



MASSACHUSETTS DEPARTMENT OF
Children & Families
Supporting Children • Strengthening Families

Annual Progress and Services Report

Federal FY2017

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Supporting Children : Strengthening Families



**Commonwealth of Massachusetts
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Department of Children and Families
Annual Progress and Services Report
2017**

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Commonwealth of Massachusetts

Department of Children & Families

Reports – Updates on Service Descriptions

Commonwealth of Massachusetts

Department of Children & Families

***Title IV-B, Part I:
Stephanie Tubbs Jones Child Welfare Services Program***

State Agency Authorized to Administer the Title IV-B Programs

The Massachusetts Department of Children and Families (“DCF”) is the state agency mandated to receive and respond to child abuse and neglect reports, and to provide an array of services to children and families across the Commonwealth. The primary mission of DCF is to protect children who have been abused or neglected in a family setting or by a caretaker. The Department seeks to ensure that each child has a safe, nurturing, permanent home, and to provide a range of preventive services to support and strengthen families with children at risk.

The Department of Children and Families (DCF) is charged with protecting children from abuse and neglect and strengthening families. With the understanding that every child is entitled to a home that is free from abuse and neglect, our vision is to ensure the safety of children in a manner that holds the best hope of nurturing a sustained, resilient network of relationships to support the child’s growth and development into adulthood. As a result of DCF involvement, thousands of families are stronger and better prepared to protect and nurture their children.

SCOPE OF DCF WORK

Each year, the Department receives, on average, 80,000 reports of abuse and neglect involving more than 100,000 children. Close to 90% of the families DCF supports come to the attention of the Department through a report of abuse or neglect; of these, 85% involve an allegation of neglect. The remaining 10% of the families DCF supports come to the Department through a combination of voluntary requests for services, Children Requiring Assistance (formerly CHINS), probate court, and Baby Safe Haven reports.

The Department provides a wide range of services to children and families, including case management, foster care, family support and stabilization, adolescent services, medical services, domestic violence services, guardianship and adoption programs and subsidies, and services and supports for transitional age youth.

Over the past five years, the Department has seen an increase in the number of youth who at age 18, voluntarily continue their involvement with the Department for academic and professional supports as they transition into adulthood. We support over 1,600 youth who request to continue to receive support from the Department between the ages of 18 and 22. Over 75% of youth turning 18 request to continue receiving services from the Department beyond their 18th birthday.

STRENGTHENING THE DCF SAFETY NET

The Department is committed to both strengthening the quality of our operations and achieving better outcomes for the children and families we serve. We have worked diligently to improve our basic practices and have integrated industry innovations into our case practices to assure better responses and better results for children and families in our five key goal areas:

- Keeping Children Safe;
- Creating Lifelong Connections;

- Ensuring Well-Being;
- Embracing Community Connected Care; and
- Exercising Effective Leadership.

1. Keeping Children Safe

We have taken, and continue to take, steps to increase our effectiveness in keeping children safe. There is a strong correlation between the frequency of Social Worker contact and better outcomes for children and families.

2. Creating Lifelong Connections

Of equal importance to our safety objective, is ensuring that we are safely strengthening families and providing our children ample opportunities for lifelong connections. We believe that every child deserves and needs a safe permanent family. To work toward that goal, the Department established three priority objectives, including:

- Safely Stabilize and Preserve Families;
- Safely Reunify Families; and
- Safely Create New Families through adoption, guardianship and kinship.

We have made significant progress in increasing family stabilization rates, reducing out-of-home placements and increasing family reunification rates, which is evidenced by 2,000 fewer children in out-of-home care compared to 2008.

3. Ensuring Well Being

Our youth provide the Department with invaluable input and advice on the agency's policies and practices by making suggestions on how we can better work with them. For example, in 2009, our Youth Leadership Council developed and ensured the enactment of a *Foster Care Bill of Rights*. The bill lists 18 rights that all foster children are entitled to, chiefly among them is the right to be treated with dignity and respect. In 2013, Massachusetts along with the other New England States developed and enacted the *Sibling Bill of Rights*, to ensure that siblings understand their rights to maintain contact with each other.

DCF has been an active partner in addressing the prescribing practices related to psychotropic medication for children in foster care. In 2009, the Office of the Child Advocate in collaboration with other state agencies began to explore the efficiency and effectiveness of the process in place in Massachusetts for authorizing consent of antipsychotic medications for children in the custody of the Department of Children and Families. In November, 2011, the Government Accounting Office (GAO) prepared a national report which highlighted concerns regarding potentially problematic prescribing practices for children in foster care.

In January, 2012, the Commissioner of DCF and the Child Advocate convened an inter-agency group to develop a plan for monitoring psychotropic medications for children in foster care. This inter-agency group includes representatives from DCF, OCA, DMH, and several divisions within MassHealth. The group identified four primary potentially problematic prescribing practices to address: 1) Children under 6 years of age prescribed a psychotropic medication; 2) Children who were prescribed four or more psychotropic medications; 3) Children who are prescribed two or more medications in the same class; and, 4) Prescriptions that are outside standard practice relative to dosage or classification.

4. Embracing Community Connected Care

The Department's interagency efforts involving housing and homeless prevention, children's behavioral health, substance abuse, early education and care, and domestic violence has provided greater coordination of services and case management, ensuring that our case practice is community connected and better integrated with the work of our sister-agencies and community providers.

One example is the work of the Departments of Mental Health and Children and Families for the Joint Residential procurement, "*Caring Together*." This procurement has generated a great deal of competition and creativity on the part of providers across the Commonwealth to ensure that services are delivered in a child's home and community whenever possible. *Caring Together* is built upon the nationally recognized Evidence Based Practice Building Bridges and eliminates the silos between residential care and community services.

This procurement transformed our service delivery system by integrating residential placement and community based services, including unifying the two separate systems, elevating the role of family and youth in the clinical, managerial and systemic practices of the provider agencies, integrating state agency utilization and quality management systems, and introducing performance based contracts that incorporate fiscal incentives for achieving desired outcomes. The Agencies have begun serving families under the new system.

In addition, DCF's Family Resource Centers (FRC) are an effective model to increase the capacity of communities to more effectively respond to the needs of families at risk. Many of these families may have received voluntary services from the Department in the past but can be better served with a more informal approach and can benefit from peer to peer support. DCF is moving towards the development of a FRC model that fully integrates a number of family support innovations and state and federal funding streams.

5. Exercising Effective Leadership

By emphasizing the use of more efficient approaches and processes, we have strengthened all aspects of the Department's operations to ensure the greatest degree of effectiveness.

The Department has made significant progress in improving our focus on achievement of targeted outcomes. DCF is providing a unique and more focused response to each family's needs, and ensuring that we are working *with* the family. This has resulted in better outcomes for children and families, reducing costs, and better targeting resources to provide services in the least restrictive, most cost-effective manner. Some of the ways in which we have accomplished this have been through:

- Improving the quality of our practice;
- Reducing and maintaining caseloads;
- Developing proven implementation science to get new initiatives to scale while ensuring sustainability;
- Effective negotiations with labor management;
- Creating a culture that embraces performance based management and managing with data;
- Establishing implementation and Continuous Quality Improvement infrastructure across the Department at systemic, management and clinical levels; and
- Instituted effective knowledge transfer through training and coaching.

Despite our many successes, there are still additional opportunities for improving our responses and achieving better results. Consequently, the Department continues to aggressively pursue transformational innovations that will improve our child protective service practices. Our priority areas for improvement include: continuing to increase placement stability, increasing timeliness to adoption, and assuring that we achieve and maintain a low foster care reentry rate.

