicide three times while in foster care. After the first two attempts, she had no one to talk to, and DCF put her back in the same home. Then at age 15 she made her third suicide attempt after she got pregnant. She was going to try to have an abortion, but then she lost the baby. Although DCF knew about her having lost the baby, no one ever asked her about it. She "bounced around" in foster care from ages 16 to 17. Then fearing the same fate as her brother, that her juvenile criminal status would feed her into the adult criminal system due to a lack of legal representation, she left the state, going to New York City alone and without any family support.

Although Miranda asked to remain in DCF's custody beyond age 18, DCF denied her request because she hadn't finished high school and did not want to enter DCF's job training program. She wanted to get her GED.

Miranda eventually did get her GED on her own at age 33. She is a vibrant mother of a six-year-old boy and works as a parent organizer. Education has been key to the success Miranda has made of her life.

Endnotes

1 M.G.L., c. 119, § 1. See also, 110 CMR 1.01, 10.02, and 1.03. For the federal legal and financial infrastructure reinforcing this commitment, see Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (June 17, 1980) (1980 act) and Adoption and Safe Families Act, Pub. L. No. 105-89, 105th Cong., 1st Sess. (Nov. 19, 1997) (1997 act).

2 42 U.S.C. 671 (19), 110 CMR 7.101 (2)(a), DCF Permanency Planning Policy (Policy # 2013-01) p.12 https://www.mass.gov/doc/permanency-planning-policy/download

3 42 U.S.C. 671 (a)(15); M.G.L., c.119 § 29C

4 Prevention services can prevent abuse and neglect before it happens (primary prevention) or can prevent the recurrence of abuse and neglect (secondary and tertiary prevention).

5 While 87% of the children in the DCF caseload need prevention services to remain or return safely home, only 10% of the funding in DCF's services accounts ($70.1 million) in the current FY 22 budget is allocated to services to keep children safely with their families. $608 million is allocated to covering the costs of the children in the caseload who are in the foster system. The need for services becomes evident when one considers that over 87% of the children in the caseload of the Massachusetts Child Welfare agency, the Department of Children and Families (DCF) are there because of what DCF defines as "neglect" and under 12% because of abuse. See DCF Annual Report 2021, p. 32 https://www.mass.gov/doc/dcf-annual-report-fy2021/download. Especially given the extent to which neglect allegations are confounded with poverty (see note 44), in many DCF cases effective services could make all the difference in strengthening families and keeping children safely at home and out of the DCF caseload.

6 DCF Annual Report 2021, p. 9 https://www.mass.gov/doc/dcf-annual-reportfy2021/download

7 LGBTQ Youth in the Massachusetts Child Welfare System A Report on Pervasive Threats to Safety, Wellbeing, and Permanency, pp. 9,10 https://www.mass.gov/doc/commission-report-on-dcf/download

8 Massachusetts doesn't publish data on the percentage of children of parents with disabilities in its child welfare caseload or its foster system. What we know is that approximately 6.6% of parents of children under age 18 in Massachusetts have some form of disability, Kaye, H.S. (2012). Current Demographics of Parents with Disabilities in the U.S. Berkeley, CA: Through the Looking Glass, and that children of parents with disabilities make up 19% of those in the United States foster care system Lightfoot, Elizabeth & DeZelar, Sharyn, 2016. "The experiences and outcomes of children in foster care who were removed because of a parental disability," Children and Youth Services Review, Elsevier, vol. 62(C), pages 22-28 https://ideas.repec.org/a/eee/cysrev/v62y2016icp22-28.html.

9 Massachusetts has only just recently submitted its Family First Prevention plan.

10 Support and Stabilization Services are the services that DCF contracts for to keep and return children safely in their homes. Family First prevention services overlap with Family Support and Stabilization services in that they are only those services to keep children safely with their families that are federally reimbursable. (See Appendix A: "What is the Family First Prevention Services Act?") Some Support and Stabilization services are not Family First prevention services because they are not federally reimbursable. Some Family First services are not Support and Stabilization services. These include some primary prevention services that may not require DCF involvement and some substance use and mental health treatment services not provided by DCF.