Integrated Case Practice Model:

The most significant reform the Department has implemented is a change in our case practice through an Integrated Casework Practice Model (ICPM). DCF began implementation of the ICPM in July 2009. Throughout implementation of this model, the Department has focused on reducing the incidence of child maltreatment by creating an approach that more effectively and efficiently targets resources where they are most needed. This approach also improves consistency in casework practice, while providing opportunities for children, families and their support systems to actively engage in the decision-making process. Under this new practice model, the Department has achieved an approximately 20% overall improvement in efficiency, including screen in rates, case opening rates, and case closing rates; resulting in a more targeted use of resources.

Well established state and national trends demonstrate that effective practice is moving away from a one-size-fits-all approach to child welfare. Key features of our Integrated Casework Practice Model include extended timeframes for screening child abuse/neglect reports and completing investigations; differential response to enable DCF to respond to allegations of child abuse and neglect based on the unique circumstances, strengths and needs of a family; and the use of nationally recognized assessment and planning tools to support consistent clinical practice in assessing danger, safety and risk.

DCF expanded its ICPM by implementing a Short Term Stabilization (STS) track for families coming to the attention of the Department. The STS track is designed to further enhance DCF's differential response system by formalizing our approach to strengthen interventions with families who would benefit from short term involvement with DCF. It also supports DCF's goal of quickly connecting families to supports and services aimed at preventing future family instability, repeat child maltreatment and case reopening.

In February 2015, Ms. Linda Spears assumed the role of Commissioner of the Department of Children and Families. Prior to taking on the role of Commissioner, Ms. Spears led the Child Welfare of America (CWLA) team that conducted a review of the Department and presented the Commonwealth with a series of recommendations to help enhance the work of DCF. THE CWLA report provided a blue print for the Department to follow on its path to reform and laid out initiatives for the Department to put into action through FY18. The CWLA report focused its recommendations on:

- Increasing social worker staff to reduce caseloads and achieve the caseload standard of 15 families per worker;
- Updating Department policies such as case transfers, children missing from care, and background record checks among others and ensuring staff are appropriately trained on the policies;
- Reviewing, strengthening and then re-launching the Department's integrated case practice model;
- Ensuring social work staff are adequately trained and licensed;

- Decoupling the area office ‘pairings’ – the management structure which has one area director managing two area offices;
- Restoring the Department to a system of six regional offices instead of the current four;
- Adding specialty staff to area offices with expertise on the issues of substance abuse, domestic violence and mental health; and
- Increasing medical staff supports to area offices by adding pediatric nurse practitioners and hiring a full-time Medical Director.

Budget Overview

Moving forward, the CWLA report will continue to serve as the Department’s roadmap. The agency will keep working to enhance policy and practice, maintain staffing and make sure social workers have the resources and support they need to get their important work done. The FY16 budget allows DCF to continue the progress that has already been made and advance efforts of reform in the years ahead.

Commissioner Spears will continue her assessment of the organization, top to bottom and meet with staff across the state, with a goal of visiting each area office this year. Her goal is to ensure that staff knows she is available to support them, lead them and learn from them. It is time to get back to the basics of child welfare work and to do that, staff needs to feel supported as they serve children and families that are plagued by society’s most difficult, damaging and complex ills.

In the long term, it comes down to two overarching priorities that will help keep children safe and families strong – 1) improve quality of practice and 2) support DCF staff. In terms of support for our staff, the Department needs to continue to provide them with adequate training, clear policies, more practice guidance, reduced caseloads and quality management oversight. They also must be provided with modern tools to enable them to be efficient and effective in their jobs.

While much of this reform effort will be directed inward, the Department will also continue to engage the community at large. Child welfare is not the work of one person or one agency – the work cannot be done alone without stakeholder support. Staff will continue working with our community partners, our children and youth, our parents and partners in the legislature. Real engagement with out partners and our families, together with a strong foundation of casework from DCF staff will be the catalyst for change in the days, months and years ahead.

DCF Contact for APSR:

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The APSR will be posted upon approval on the DCF web site, in the Reports section- <http://www.mass.gov/eohhs/gov/departments/dcf/>. The FY 2016 APSR is posted at: <http://www.mass.gov/eohhs/docs/dcf/reports/annual-progress-and-services-report-2016.pdf>

SUMMARY

In the coming years, the Department will continue its commitment to focus on continually improving our basic casework practices, as well as incorporating nationally recognized innovations. We will remain mindful of the importance of our positive presence in the lives of children and families and the communities in which they reside across the Commonwealth.

We will continue to strengthen our efforts to support staff in carrying out the challenging and rewarding responsibilities of our critically important work. Our partnership with providers to ensure the availability of quality services will continue to be a priority. Through our shared collaboration and diligence, we will also continue to strengthen the safety net for children and families for all in the Commonwealth.

IV-B, Part 1 Funds

DCF utilizes IV-B, Part 1 grant funds to support caseworker travel as they work with DCF families in the programs outlined above.

DCF Title IV-B, subpart 1		
	SFY16 Spending	SFY 2017 Projected
Protective Services		
<i>Protecting the Welfare of Children: Case Management Support (Social Worker Travel)</i>	\$2,333,233	\$2,600,000
<i>Supporting At Risk Families at Home or with Reunification: Family Support Services</i>	\$184,803	\$325,000
<i>Supporting At Risk Families at Home or with Reunification: Family Resource Centers</i>	\$239,298	\$519,020
Administration		
Personnel and Overhead	\$23,583	\$78,666
Supplies and Administrative Costs	\$22,501	\$121,750
Administrative Activities	\$2,026	\$15,050
To Be Determined	\$0	\$95,152
<i>Administrative %</i>	<i>1.71%</i>	<i>8.27%</i>
Total	\$2,805,444	\$3,754,638
Planned Carryforward to SFY18	N/A	\$933,116

Commonwealth of Massachusetts

Department of Children & Families

Title IV-B, Part II: Promoting Safe and Stable Families

PROMOTING SAFE AND STABLE FAMILIES PROGRAM

TITLE IV-B, SUBPART II

FY16 Report

I. INTRODUCTION

In this twentieth year of the Community Connections Initiative the Department of Children and Families (DCF) recommits to the philosophy that has guided the initiative since its inception. Community Connections first developed this philosophy in cooperation with community and agency representatives. It was based on the premise that the prevention of child-abuse and neglect is best served by a family-centered approach by which those that seek to help children must see them within the context of the child's immediate and extended family and then look to both the formal and informal local supports and resources available. Over the years we have seen that these supports and resources are not only more likely to inspire trust, build empathetic relationships, and be culturally effective, but will last long beyond involvement in the child welfare system. Community Connections has also consistently promulgated the philosophy that each family has a right to be respected as individuals, they each have the ability to change and thrive, and have the prerogative to identify the help they need. As Community Connections programs grew they began to increasingly partner with DCF policy makers and Area Offices, and have had significant input into the evolution of strength based practice.

Community Connections has been a leader in developing an integrated community response system in Massachusetts, promoting the idea that responsibility for the well-being of children and families must rest not simply on state government but be shared with cities, towns, local agencies and organizations and, perhaps most importantly, with families, friends and neighbors. Families and community leaders must also have an opportunity to provide meaningful input as state and local agencies make policies that impact them.

The Programs of the Community Connection Initiative which follow are also committed to the Protective Factors disseminated by the Center for the Study of Social Policies. Community Connections Coalitions (CCC), Family Resource Centers (FRC) and Family Nurturing Centers (FNC) address the issues of Parental Resilience, Social Connections, Knowledge of Parenting and Childhood Development and Concrete Support in Time of Need. FRCs and FNCs also address the Social and Emotional Competence of Children. The Fatherhood Initiative addresses Parental Resilience and Knowledge of Parenting and Childhood Development. Family Representation has led the way to ensure that each program has made a priority of, and very significant progress toward, incorporating Family Voice into all the Protective Factors-based initiatives.

Systems change

The Community Connections Initiative follows a strategic vision of systems change that was shaped by a multilevel organizing strategy focused on building empathetic relationships between families and sources of support at a community level. The work explicitly links those efforts to state government. This coalition building, in some of the most significantly challenged communities in the Commonwealth, laid the groundwork for a number of subsequent reforms that were unanticipated twenty years ago. Community Connections became the incubator, not just of a different way of thinking, but of particular strategies that

are now institutionalized and include: parent involvement in planning, service delivery, and evaluation; wider use of peers, groups, and informal supports; and the employment of demographic data to inform and focus efforts and direct resources geographically.

One of the most important instances of Community Connections Coalitions (Coalitions) and the Community Development Team significantly enhanced systems change. Coalitions were primarily responsible for recruiting and supporting parents who were formerly involved with DCF to participate the Department's 2008 Strategic Planning Process. One result of that process was implementation of the DCF Integrated Case Practice Model, a comprehensive remodeling of policy and practice that is a community-connected, strength-based model. Lessons learned from the Community Connections coalitions in engaging families and partnering with community agencies has significantly informed the development of the model and continues to influence and guide its implementation.

Many other institutions, agencies and organizations have looked to the Community Connections initiative for leadership. Coalitions have continued to build a foundation upon which its philosophy and strategies can take hold and, ideally, flourish. Family involvement and partnership are now widely seen as the cornerstone of good child welfare practice in Massachusetts. Parents have been ready and willing to step forward into advisory roles largely because of the measure of trust and confidence they have built in working with the coalitions.

Community Connections has been the incubator of strategies for improved family driven practices that are now institutionalized into practice. Over time, as the DCF Community Connections Initiative has piloted new family support/family preservation programs, they have looked to Community Connections coalitions to site or partner with these programs. The involvement of coalitions in the development, implementation and on-going functioning of these programs has been vital.

The sum of the Community Connections Initiative has grown to be far greater than its parts. The Coalitions, the Team and the programs mentioned above have been and will continue to be consistent advocates for family-centered practice within the child welfare system of care. Their systems change advocacy has and will continue to expand in ever-widening circles within communities and across the state.

One key strategy for organizing the work of Community Connections Coalitions and the Community Development Team has been to link the work of the Protective Factors to Coalition Actions Plan objectives. The Protective Factors are the foundation of the Strengthening Families framework. These are:

- Parental Resilience
- Social Connections
- Knowledge of Parenting and Childhood Development
- Concrete Support in time of Need
- Social and Emotional Competence of Children

II. FAMILY SUPPORT NETWORKS IN HIGH RISK COMMUNITIES/COMMUNITY CONNECTIONS COALITIONS

- **DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voice**
- **DCF Strategic Plan Objective 3.1.7 - Continue to Ensure Access to Community Services**

The Original Community Connections Mission Statement determined that the primary mission of Community Connections was to:

- Facilitate the organization of a family support system in neighborhoods throughout Massachusetts to coordinate, engage and mobilize stakeholders, build partnerships, find resources to enhance community assets and ultimately bring about institutional change
- Promote a framework for planning that is prevention focused, collaborative and builds upon the strengths and diversity of neighborhoods and thereby, make maximum use of the vision, talents and resources of residents, service providers, schools, churches and community groups
- Connect families to community based resources and support
- Listen to families and community representatives in order to identify challenges and ensure they have a voice in decision-making that affect their families
- Create awareness and find resources to address the needs of families, identify emerging issues, community assets

Community Connections Coalitions continue to work toward the initiative's goals using a myriad of strategies. The following categories represent the most common strategies shared by coalitions in FY15.

Connecting families to community-based resources and support

■ DCF Strategic Plan Objective 3.1.7 - Continue to Ensure Access to Community Services

Coalitions work diligently to make sure that families have the information they need. Thousands of families across Massachusetts receive information about and access to informal and formal supports. Coalitions increasingly take advantage of new social networking approaches to reach even more families. In FY15 coalitions assisted:

14,6388 families who received Information and Referral assistance
--

29,564 families who received assistance with Concrete Needs
--

145 families who attended Parent Support Groups
--

6,997 unduplicated number of referrals received from schools, families/friends, churches, health care providers, human service providers, family resource providers and government agencies
--

1028 parents received support from other coalition participants
--

The work of the coalitions in this area has also informed the development of other Community Connections state-wide initiatives, some of which include Patch Programs, Grandparents Raising Grandchildren support, and Family Nurturing programs. Examples of Progress include:

- **Lawrence/Methuen Community Coalition (LMCC)**

LMCC through its' steering committee and additional planning committees were committed to providing additional opportunities for resource distribution and alignment. LMCC has positioned itself to become an umbrella coalition to multiple family supportive programming initiatives within the community. As each

program has been developed, the coalition has played an active role in the develop of the program through its' network of providers, community members and partners. LMCC's coalition has provided for the development of additional areas of identified community need with matching resources, trainings, and community workshops both for residents and for service providers. All initiatives are linked back to the coalition as it supports the work within each program area. A more recent expansion is the development of a substance abuse prevention task force. The task force has included additional service providers in the work of the LMCC.

Through the identification of additional providers, many new services have been identified and accessed by staff and families. Extensive efforts were made to actively link new FRC funding and Patch related programming to support issues and needs identified by coalition members and member agencies. Many census tracts that make up Lawrence are among the poorest in the State of Massachusetts, thereby making resources accessible is a main priority for the coalition.

- **Dorchester CARES**

Dorchester CARES increased resident awareness of the number of agencies that provide services specifically to strengthen their families. To eliminate the duplication of services, community partners worked collectively on a number of community activities that exemplified community connected practice and enriched relations between residents and providers. Information was disseminated at the annual Peace Walk, the Fatherhood Engagement Series, Annual Back to School Event, and at Community Game Nights.

Engaging, mobilizing and listening to families while making sure they have a voice in decisions that affect their families

■ DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voice

Leadership Development and Advocacy consists of supporting parents with the resources and skills needed to successfully advocate for themselves and their families. This has been a longtime Community Connections priority. Residents have been provided with leadership and advocacy training, and have benefited from coalition support for resident led advocacy groups. In FY15 Coalitions supported residents as they worked to become leaders in their communities and connected them to the information and resources needed to support self-advocacy and self-help efforts.

1,877 parents provided support to coalitions programs and activities such as newsletters writing, special activities, and outreach materials

329 individuals acted as advocates represented the coalition regarding issues in the community

Another important part of Parent Leadership Development and Advocacy is participation on governing bodies. Coalition governing bodies were initially required to be comprised of 51% of local parents and residents. This expectation has been challenging for many coalitions. One of the factors in recruiting parents to serve on governing bodies has been disinclination to deal with the logistics of governance. Many coalitions have met these challenges by developing Parent Advisory Councils that are significantly linked to their decision-making body. Although Community Connections has made great strides in this area, we recognize that this challenge needs to remain a priority. In FY15:

429 Residents are estimated to have participated in governing boards/Advisory councils

The work of the coalitions in this area of has also informed the development of other Community Connections state-wide initiatives which include: Family Representation, Family Resource Centers and the Fatherhood initiative. Examples of Progress include:

- **Northern Berkshire Community Coalition – Community Connections (NBCCCC)**

In order to create a community of neighbors who are informed and engaged in supporting one another, the NBCCCC created a Community Outreach Volunteer Training, which included 13 presentations from various health and human service agencies and community organizations in the area. The also conducted 11 workshops on topics such as conflict management, different styles of leadership and fundraising, community assessments, and service projects. A change to holding these trainings during evening hours allowed for a more diverse population of participants- high school students to college professors. During the training, participants conducted a community assessment, in which they identified the assets and needs within the northern Berkshires. That assessment helped participants determine their community project, which had the purpose to either meet a need or build upon community assets. Lastly, the participants were broken up in two project teams to plan and execute a service project of their choosing, based on the information they gathered during the community assessment. One team chose to focus on improving the local homeless shelter while the other chose to hold a fundraiser to support the creation of an upcoming youth center. As part of their training, each team had to write a proposal for their chosen projects outlining how'd they use the funds they were requesting (each team could request up to \$500 from NBCCCC to support their projects), detail their projects and its goals, and showcase how they planned to match 50% of their requested funding through in-kind donations (which could include volunteer hours, donations from local businesses and donated skilled labor.) These experiences helped residents gain a feeling of efficacy, community and skill building, while contributing greatly to the needs in the area.