11 The public Request for Information posted on the Commonwealth's contract procurement website Commbuys is here: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1034-0009-DSS09-67937. Support and Stabilization Services are services to keep and reunify children safely with their families. They are funded in DCF budget line item 4800-0040. They include intensive in-home services, parent aides, counseling services, parenting groups and other similar services. Although this line item was intended to fund only those services that were used to strengthen children's families so children can stay safe at home and out of foster care, DCF proposed to further deplete funds available for services to families by using this line item to fund services provided in foster and congregate care settings as well.

12 This is the first procurement for prevention services we are aware of for which DCF or its predecessor DSS has sought public input.

13 DCF notes that it conducted background research for the RFI by consulting with focus groups from its Family Advisory council. See Request for Information RFI) on Support and Stabilization Services, October 29, 2021, pp. 5-6 at https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1034-0009-DSS09-67937. While there is value in having an internal council that includes families and youth who have been involved in the child welfare system, that is different from partnering with families and youth who are members of the public who don't work for DCF. The online RFI form seeking public input was cumbersome and not well suited to directly individual feedback. The Office of the Massachusetts Child Advocate has conducted focus groups to solicit input from families and youth to convey to decision makers. While input is important, it is not a replacement for partnering and engaging with families in the back and forth of shaping policy. The latter is what is essential in policy planning for services to families.

14 Family Matters 1st wrote to DCF asking for an opportunity to provide input into its Family First prevention plan, but DCF declined. See "DCF Needs Family Input," letter to the editor of the Boston Globe published December 28, 2021 https://www.bostonglobe.com/2021/12/28/opinion/dcf-needs-family-input/

15 See Administration for Children Youth and Families Information Memo ACYF-CB-IM-19-03, issued August 1, 2019 https://cdn.ymaws.com/www.naccchildlaw.org/resource/resmgr/news_items/acyf-cb-im-19-03_cb_informat.pdf

16 Colorado, Nebraska, Oregon, Rhode Island, North Carolina and California are a few examples. See links in Recommendation no. 1.

17 DCF does not provide direct services but contracts with a network of providers for the services it provides to families.

18 This option is complicated by the Family First Act's requirement that Title IV-E funds are available only as the federal payor of last resort. This means that if Medicaid or other federal funds are available to cover the cost of treatment, Family First cannot be used. Nonetheless, there is room for exploration here for DCF involved families. In addition, Family First separately provides for funding of family-based residential care as a foster care (rather than a prevention expense). This too calls for careful consideration.

19 Reasonable efforts are required by federal and state law. Under Massachusetts law, G. L. c. 119, § 29C, with respect to **removal**: if a Juvenile Court judge grants temporary custody of a child to DCF, the judge "shall certify that the continuation of the child in his home is contrary to his best interests and shall determine whether the department . . . has made reasonable efforts prior to the placement of a child with the department to prevent or eliminate the need for removal from the home." With respect to **reunification**: "If a court has previously committed, granted custody or transferred responsibility for a child to the department or its agent, the court shall determine not less than annually whether the department or its agent has made reasonable efforts to make it possible for the child to return safely to his parent or guardian." Federal law also requires reasonable efforts be made to prevent removal and pursue reunification: "reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home." Section 42 U.S.C. § 671(a)(15). Congress conditions federal foster care funding on meeting reasonable efforts requirements. See Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500 (June 17, 1980) as amended by Adoption and Safe Families Act, Pub. L. No. 105-89, 105th Cong., 1st Sess. (Nov. 19, 1997) See generally, Care and Protection of Walt, 478 Mass. 212 (2017)

20 These recommendations apply equally to services to prevent removal and to promote reunification. As explained more fully in note 50, more federal funding is available under the Family First Act for services to prevent removal, than for reunification, but Family First does enhance reunification funding, both are mandates under state and federal law, and both are essential for families.

21 Our best understanding is that currently in Massachusetts many in-home family skill-based services are terminated after three months, and sometimes extended for an additional three to six months. Family First provides funding for 12 months of a given services and this time can be extended (See note 51).

22 While lack of expertise in substance use and disabilities were the issues that parents raised most explicitly, the need for more skill and training in cultural competence and trauma responsiveness, and in understanding poverty, racism, and implicit bias were themes that ran through their responses as well. In addition, although we did not have the opportunity to speak to a directly impacted LGBTQ individual for this project, we are well aware that greater competence in identifying and understanding the service needs of LGBTQ individuals is needed at DCF.

23 Child Welfare League of America, 2021

24 Parents, particularly those in the group of directly impacted persons, emphasized that they were less likely to seek out services from people who were mandated reporters. This may explain why many had not been involved with Family Resource Centers.

25 See https://www.mass.gov/childrens-behavioral-health-initiative-cbhi and http://www.rosied.org/page-73524 for information about the Children's Behavioral Health Initiative

26 See information about the Franklin County Drug Court at https://www.mass.gov/service-details/specialized-court-sessions and https://www.mass.gov/news/massachusetts-trial-court-awarded-federal-grant-to-significantly-expand-franklin-county-family-drug-court

27 Refers to an involuntary commitment of a person into a treatment facility pursuant to M.G.L. c. 123, § 35.

28 Formerly called the Service Plan.

29 This is referred to as the "Clinical Formulation" and is considered the foundation of the Family Action Plan.

30 In a 2015 Letter of Findings, the federal Departments of Justice and Health and Human Services found, in a similar case, that DCF's excluding the family members of a disabled parent from her training in parenting skills violated the Americans with Disabilities Act and the Rehabilitation Act both of which require accommodating the disabilities of parents in child welfare cases.

31 While all the youth we spoke to were abused or experienced trauma in the Massachusetts foster system and those featured in this report described significant educational barriers, we do not assert that this is representative of all children currently in the foster system. The current Massachusetts data should be considered regarding rates of abuse, placement instability, length of time in care, educational outcomes, rates of congregate care and associated outcomes, and rates of aging out and associated outcomes in notes 74, 75 and 76 below.

32 For information about services available to youth who have aged out of the foster system without permanent homes, see The Answer Book: Making the Most of Foster Care, https://www.mass.gov/info-details/the-answer-book-making-the-most-of-foster-care. See also, DCF's report of the services it offers to transition age youth in its FFY 2022 Annual Progress and Services Report, at p. 146, https://www.mass.gov/doc/dcf-ffy22-annual-progress-and-services-report/download

33 An education advocate helps a family advocate for special education services for their children.

34 See *Care and Protection of Walt*, 478 Mass. 212 (2017), *Care and Protection of Rashida*, 488 Mass. 217 (2021), and cases, statutes, regulations and policy cited therein

35 This refers to the Department's planning process for its June 2022 procurement of Support and Stabilization services, and its submission of its Family First prevention plan. Massachusetts has sought public input on Support and Stabilization services and is reaching out to identify people with lived experience to provide input. DCF has not engaged to date in any public planning process for its Family First prevention plan, and declined a request from a group of DCF-involved families and youth for an opportunity to provide input into the plan before it was submitted to the federal Children's Bureau for approval.

36 DCF has not shared this plan publicly.

37 See note 14 regarding DCF's denial of a request by families and former foster youth to provide input into DCF's prevention plan.

38 The Colorado prevention plan is here: https://co4kids.org/sites/default/files/Family%20First%20Prevention%20Plan.pdf. Colorado created a 27-member Family First implementation team with a wide range of stakeholders including constituents. The team's values included: 1. Family and youth voices are the loudest – heard, considered and respected, and 2. Children, youth and families are best served by a systemic and community-engaged, integrated approach to identify and meet their needs.

39 The Connecticut prevention plan is here: https://portal.ct.gov/DCF/Press-Room/Press-Releases---Latest-News/CT-Family-First-Prevention-Plan. Connecticut engaged in a collaborative planning process for its Family First prevention plan which included 400 community partners including parents and youth with lived experience. As the prevention plan described the planning process: "The priority was to ensure that children and families were truly at the center of the work." Equally important to the inclusion of multiple partners was transparency of the process. Connecticut also established a Family First website: https://portal.ct.gov/DCF/CTFamilyFirst/Home

40 The California prevention plan is here: https://www.cdss.ca.gov/Portals/9/CCR/FFPSA/CA-FiveYear-State-Prevention-Plan-Draft.pdf. California obtained feedback from multiple parent and youth groups in developing its prevention plan. These same groups will also serve as venues to discuss implementation and will serve the child welfare agency in the creation of an advisory body which centers lived experience and influences the local and statewide implementation process.