- **Community Connections of Brockton (WCCC)**

The Brockton Parents Magazine is created by parents and for parents, offering helpful insights on local issues and resources for families. This project not only serves to inform the community, but it also gives local parents a voice in writing the articles and choosing topics that are important to them and acts as a tool to empower them. In the past year the team has grown in number and in skills. The demand for the magazine has increased dramatically. Support for the magazine has also increased as local non-profits and businesses have used the magazine to reach a large number of residents. Today many parents are able to share their ideas, poems and advices with the community. Over the past year the coalition distributed 30,000 magazines. Currently, the magazine is a quarterly publication; 7500 magazines are distributed for every season. Magazines are also available on the WCCC website. The Brockton Parents Magazine is able to highlight a lot of the important people of the city that are doing impressive things to support the residents and community of Brockton.

Identifying challenges, coordinating responses, and engaging the community in a Collaborative change process.

■ DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voices

Engaging families in the work of building stronger, healthier, and safer communities is an on-going mission for coalitions. Coalitions often rally residents, providers, local government leaders, and other stakeholder to advocacy and action by working together on tasks forces, committees, and/or action

councils. In FY15 many more residents participated in the activities and events planned and implemented by these working groups. In FY15:

7,279 unduplicated families participated in all coalition activities and initiatives

The work of the coalitions in this area of has also informed the development of other Community Connections Coalitions state-wide which include: Family Representation, Family Resource Centers and DCF Patch Practice. Examples of Progress include:

- **Worcester Community Connections Coalition (WCCC)**

The coalition convened groups of parents to address the issues of housing, employment/ financial struggles and food insecurities. These were the top three priorities identified by local families in their last year's community survey and focus groups. Families participated in leadership, advocacy, program planning and civic engagement efforts to implement grassroots strategies to help address these issues. Parents in the Coalition partnered with Workforce Central to distribute additional information to the Worcester community through the coalition's email blast, including new listing of employment services in Worcester, and met with the leadership of Workforce Central to discuss how to strengthen access to their services.

- **Jamaica Plain Community Connections Coalition/Arbol de Vida**

The coalition is a significant partner in the collaboration of local health, education, early childhood, and housing organizations to reduce racial and ethnic inequities among Jamaica Plains' lowest income and minority families. This JP Campus of Care Collaborative is in its second year of a five year \$106,000 grant from Boston Children's Hospital. They have completed a logic model and a data collection system. Parenting Workshops and Leadership Development training have been provided. In addition, approximately 700 parents and children have attended Family Fun Nights.

Creating Awareness Around the Needs and Emerging Issues for Families, Especially Those That Threaten Their Well-being Such as Child Abuse, Domestic Violence, and Community Violence

■ **DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voice**

■ **DCF Strategic Plan Objective 3.1.7 - Continue to Ensure Access to Community Services**

Coalitions bring families together by hosting community events and celebrations, providing opportunities to socialize/ interact with neighbors and community institutions and organizing workshops, forums and summits on topics of common interest. Participating in the coalition is itself a way to develop relationships and find common ground. In FY15

863 total activities and initiatives

The work of the coalitions in this area of has also informed the development of other Community Connections state-wide initiative which includes: Department of Children and Families Fatherhood Engagement. Examples of Progress include:

- **United Neighbors of Fall River (UNFR)**

By holding 9 Parent Cafes and 12 Family Fun Nights UNFR engaged with more than 2800 residents and 350 school staff and administrators. Parent Cafés addressed the specific topics, such as incorporating the protective factors, peer pressure regarding drugs and alcohol, promoting a work ethic, and building school attendance. In addition to enjoyable activities, Family Fun Nights also addressed issues of health, nutrition, and available local resources

- **Community Connections of Cape Cod (CCCC)**

Opiate addiction continues to be one of the primary issues that plague Cape Cod and the Islands. The rate of opiate addiction, particularly heroin, has increased significantly on Cape Cod and the local hospital has the highest rate of babies born addicted to opiates in the state. All of the grandparents who are raising their grandchildren with whom CCCC have been, say the issue of substance abuse has been the precipitating factor in their having custody of their grandchildren. The coalition continues to work with local agencies and organizations to bring awareness of this issue to the community, in addition to suicide prevention, intervention and post intervention work to the community.

Engaging Community Stakeholders, Building Partnerships, Finding Resources to Address Emerging Issues, Building Community Assets

■ **DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voice**

■ **DCF Strategic Plan Objective 3.1.7 - Continue to Ensure Access to Community Services**

The primary work of coalitions is not to provide services but rather organize services in the community to best meet the needs of their children and families. The work of each coalition is different and based on local strengths and challenges. Engaging community stakeholders is an ever present priority for coalitions within their own membership, and becomes more challenging as they engage in the process of educating other agencies and organizations within their communities to prioritize inclusiveness. Building partnership is an evolving task as coalitions respond to changing circumstances within their communities. One great strength of Community Connections is that, while coalitions are required to submit and be accountable to an annual Action Plan, their DCF funding allows them to be flexible and to respond to emerging issues, community crises, and unforeseen consequences. In FY15:

1,028 families participated in coalition activities
677 community agencies partnered with coalitions
32 government agencies partnered with coalitions

The work of the coalitions in this area of has also informed the development of other Community Connections state-wide initiatives which include: the DCF Patch Practice Model and Family Resource Centers (described in Section IV). Examples of Progress include:

- **Community Connections of Brockton (CCB)**

This past year CCB has engaged with the faith community and partnered with several pastors and church leaders on many small projects and events to support the Community Connections Parent Representatives. Parents hold official seats at the Brockton Interfaith Community Board, giving the coalition an opportunity to expand their work on issues that are import to local residents. Over the years BIC's board was represented of the churches in the area. This was the first time an organization was asked to be represented in the BIC board. Some of the work the coalition has done in collaboration with the faith community was a community assessment and quality of life survey, a citizenship clinic, and a raise the minimum wage campaign. CCB also hosted a brunch for the clergy with the goal of fostering new relationships among the leaders of different denominations and so better identify best ways to support the work being done in the city.

- **Southbridge Community Connections Coalition (SCCC)**

SBBB partnered with the Center of Hope to obtain a Community Block Grant and create a "Pay it Forward" Mentoring Program. The program consisted of training teenagers from 9th thru 12th grades to become Mentors to work with kids from 6th thru 8th grade. They initially did a pilot program with 25 mentors. This was such a success SCCC started recruiting and training additional mentors. They built a strong partnership with the school and received many referrals directly from them. The SCCC also set up informational tables at the school lunches to talk about the program and what it entailed. Many kids signed up on their own as well. There were over 100 participants in this program which received great appreciation and feedback from the parents. Mentors received a stipend but more importantly they finished the program feeling a great sense of pride for being a positive role model in the lives of mentees.

Working with the Department of Children and Families/ Opportunities for Families to Learn How DCF Works and for Social Workers to Work in the Community

■ DCF Strategic Plan Objective 3.1.7 - Continue to Ensure Access to Community Services

■ DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voice

When DCF provided the original PSSF funds to develop the Community Connections coalitions relationships were initially uneasy and sometimes conflictual. Efforts led primarily by the Community Development Team have improved relationships tremendously. Community Connections coalitions across the state now share many priorities and cooperate and/or collaborate with DCF. In FY15:

495 Families were referred to DCF by coalitions

339 Families were referred to Family Resource Centers of Patch Programs

Examples of progress include:

- **New Bedford Community Connections Coalitions (NBCCC)**

One of NBCCC's primary goals is to increase the public's awareness of the multi-faceted needs and challenges facing foster children, and to create broad based philanthropic support for resources and supports that seek to enrich their well-being and development. NBCCC was able to support the DCF area office by supporting and retaining foster parents in two events this past year. They co-sponsored the

annual foster children's holiday party, which was one of the largest ever with over 260 foster children and foster parents attending. This year's Foster Parent Appreciation Dinner was also a success with over 80 foster parents attending. Both events also provided opportunities for DCF workers to connect with families and the community.

- **Fitchburg Community Connections Coalition (FCCC)**

FCCC assisted the local DCF office in promoting one of their primary objectives: engagement of DCF in community-connected practices. DCF Social Workers regularly use the FRC for supervised visits, and regularly refer DCF clients to FRC programs, such as Parenting Journey. DCF provides a staff member from the area office to sit on the FCCC Steering Committee. Clients to FRC programs, and FCCC are used frequently for supervised visits. FCCC also works closely with DCF Area Foster Care Coordinator in recruitment efforts.

To meet the issue of food insecurity, The FCCC assisted the local DCF area office by providing 92 gift cards for local homeless families living in motels and were being case managed by DCF case workers. They also provided some cribs and car seats to families upon request. The FCCC director worked closely with the local DCF Area Manager in coordinating these efforts. DCF workers work with FCCC on projects and events including co-facilitation of parent support groups.

- **The Brick House Community Resource Center (BHCRC)**

The Montague coalition works with the DCF Area Office in obtaining feedback from families to improve their access to systems of care. The coalition attends DCF quarterly Systems of Care meetings to increase social workers' knowledge of local resources. They have hosted an annual Legislative Breakfast that includes a presentation DCF's work. They partnered with DCF to create an "Ambassadors Package" about the range of DCF work that allows DCF, BHCCC and others to present information and lead discussions about the benefits of this work.

Community Connections Coalitions Evaluation

Community Connections' evaluation strategy relies on the ability to conduct a strong internal self-evaluation capacity and self-assessment. It requires a collaborative process in which goals are defined and a well thought out action plan is developed that identifies outcomes consistent with those outlined in the Community Connections Logic Model. This Logic Model as well Action Planning and Outcome Measures tools and requirements were developed over time by a committee consisting of coalition representatives and the Family Support Team with the assistance of an evaluation specialist from Tufts University. Year End Reports are submitted to sum up and enhance the coalitions profile and to inform the Community Connections Annual Report.

Evaluation has been and continues to be a challenge for the initiative to implement and for the coalitions to achieve. While most Action Plans and all Year End Reports have been submitted each year, Outcome Data has been less than uniformly provided. Performance Measures, capacity assessment procedures, and tools have been developed but not yet implemented.

	Participation					Parent Leadership and Advocacy		
	Total Number of Families Participating in Coalition Activities	Total Coalition Committees, Activities and Initiatives	Total Community Organizations Participating in Coalition Initiatives	Total Coalition Convenings	Total Government Agencies Partnering with Coalition	Parents Supported Coalition Programs or Activities	Parents Provided Support to Other Coalition Participants	Parents Acted as an Advocate on Behalf of the Coalition
Cape Cod Neighborhood Support Coalition	447	24	89	11	16	4	15	1
Chelsea Community Connection	255	24	30	23	4	10	0	6
Community Connections of Brockton	723	28	150	94	17	1661	39	99
Dorchester Cares	194	29	14	22	5	47	38	18
Enlace de Families/Holyoke Unites	376	76	48	51	17	22	10	16
Fitchburg Community Connections Coalition	154	25	33	6	9	2	42	7
Gill Montague Community School Partnership	156	46	109	305	8	13	53	9
Jamaica Plain Coalition: Tree of Life	242	147	55	61	22	9	22	6
Lawrence/Methuen Community Coalition	251	26	54	36	14	44	164	39
Lowell Alliance for Families and Neighborhoods	69	69	69	31	12	40	42	26
Lower Roxbury Coalition	68	23	20	7	9	6	27	7
New Bedford Community Connections Coalitions	172	45	103	8	10	6	8	6

			Participation					Parent Leadership and Advocacy		
			Total Number of Families Participating in Coalition Activities	Total Coalition Committees, Activities and Initiatives	Total Community Organizations Participating in Coalition Initiatives	Total Coalition Convenings	Total Government Agencies Partnering with Coalition	Parents Supported Coalition Programs or Activities	Parents Provided Support to Other Coalition Participants	Parents Acted as an Advocate on Behalf of the Coalition
North Quabbin Community Coalition			508	53	130	145	27	0	1	1
Northern Berkshire Community Coalition			71	78	61	70	19	10	24	1
Southbridge Community Connections			306	56	111	22	52	22	136	36
Springfield Family Support Programs			397	21	54	25	23	52	21	17
United Neighbors of Fall River/Community Connections			3166	113	252	53	22	416	39	13
Worcester Community Connections			119	33	99	22	12	13	3	21

III. FAMILY ENGAGEMENT

■ DCF Strategic Plan Objective 5.1.1 - Strengthen Opportunities for Family Voice

- ***Family Representative***

The Director of Family Engagement continues to promote partnerships between the Department of Children and Families and community members. Over time she has very significantly contributed to the involvement of parents (including formerly DCF - involved family members and fathers) in planning, delivering and monitoring of DCF services. These representatives advise the Department on policy and practice and provide feedback on the quality of services.

Family Representatives serve on the Family Advisory Committee (which advises the Commissioner), Senior Staff, the Statewide Managers Meetings, and DCF Area Boards, among others. Since 2010, the number of Community Representatives doubled from 100 to over 200 in FY 15. DCF Area Offices have increased their knowledge of the benefits of engaging families in multiple ways and has made noteworthy gains in implementing family-centered, community-based programming that integrate into policies and practices.

The work of the Director of Family Engagement has been facilitated by the work of the DCF Community Support Team and by Community Connections Coalitions, both of which are important bridges between DCF and the community. Due in part to the measure of trust and confidence the team has built from their work with the coalitions; parents have been ready and willing to step forward into advisory roles. The following initiatives are the primary focus of the work. FY 2015 has seen significant changes at the Department of Children and Families, resulting from a new administration and re-alignment of the work of Family Engagement with -a stronger emphasis on safety. Additionally, early retirement of multiple staff (including the Director of Family Engagement) created an opportunity to assess and change existing administrative structures that build upon practice strengths while addressing challenges. The Coordinator of Family Engagement will now be part of a new organizational structure, and will report to the Director of Community and Family Engagement. The Coordinator will focus on policy and practice development that will engage families, build on a strength-based model and assist Area Offices in working toward consistent practices that include evidence-based intervention that supports all families.

- ***The Family Advisory Committee***

The Family Advisory Committee (FAC) is a group of Family Representatives comprised of foster and adoptive parents, mothers, fathers, and kin who have formerly had open protective cases with DCF, and/or people who were involved with DCF as youth. These are community members invested in the safety and well-being of children across the Commonwealth.

The Department makes its decision-making processes more transparent by engaging Family Advisory Committee members in the review of new initiatives. The FAC provides the opportunity for parents and other community members to have input into the development of practice, policies and programs that affect families. The FAC builds mutual accountability between the Department and the families it serves by creating opportunities for dialogue and learning from both perspectives.