41 Children's Bureau, Capacity Building Center for States https://capacity.childwelfare.gov/states/resources/strategies-for-authentic-integration-of-family-and-youth-voice-in-child-welfare

42 Children's Bureau, Capacity Building Center for States https://capacity.childwelfare.gov/states/resources/strategic-planning-in-child-welfare-strategies-for-meaningful-stakeholder

43 Administration for Children and Families, Children's Bureau, ACYF-CB-IM-19-03 (August 1, 2019) https://www.acf.hhs.gov/cb/policy-guidance/im-19-03

44 A public health approach to child welfare involves taking a broader view of the social determinants of child safety and well-being. Given that over 87% of the cases in DCF's caseload are based on neglect allegations, (See Dept of Children and Families, Annual Report Fiscal Year 2021, p. 32, Table 29 c), and that the child welfare system so often confounds poverty with neglect, addressing families' concrete needs before they get involved with DCF whenever possible is critical. See, It's Time to Stop Confusing Poverty with Neglect, Jerry Milner and David Kelly, (then Associate Commissioner and Special Assistant to the Associate Commissioner, U.S. Children's Bureau, Department of Health and Human Services), January 17, 2020, https://imprintnews.org/child-welfare-2/time-for-child-welfare-system-to-stop-confusing-poverty-with-neglect/40222 Elsen and Gewirtz, Deep Poverty Increases Risk of Child Welfare System Involvement, Commonwealth Magazine, July 27, 2019, https://commonwealthmagazine.org/opinion/deep-poverty-increases-risk-of-child-welfare-system-involvement/ It is also necessary to address other issues such as substance use disorders, mental health and domestic violence issues that pose risks to child safety.

Measures that stabilize families such as increasing family income supports, improving emergency housing assistance, preventing evictions and foreclosures, and ensuring access to the Child Tax Credit all are critical elements of a public health approach to child welfare and all will reap huge benefits for children while saving the Commonwealth the enormous costs of unnecessary foster care. While these policies are beyond the scope of this report, they are essential elements of a public health approach to child welfare.

45 See, System Transformation to Support Child & Family Well-Being: The Central Role of Economic and Concrete Supports, Dana Weiner, Clare Anderson, Krista Thomas, July 2021 https://www.chapinhall.org/wp-content/uploads/Economic-and-Concrete-Supports.pdf

46 See note 39 for link to Connecticut's prevention plan. Connecticut would use a broad definition of "candidate for foster care," the Family First eligibility requirement, (See, Appendix A, "What is the Family First Prevention Services Act?) in order to make multiple populations eligible for Connecticut's Community Pathway. Those with issues that could present risks but who do not present immediate safety concerns could be referred to services through a Care Management Entity outside of the child welfare agency.

47 See note 40 for link to California's prevention plan

48 According to DCF's data, in Massachusetts Latinx children are reported at 4.3 times the rate of white children and Black children at 3.1 times the rate of white children. In Boston, Latinx children are reported at 6 times and Black children at 8.9 times the rate of white children. See the full analysis at: https://www.mass.gov/doc/dcf-equity-analysis-presentation/download

49 Anecdotally it appears that, currently in Massachusetts, family skill-based services are often terminated after three months, and sometimes extended for an additional three or six months.

50 While the Family First Act provides open-ended Title IV-E funding for services only for "candidates for foster care" to prevent foster care placements, it also enhances Title IV-B (capped) funding for reunification services by eliminating the time limit for reunification services while children are in the foster system. (See, Appendix A, "What is the Family First Prevention Services Act?") To the extent that reunification services are not federally funded they are nonetheless an essential element of an effective Support and Stabilization services array to keep children safely with their families and most be covered by state or other sources of funding.