Although the past year has been a transition period for the Family Advisory Committee with the retirement of the Director of Family Engagement. The FAC completed most of the year's activities which assist DCF in increasing community/parent participation, including:

- Ensuring parent participation in Area Boards as well as in all areas where decisions are being made that impact the lives of families and children
- Developing relationships with Area Directors/Area Offices to assist with board development, strategies for recruiting former consumers for area boards, Father Engagement Leadership Teams (FELTs), Trauma Informed Leadership Teams (TILTs) and other work groups
- Maintaining fidelity to Family Engagement Model
- Implementing training, and coaching for Intake Assessment tools.
- Obtaining systematic feedback from the families it serves on the effectiveness of its interventions and practice
- Working with the Commission on the Status of Grandparents Raising Grandchildren in the implementation of their mission
- Participating in cross system and cross secretariat collaboration centered on improving the well-being of children and families through public policy initiatives
- Increasing the quality of care and positive outcomes of children in the foster care system

- ***Grandparents Raising Grandchildren***

Responding to a need in their communities, several Community Connections coalitions began to run support groups for grandparents who were raising their grandchildren. As the need for more of these groups became apparent statewide, a Governor's Commission was established to address issues of concern raised by grandparents and other kin who are raising these children. Since its inception in FY09, the DCF Director of Family Engagement has guided the work of the Commission. In 2010, The Commission worked with Community Connections coalitions to conduct a statewide Learning and Listening Tour and thereafter based its work plan on suggestions received on the tour. It continues to incorporate feedback from grandparents and kin through annual conferences and ongoing dialogue. The work of The Commission, in conjunction with the Community Development Team, continues to guide the work of the committee. It also continues to ensure that an increasing number of grandparents are involved. Generous donations of time and resources from community members that have resulted in many accomplishments including:

- Providing accurate and accessible info in order for grandparents to access support and knowledgeable decisions
- Creating and sustaining the website <http://www.massgrg.com>
- Developing and revising tip sheets for grandparents regarding: available supports in the community, DCF policies and practice legal issues facing grandparents and how to work with the courts as well as substance abuse and its impact on families
- Information about the commission and its mandate
- Assisting in the creation and support of a model for Grandparents Support Groups that is being implemented across the state
- Informing DCF, FRCs and other community partners about issues facing grandparents and kin
- Creating a network of supporters and facilitators for support groups that meet quarterly
- Providing legislative advocacy on bills that impact the lives of children and families
- Plan an annual statewide conference for grandparents, kinship caregivers and providers

- **Office of the Ombudsman**

The Family Representative supports DCF's Ombudsman's Office with complex cases. Some FAC members serve as Family Liaisons who receive referrals from the Ombudsman's Office. Family Liaisons are parents who were formerly involved with DCF. Their cases are closed, and they have become parent representatives on the Family Advisory Committee, and on Regional and Area Boards throughout Massachusetts.

They are carefully selected and trained. Liaisons provide concrete peer support, and have been instrumental in helping families effectively engage with the Department to produce successful outcomes. The program has been enormously helpful to families, particularly in ensuring that they have a voice, are empowered, and have the tools, to successfully navigate a complex system.

IV. FATHERHOOD ENGAGEMENT

- **DCF Strategic Plan Objective 1.1.5 - Strengthen Fatherhood Engagement**

- **DCF Strategic Plan Objective 4.1.2 – Strengthen Placement and Educational Stability & Educational**

The Fatherhood Engagement program has promoted a system of care and services for fathers by providing training that focuses on facilitation of evidence-based fatherhood groups. It also provides curriculum materials for DCF staff and community partners who provide fatherhood groups to DCF-involved fathers. Additionally, guidance on how to engage partnerships and collaboration with community partners and other state agencies to promote services for fathers is provided. Community Connections coalitions have played a crucial role in creating and expanding services for DCF involved fathers.

Fatherhood Engagement work depends on encouraging a collaborative approach to changes and practice. The work of encouraging cultural changes, not only within DCF but in other statewide agencies and communities, has been an enormous undertaking. Societal challenges include the belief that fathers are not nurturers in their own right and that there is inherent and unmovable barrier between the fields of Domestic Violence and Fatherhood Engagement. In order to minimize barriers and create a better system of care that includes fathers, the department continues to provide guidance and encourage a collaborative approach between these two groups. The Fatherhood Coordinator negotiates and builds trust between systems in order to promote sustainable and effective approaches.

In promoting Fatherhood Engagement in communities across the state, Community Connections coalitions have played a critical role in supporting and expanding services to DCF and non - DCF involved fathers. This practice has created a fundamental partnership between community partners and DCF area offices. The Family Nurturing Center (FNC) in Boston and Enlace De Familias in Holyoke have been providing practice support and facilitation training for fatherhood groups for many years.

- **Statewide Impact**

For many years DCF has held a Fatherhood Engagement Summit, which is an opportunity to engage cross-sector of senior leadership and upper management in conversations about best practice conversation and how to promote positive fatherhood engagement across a broader spectrum. The goal is to continue to build on previous successes of the Fatherhood Summit and expand the number of participants. This year's summit brought together various participants from multiple agencies which are exploring their capacity to provide support to fathers in a responsible way. The summit served as a launching pad for leadership to

begin crafting a state-wide strategic plan to address the needs of fathers within the state's family serving systems.

- ***Statewide Fatherhood Engagement Leadership Team (FELT)***

FELT has expended across DCF Area Offices, and is the vehicle used by many offices to host practice discussions on best ways to engage fathers, and ideas that inform office- wide policies. Community Connections coalition representatives are core members of each team, and share from a community perspective the impact of DCF policies on families and the community in general.

V. THE CHILDREN'S TRUST / SUPPORTING FAMILY RESOURCE CENTER

- **DCF Strategic Plan Objective 3.1.2 – Expand Family Resource Centers**

- **DCF Strategic Plan Objective 2.1.2 – Establish a Strengthening Families and Positive Youth Development Framework for Case Practice**

- **DCF Strategic Plan Objective 4.1.2 – Strengthen Placement and Educational Stability & Educational Achievement**

- **DCF Strategic Plan Objective 4.2.5 – Continue to Enhance Management and Outcome Reporting**

Historically DCF has utilized PSSF funds to support Family Resource Centers (FRCs) bringing the number to eleven (11) in 2013. These FRCs were sited with and administered by Community Connections coalitions. They undertook a wide range of activities to assist and empower families. They advocated for families who felt as if service providers didn't understand their specific needs, educated families about services available to them, offered ways to access those services, and shepherded families through the maze of providers and paperwork needed to access services. Advocates worked with families around immediate hands-on problems such as obtaining food, creating a transportation plan, making a budget, accessing day care, working with utility companies regarding shut-offs, and translations. Family Resource Centers also informed local service providers regarding concerns gathered from families in order to assist them in making services that are strengths based and better address families' needs. In addition, they partnered with service providers, schools and DCF to address issues of language and cultural sensitivity.

In order to expand upon this model, DCF partnered with the Massachusetts Children's Trust. The DCF/CT Team provided technical assistance and support in all areas of program planning and training. Family Resource Centers offer core services that provide support, build protective factors, educate and promote family stability, as well as assist all families with children prenatal through 12 years old in becoming strong and secure.

FRC's are community-based, culturally competent programs that provide a variety of services to children and families, including evidence-based parent education, parent and youth mutual self-help support groups, information and referral, grandparent support groups, mentoring, educational support, cultural and arts-related events, and other opportunities. FRC's also provide services specific to Children Requiring Assistance (CRA) who are having serious problems at home or at school such as running away or truancy and those who are sexually exploited, as required by Chapter 240 of the Acts of 2012 (Chapter 240).

In 2012, Massachusetts enacted Chapter 240 of the Acts of 2012, which set the stage for reform of the Children in Need of Services (CHINS) program. CHINS was created in the 1970s as part of the movement in juvenile justice to shift youth behavior such as running away, truancy or failure to follow parental rules from crimes that were treated as delinquency to status offenses that necessitated help or intervention. The

next generation of that reform effort is currently underway in the state. A major component is creation of Family Resource Centers is to serve a redefined adolescent population, which programming the state now calls Families and Children Requiring Assistance (CRA). DCF, in partnership with the Executive Office of Health and Human Services (EOHHS), has procured an enhanced FRC program that is intended to build upon the existing DCF Family Resource Center program model and expands the population served to include a defined set of services for the Children Requiring Assistance population and their families. Eighteen of the initial “pilot” program contracts, fully supported by state funds, are now fully operational.

The FRC model is based primarily on the Five Promises framework. This framework was originally developed by the America’s Promise Alliance (www.americaspromise.org), a collaborative effort between nonprofits, businesses, communities, educators, and families. It was modified for the FRC’s by the Massachusetts Executive Office of Health and Human Services (EOHHS). The model outlines five key supports and goals intended to promote positive youth development outcomes: 1) health and mental health; 2) safety and housing; 3) school and work; 4) civic and community engagement; and 5) caring adults

The FRC model also incorporates elements of the Strengthening Families- Protective Factors framework (Center for the Study of Social Policy, 2015), The Systems of Care (Stroul, 2002), and the Positive Youth Development (The Colorado Trust, 2004) framework. Taken together, these frameworks align with the overarching of child welfare services.

This Fiscal Year the overall purpose of the FRC has been to provide overall programming and services based on universal access and to promote family stability and self-sufficiency. Each FRC completed a readiness review for DCF to assess their competency in providing comprehensive services to families and their children. FRC resources are intended to ensure universal, strength based programs that are educational and supportive in nature and which assist all families with children prenatal through 18 years.

Monthly reports and data collections submitted by 12 full-service and six micro-service Family Resource Centers completed this year show a significant increase in families served. Statewide, the FRC’s provided over 15,000 discrete services and support to families including:

4,753 to unduplicated families
5,200 to unique individuals
8,800 external services referrals

The Family Resource Centers held 83 support groups for parents and their children to address their issues together. Additionally, groups were held addressing the following issues: parenting issues, mutual self-help, grandparents raising their grandchildren. FRC’s continues to enhance the Department’s flexibility to provide a mix of family support services on local level. This benefits not only communities with current FRC’s but also serves as a catalyst for possible statewide expansion. In FY15:

2,721 enrolled participants

VI. FAMILY NURTURING CENTER OF MASSACHUSETTS (FNC)

- **DCF Strategic Plan Objective 1.1.5 - Strengthen Fatherhood Engagement**
- **DCF Strategic Plan Objective 3.1.7 – Continue to Enhance Access to Community Services**

This year has continued with a strong demand for training and consultation for Nurturing Programs for both the Family and the Fathers Curricula. DCF offices that have begun Nurturing Fathers Programs are now exploring the possibility of offering a Family Nurturing Program as well.

The Family Resource Centers (FRCs) throughout the state have completed a year of piloting their first Nurturing Programs and this year FNC provided additional training for them at their request. The demand for facilitator training has been stronger than ever. Throughout the year we have continued to focus on three areas:

- ***Capacity building***

In building capacity FNC conducted the following facilitator training in FY15.

- Department of Children and Families Nurturing Fathers Program
- Department of Children and Families Nurturing Parenting Program
- Family Resource Center Training
- Department of Housing and Community Development Nurturing Fathers Facilitator Training
- Department of Housing and Community Development

Total of 269 participants

- ***Nurturing program development***

Nurturing Programs conducted in the Boston Area include:

- Family Nurturing
- Nurturing Fathers
- Nurturing Program for Birth, Foster and Kinship Families
- DCF Nurturing Program for Parents and Adolescents

In FY 15, participants included:

108 DCF workers
50 Family Resource representatives
19 Community Connection coalition representatives
92 community representatives included seventy-three parents and forty- four children and teens

Programs assisted parents with transportation, clothes, books and toys. They provided families who lack a support-system individual support and lead the way for group members to support each other. Twenty-three DCF staff members acted as facilitators for these groups.

- ***Consultation and technical assistance to nurturing programs***

Consultation and Technical assistance included such activities as orientation to the program, development of program plans and time-lines and consultation with the Family Engagement Leadership Team (F.E.L.T). FNC provided training in administration and scoring of evaluation tools. They provided ongoing advice, mentoring, and support throughout the delivery of the program through phone calls, emails and occasional visits. FNC also worked with programs and the DCF Central Office to enhance existing curriculums and develop new ones.

- ***Fathers Speak***

Fathers Speak is a team of Fathers that have graduated from the Nurturing Fathers' Program and who now have closed cases with DCF. They worked to understand the various systems that involve children and families and were successful in navigating them.

They go throughout Massachusetts sharing their stories and promoting positive fatherhood engagement. Presentations this year took place at 7 DCF Area Offices.

- ***Nurturing network development***

FNC offered an opportunity for statewide networking and relationship building by holding state-wide annual Nurturing Network Meetings. This year's meeting was very successful with 70 people in attendance. The program featured the work that the Department of Housing and Community Development (DHCD) is doing in the shelter system with the Nurturing Fathers Program. Announcements of ongoing work, and new programs from a national leader in Fatherhood Nurturing Programs, Dr. Stephen Bavolek were also presented. In addition, FNC provided new on-line registration for FNC trainings which allows better access for registrants and allows FNC to keep more accurate accounting of registrants, and communicate with them through group emails. FNC continued to update and expand its e-mail list of Nurturing Network participants, and maintained and posted on its web site a calendar of Nurturing Programs offered in and around Boston and trainings throughout the state.

VI. PATCH

- **DCF Strategic Plan Objective 2.1.2 – Establish a Strengthening Families and Positive Youth Development Framework for Case Practice**
- **DCF Strategic Plan Objective 2.1.3 – Strengthen Safety Organized, Trauma Informed, and Solution- Focused Clinical Approaches**

Examining core Patch practices within the context and development of DCF case practice policies has consistently been, and remains, a priority of the Community Connections Initiative. Over time, DCF has found that Patch principles and practice are appropriate not only for neglect and less complicated abuse cases, but for working with the most challenging family situations, even those that involve serious safety concerns and children presenting with complex situations and needs.

The initial PATCH sites were developed by DCF Community Connections coalitions and were located within the coalitions. The Patch approach offers a practice framework that supports the multi-level systems changes necessary to develop a shared practice among DCF, other state agencies, schools, community organizations and families themselves. Changes included: the growth of a community centered understanding of family assets and needs regarding individual families as well as groups of families and the development of a shared responsibility for safety, permanency and well-being outcomes. A shift in roles and responsibilities has resulted in teamed practice that crosses agency silos.

Patch shared practice is rooted in neighborhoods and depends on encouraging a collaborative change process not only in families but in communities as well. Teams develop local knowledge to understand the strengths and challenges of communities and to work as local change agents. Housing, health care, child care, neighborhood safety and education are all community level concerns. Patch team members help to facilitate community level responses to shared or emerging problems. They negotiate the differences between “family needs” and “systems requirements”, working to minimize barriers and to create a better fit between systems and communities. Patch team members work persistently and in a

variety of ways with both families and communities to partner and build trust so that the work of DCF can be successful and, ultimately, effective.

Team members work toward preserving and strengthening family bonds and intervening only when necessary. They work not only with DCF involved families, but also with families who may be at risk and those who have had previous DCF involvement, in order to mobilize informal community resources that will support families, create opportunities, and motivate change. Service plans are developed to strengthen a family's capacities to care effectively for their children in sustainable ways that are grounded in their own natural environments. Care is taken that these services are compatible with a family's identity, culture and history.