51 See federal Administration for Children and Families, Program Instruction ACYF-CB-PI-18-09 p. 4, par 2.

52 See, e.g., Interventions Relevant to Children and Families Being Served with Family First Funding that Have Been Shown to be Effective with Families of Color, Pecora, Klein and Foster, Casey Family Programs (2021) https://cdn.ymaws.com/www.naccchildlaw.org/resource/resmgr/policy/2021/race_equity_hub/ffpsa_interventions_families.pdf

53 ACF Information Memorandum 21-04 https://www.acf.hhs.gov/cb/policy-guidance/im-21-04

54 Rise Magazine, May 2021 https://www.risemagazine.org/2021/05/someone-to-turn-to-insights3/

55 Chapin Hall Policy Brief, Weiner, Anderson and Thomas (July 2021) https://www.chapinhall.org/wp-content/uploads/Economic-and-Concrete-Supports.pdf

56 While Massachusetts has effective family-based residential substance use treatment centers which allow children to remain safely with their parents while their

parents are getting the treatment they need, access to these programs remains an issue. There are a total of 191 beds in several types of facilities: family residential treatment programs, pregnancy enhanced residential treatment programs (where women receive treatment while pregnant and then a limited number can return with their babies post-partum), family supportive housing programs, and one co-occurring enhanced program. Note, at the current time there is not a waitlist for family-based residential substance use treatment, which may be the result of decreased demand due to Covid-10 risks in residential programs. Note, this report does not delve into the reasons for lack of access, but we note that lack of access may be due to several factors other than lack of beds alone. For example, staff scheduling issues may also impede access, leaving needed beds empty.

57 While many families come to DCF's attention and lose custody of their children because of substance use disorders, DCF does not provide substance use disorder services directly, nor does DCF involvement result in priority access to substance use treatment for the parents of children who have entered the foster system or are at risk of entering the foster system. MA does give priority access to substance use treatment for pregnant women. We note that even in the absence of a formal policy of priority access, improved communication between DCF workers and substance use treatment providers could facilitate access to treatment for DCF involved families, as could improved expertise by DCF workers as to the specific treatment needed and where to find it.

58 Underlying issues include depression, other mental health issues, conditions of poverty that can cause or contribute to stress and depression, or domestic violence.

59 This is referred to as the "payor of last resort requirement." See Social Security Act, Title IV-E, 42 USC, §671 USC(e)(10)(C) and Administration of Children, Youth and Families Program Instruction ACYF-PI-18-09 https://www.acf.hhs.gov/cb/policy-guidance/pi-18-09 p. 12.

60 Although Family First requires that children legally be in DCF custody as a condition of reimbursement, this may not have to require ever physically separating children from their parents. For more detail on how states can administer Family First funding for family-based residential substance use treatment see IMPLEMENTING THE FAMILY FIRST PREVENTION SERVICES ACT: A Technical Guide for Agencies, Policymakers and Other Stakeholders https://www.childrensdefense.org/wp-content/uploads/2020/07/FFPSA-Guide.pdf. See also, The Family First Act, Section 50712, and Administration of Children, Youth and Families Program Instruction ACYF-PI-18-07, https://www.acf.hhs.gov/cb/policy-guidance/pi-18-07 p.4 .

61 https://www.pacesconnection.com/blog/a-community-based-approach-to-supporting-substance-exposed-newborns-and-their-families

62 This would depend on how a state defines "candidate for foster care" and whether that definition is approved by the federal Children's Bureau. See, e.g. District of Columbia's approved prevention plan, at p. 7, which included reunified children as eligible for Title IV-E prevention services ("candidates for foster care") in its plan.

63 Family First enhances capped Title IV-B funding for time limited post-reunification services.

64 DCF's Family Assessment and Action Plan policy states at page 2: "in the clinical formulation, the Social Worker states whether continued Department involvement is being recommended or not and the reason(s) for this recommendation; and identifies the priority areas of focus for the Action Plan to enable the family to provide for the safety, permanency, and well-being of each child. https://www.mass.gov/doc/family-assessment-action-planning-policy-1/download

65 Federal law requires that DCF case planning for children in the foster system be "jointly with the parent(s) or guardian of the child in foster care." 45 C.F.R. § 1356.21(g)(4). DCF's Assessment Policy states that DCF: "identifies and engages all family members who have a role to play in the child(ren)'s safety, permanency and well-being, including all parents/guardians, individuals residing in the home (kin and other), children in Department placement, minor siblings residing out of the home and/or others identified by the family as important to them.... For families who must stay involved, jointly developing a plan to support the family in strengthening their capacity to meet the safety, permanency and well-being needs of each child."

66 Federal law requires that for youth over 14, their case plan "be developed in consultation with the child". 42 USC 675 (5) (C (iv)

67 Much of the literature on family engagement addresses the need for engagement of families and youth in both their individual cases and in policy planning at the system level. A key element of family engagement in individual cases is effective collaboration in case planning. See e.g., Family Engagement: Partnering with Families to Improve Child Welfare Outcomes, Children's Bureau, September 2016, p. 4. https://www.childwelfare.gov/pubPDFs/f_fam_engagement.pdf. See also, Children's Bureau Memo 19-03 Engaging, empowering and utilizing family and youth voice in all aspects of child welfare to drive case planning

and system involvement, https://www.acf.hhs.gov/cb/policy-guidance/im-19-03

68 When DCF workers don't have expertise, they need to be able to partner with those who do within DCF or in sister agencies such as DPH, DDS, DMH, the Domestic Violence Services system, or the community-based service system.

69 While lack of expertise in substance use and disabilities were the issues that parents raised most explicitly, the need for more skill and training in cultural competence and trauma responsiveness, and in understanding poverty, racism, and implicit bias were themes that ran through their responses as well. In addition, although we did not have the opportunity to speak to a directly impacted LGBTQ individual for this project, we are well aware that greater competence in identifying and understanding the service needs of LGBTQ individuals is needed at DCF.

70 DCF's Request for Information on Support and Stabilization Services, reported that DCF's own area office staff ranked services for intellectual disability and/or autism highest for both adults and children as the area in which more services were needed, See RFI on Support and Stabilization Services, p. 14. https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1034-0009-DSS09-67937. Supports and Stabilization Services

71 Despite clear and detailed findings of the Department of Justice in the Sara Gordon case regarding DCF's legal obligations to provide reasonable accommodations to a parent with disabilities, https://www.ada.gov/ma_docf_lof.pdf, and a subsequent settlement agreement, https://www.ada.gov/mdcf_sa.html, DCF still has a long way to go in reasonably accommodating its services to parents with disabilities.

72 One key issue is ensuring that parents who are not affirming of their LGBTQ children receive services and supports to grow in their understanding and acceptance. Research demonstrates that parental acceptance has a profound positive and protective effect on the lifelong well-being of LGBTQ youth. DCF must ensure that parents receive services and resources on how to move from rejecting behavior to accepting behavior to try to improve their parent-child relationship and ability to care for their child. See also, July 2021 report of the Massachusetts Commission on LGBTQ Youth, regarding the crisis involving LGBTQ youth who are DCF-involved, https://www.mass.gov/doc/commission-report-on-dcf/download

73 When a case goes to court, attorneys for parents and youth also have an important role to play in helping their clients navigate the DCF system. However, many cases in which families are involved with DCF for years don't go to court and families and youth don't get assigned attorneys.

74 For this report we interviewed a limited number of individuals who were involved in the Massachusetts foster system, and they left the system a while ago. Although all five were abused or experienced trauma, and most encountered educational barriers, we do not suggest that all youth in the current foster system have this experience. Current data is useful though in providing a view of the current prevalence of these issues. Although Massachusetts safety and well-being data for youth in foster care is limited, the current data that is available suggests that youth in foster care in the Commonwealth are struggling:

Placement instability and length of time in the foster system: Placement instability means that children already traumatized by the circumstances that required their removal from their homes and separation from their parents are then forced to cycle through foster placements. Placement instability compounded by the growing length of exposure to that instability deepens the trauma of youth in foster care, negatively affects their neurological and emotional development and educational progress, and makes it difficult for them to bond or form positive and supportive relationships with their caretakers. See, e.g., Lowenstein, K., Shutting Down the Trauma to Prison Pipeline: Early, Appropriate Care for Child-Welfare Involved Youth 8 (2018), https://www.cfjj.org/trauma-to-prison; Mass. Department of Elementary & Secondary Education ("DESE") & Mass. DCF, Promoting Educational Stability and Success for Children in Foster Care 1 (June 2014), https://static1.squarespace.com/static/5eba93aff8ad71474552da2d/t/5ec59618f345100a553f8694/1590007324563/DCF_DESE_Joint_Memo_Fostering_Connections_2014.pdf ("Each time a child changes school [due to placement instability], she/he loses approximately 6 months of knowledge and skills"). As of the most recent report, Massachusetts had the second highest rate in the nation of placement instability for children in foster care. See Children's Bureau, Outcome 6: Placement Stability, in Child Welfare Outcomes Report (2018) https://www.acf.hhs.gov/cb/report/cwo-2018. Moreover, Massachusetts children's average length of stay in foster care has increased each year from 661.6 days in 2017 to 712 days in pre-pandemic 2019 to the current high of 781 days in 2021; DCF FY 2021 Annual Report, see link above, at 16.

Abuse: While very limited data is available, what data does exist shows that the rate of abuse of youth in the Massachusetts foster system is higher than the national median. Mass. Dep't of Children & Families, Annual Report Fiscal Year 2021, p. 44 https://www.mass.gov/doc/dcf-annual-reportfy2021/download (reporting that 98.99% of children in the MA foster system are not abused compared to the national median of 99.5%).

75 Current **Educational outcomes** for youth in the MA foster system are alarming: Youth in the foster system are more likely to repeat grades, to have higher absentee rates, and to experience school exclusion than their peers not in foster care. See Mass. Office of the State Auditor, Educational Services for Students in Foster Care and State Care 9 (Apr. 2019) [hereinafter Educational Services] https://www.mass.gov/doc/local-financial-impact-review-educational-services-for-students-in-foster-care-and-state-care/download Mass. Court Improvement Program, Stable Placement, Stable School: Improving Education Outcomes of Children in Foster Care in Massachusetts 4-5 (2019), https://www.mass.gov/doc/stable-placement-stable-school-improving-education-outcomes-of-children-in-foster-care-in/download. Massachusetts foster youth are also significantly less likely to graduate from high school than their peers not in foster care. See Educational Services, above, at 9. Compare Mass. Dept of Children & Families, Annual Report Fiscal Year 2020 (2021) (finding that in 2018, less than two-thirds [63.6%] of students in the Massachusetts foster system graduated from high school within five years) with Cohort 2019 Graduation Rates, Mass. Dept of Elementary & Secondary Educ. ("DESE"), https://profiles.doe.mass.edu/grad/grad_report.aspx?&fycode=2019 (finding that in 2018, 89.7% of all students graduated in five years and that no other sub-group, including students of color, low-income students, students with disabilities and English learner students had a five-year graduation rate as low as the rate for students in foster care).

76 **Aging out with no permanent family:** Massachusetts has the sixth highest rate in the nation of youth leaving foster care with no permanent family. Annie E. Casey Found. Kids Count Data Center, Kids Exiting Foster Care by Exit Reason in the United States: Emancipation (2019), https://datacenter.kidscount.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=1&loct=2#ranking/2/any/true/1729/2632/13051. It is well-documented that youth who have been removed from their family and become adults without another permanent home are at high risk for poor outcomes such as homelessness, unemployment, criminal justice system involvement, poverty, health problems, and a next generation of child welfare involvement. See Nat'l Youth in Transition Database ("NYTD"), Data Brief #7: Highlights from the NYTD Survey 7-8 (Children's Bureau, Nov. 2019), https://www.acf.hhs.gov/sites/default/files/documents/cb/nytd_data_brief_7.pdf, finding that aging out youth are experiencing homelessness, giving birth to or fathering a child, and not having any health insurance); Dworsky et al., Outcomes at Age 19, in Midwest Evaluation of the Adult Functioning of Former Foster Youth (Chapin Hall at the Univ. of Chi., May 2005) (working paper), https://www.chapinhall.org/research/midwest-evaluation-of-the-adult-functioning-of-former-foster-youth/ (aged-out youth more likely to report pregnancy, experience homelessness, and report health problems).

77 DCF's permanency planning policy sets out its criteria for allowing youth over 18 to sustain a connection with the Department for the purposes of receiving transitional services. See Permanency Planning Policy pp. 52 – 62 https://www.mass.gov/doc/permanency-planning-policy/download

78 DCF is required to provide a transition plan to connect youth to services before the youth turns 18. The elements of that plan are set out on pp. 60-62 of its Permanency Planning Policy (see link in note 77). Anecdotally it appears these plans are rarely sufficient for youth who do not sustain a connection with DCF after age 18.

79 More detail is contained in the submission of the Disability Law Center in response to DCF's Request for Information (RFI) for Support and Stabilization Services. See also, https://www.npr.org/2021/04/22/988806806/state-foster-care-agencies-take-millions-of-dollars-owed-to-children-in-their-ca , https://www.themarshallproject.org/2021/05/17/these-states-take-money-meant-for-foster-children

80 See Family First Prevention Services Act, Section 50753

81 http://ifoster.org/

82 See notes 74 and 75.

83 See note 76.

84 See resources on Family Teaming Models in Family Engagement: Partnering with Families to Improve Child Welfare Outcomes, Children's Bureau, pp. 5-6 https://www.childwelfare.gov/pubPDFs/f_fam_engagement.pdf.

Also see information re. allowing parents with disabilities to rely on family members as a reasonable accommodation required by the Americans with Disabilities Act, in recommendation 10.

85 https://www.childwelfare.gov/pubpdfs/protective_factors.pdf

86 DCF states that it uses a Protective Factors framework to help assess child safety. See DCF Protective Intake Policy, p. 4 https://www.mass.gov/doc/dcf-protective-intake-policy/download. In its listing of protective factors, under social connections, it lists "parent/caregiver maintains healthy, safe and supportive relationships with people, institutions and the community that provide a sense of belonging." The proposal in this report goes beyond evaluating the quality of parents' social connections. Instead, it would actively use and build on extended family to support

and strengthen parents so their children can live safely within their families.

87 https://www.childwelfare.gov/topics/supporting/support-services/familycare/

88 https://www.childwelfare.gov/pubPDFs/factsheets_families_partnerships.pdf

89 https://ctfalliance.org/partnering-with-parents/bfpp/

90 This means Congressional authority to appropriate the funding needed to reimburse states for a part of their Title IV-E program costs remains in place without any periodic reauthorization. It also means that there is no upper or lower limit on the amount of annual federal funding that must be appropriated for this purpose. Reimbursement to the states is limited only by the amount of money that the state spends under the program and by statutory definitions of who and what is eligible for federal reimbursement. See Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act, Congressional Research Service, https://www.everycrsreport.com/reports/R42792.html#_Toc339461873

91 To be considered "evidence-based" services must be approved by the Title IV-E Prevention Services Clearinghouse. https://preventionservices.abtsites.com/

92 The Family First Act uses the term "in-home" parent skill-based services. Federal guidance clarifies that these services do not have to be provided in the parents' home. ACYF-CB-PI18-09, p. 3

93 https://preventionservices.abtsites.com/

94 See note 51.

95 Funding for reunification and post-reunification services does not come from open-ended Title IV-E funding. Instead, the FFPSA enhances capped Title IV-B funding by eliminating the time limit on federal reimbursement for reunification services while children are in the foster system and covering 15 months of itemized post-reunification services. See 42 USC, § 629a

96 These placements can be funded either by using Title IV-E prevention services funding to prevent a foster care placement, or using Title IV-E foster care funding to cover the cost of placing children in state custody with their parents in family based residential substance use treatment centers. See Family First Prevention Services Act, Section 50712. If Federal Foster Care funding is used, some state agency needs to have custody of the child which could be designated by either a voluntary or involuntary court order. If they are funded as prevention services, the state does not need to have custody of the child(ren).

97 States submit this plan as an amendment to their existing Title IV-E plan.

98 This is from Eva's Testimony on October 29, 2019 in the Massachusetts legislature in support of a bill to enact the Family First Prevention Services Act in Massachusetts.

99 An education advocate helps a family advocate for special education services for their children.

100 This refers to the involuntary commitment to a treatment facility, under M.G.L. c.123, § 35, of a person with a substance or alcohol use disorder.

101 In a 2015 Letter of Findings, the federal Departments of Justice and Health and Human Services found, in a similar case, that DCF's exclusion of the family members of a disabled parent from her training in parenting skills violated the Americans with Disabilities Act and the Rehabilitation Act, both of which require accommodating the disabilities of parents in child welfare cases.