Core Patch teams typically include a Patch coordinator, a DCF supervisor and social workers, a family support advocate, and in some cases a Department of Youth Services (DYS) worker. Extended teams may also include educators and community organizations.

Patch sites have participated in quarterly practice development sessions since FY09 and, since FY13 have been joined by key staff from the Family Resource Centers. The sessions were built on an agenda of cross-site peer consultation. During FY 14 and 15, practice development continued with a focus on individual site consultation. Because of significant DCF and community staff turnover at the Patch sites, the DCF Community Development team has been working with longtime Patch consultant, Carolyn Burns, to plan a Patch reorientation to bring together the new and experienced Patch staff from the four sites and Area Offices. Findings from the day will result in a plan going forward to continue Patch practice development for the sites individually and collectively, and in enhancing Patch-like practice for all DCF Area Offices.

Patch principles have significantly informed the development of DCF's Integrated Case Practice Model, the implementation of the Family Resource Centers and a number of other system reforms currently underway. During late FY 15 the focus has been to re-align the work of the four Patch sites with the priorities of a new administration that now has a stronger focus on safety. In parallel, there will be a renewed effort to understand and document the opportunities to transfer successful elements of Patch practice into mainstream DCF practice. Most recently the specific focus has been on understanding the relationship between Patch teams and Family Resource Center practice. Participants have reviewed the population of families they serve and how they overlap and differ. They have developed an understanding that:

- Their practice methods are the same,
- They are all applying a strengths based, community connected practice approach,
- They are creating conditions for the growth of Protective Factors, and
- They may be serving some of the same families, simultaneously or in sequence, towards the same long-term outcomes of safety, permanency and well-being for children.

During a time when DCF is reformulating an approach to evaluation, efforts have focused on building a community connected case practice model that can encompass the practice of Patch teams and Family Resource Centers. The Patch and Family Resource Center leadership will continue the development of this model for the DCF Area Offices that continue to have both Patch and Family Resource Centers.

As the positive outcomes of Patch practice became evident, the goal of the Community Connections Initiative was to replicate the model as widely as possible as funds became available. However, as it became apparent that co-locating a unit of social workers with community supports could not feasibly be implemented statewide, the goal shifted. Instead of seeking to expand Patch one site at a time, DCF

began shifting the focus of its efforts toward incorporating a Patch-like approach into all DCF case practice in more economically sustainable ways.

IX. THE ROLE OF THE COMMUNITY DEVELOPMENT TEAM

From the beginning of the initiative, a Family Support Team (now known as the Community Development Team) was established to provide technical support to Community Connections Coalitions in order to develop their organizational structures, build their memberships and governing bodies, and expand their relationships with local residents and agencies. They have assisted the Department and other local agencies to be culturally sensitive to community diversity, to build a common understanding of respective roles and responsibilities and to effectively communicate how communities can help local families before, during and after DCF involvement. Working primarily with Community Connections Coalitions, as well as with all of the other Community Connections Initiative programs, they have consistently and successfully promoted the inclusion of family voices in a wide range of state-wide agencies and organizations as well. These efforts have spearheaded significant systems change across the state.

The role of the Community Support Team has evolved over time to include contract management, program development and support of numerous initiatives and activities that focus on some aspect of systems change. The Team has significantly contributed to every activity detailed in this report. Their role goes well beyond simple oversight of the expenditure of these key federal funds. Some examples of their work are participating and/or staffing interagency workgroups, convening Regional Diversity Teams, attending Coalition Steering Committee meetings, and convening monthly meetings of Community Connections Directors. The Team excels in managing from the middle. Their activities are supported by ability to gain the trust of community residents, agencies and organizations, to lead by example, to promote resident leadership when possible, to contribute multi-disciplinary viewpoints and information in planning sessions and to promote conflict resolution during difficulties and gain the trust. They help balance the complexities of system change ideals with the practicality of doing more with limited resource. They also broker the realities of community organizing with the system's tendency toward intractability, especially during difficult times

X. FUTURE DIRECTIONS

For the past several years, the work of the Community Development Team has been focused on refining a model that brings the key elements of the Community Connections family of programs into a more unified, and scalable approach. The Family Resource Center is a natural focal point, with elements of the Community Connections approach woven throughout its development. Working with a governing council comprised of stakeholders representing multiple sectors of the community and hard-wiring the use of Evidence-Based Parenting Programs, particularly Nurturing Parenting Programs, the FRC program model is clearly more evolutionary, than revolutionary.

The advent of the enhanced FRC provides us with a set of significant opportunities and some unanticipated challenges. In order to continue building an integrated model, DCF will be purchasing a platform for integration henceforth. Elements of the community engagement and partnership development aspects of Community Connections are inherently a part of this new program. Future full state funding of FRCs may consequently create a small pool of resources for reinvestment. DCF proposes to utilize these PSSF funds to start a new program which we envision as a precursor to full Family Resource Center development. This model is grounded in the recognition that best practices for engaging communities and building relationships takes time. It also involves a pragmatic understanding that this time window does not necessarily align with a program development timetable shaped mainly by the state appropriations

process. Prioritization and selection of this next generation of programs would be on the same basis by which new FRC programs have been sited. This will afford DCF the lead time to develop relationships in communities of both necessary breadth and depth to support sustainability of a “full service” FRC at a future time, when funds are appropriated by the state legislature and procured in the same manner as other FRC programs. As each program moves to full state funding as an FRC, DCF will reinvest that PSSF funding into additional development.

This developmental framework addresses a number of shortfalls in our historical development approach. First, it is scalable by definition. Secondly, it affords opportunities to develop partnerships that can focus on “hot spot” issues linking the direct service work of DCF and other agencies to areas of similar interest in communities that focus on tangible, concrete issues related to safety, permanency and well-being. In this way, Patch becomes the way of doing the work, not just a specific place or funded “pilot” program.

By doing so, we will continue to use PSSF funds as an incubator for innovative program development that responds to emerging or unmet needs and also be a strategic lever for systems change. We will use these critical resources to help bridge gaps where they exist, – whether at a direct service level, or more critically, at systems that can either support families or, often as not, pose additional challenges to them.

In order to maximize successful programming that strengthens families and supports family engagement, there are several programs that are enormously helpful in bringing family voices. In addition to the funds used to support Community Connections programming, the remaining IV-B, subpart 2 funds are used in training and supporting of Fatherhood Programs, Family Advisory Committees and Grandparents Raising Grandchildren. Multiple communities are struggle with the current opiate epidemic that is forcing many grandparents to take on the task of raising their grandchildren. Funds also support parent stipends for parents who are engaging the department in multiple levels of Family Centered work. Also the funds support DCF staff allocated to support community programs. As part of family preservation, funds for adoption promotion and support services are used to encourage more adoption of children from the foster care system. Additionally preventive services to families are provided during pre-placement and follow-up post foster care. These services are designed to improve parenting skills and prevent disruption of the adoption process.

Commonwealth of Massachusetts

Department of Children & Families

Chafee Foster Care Independence Program/ETV Program

CHAFEE FOSTER CARE INDEPENDENCE PROGRAM and EDUCATION and TRAINING VOUCHER PROGRAM

2016-2017

Agency Administering the Chafee Foster Care Independence Program (section 477(b)(2) of the Act)

The Massachusetts Department of Children and Families administers the Chafee Foster Care Independence Program. The funds provided through the CFCIP support an array of services with the objectives of preparing youth and young adults ages 14-21 for successful transitions to adulthood while assisting them develop permanent connections to caring and committed adults. The Chafee funded programs are based on the principles of positive youth development and address each of the purpose areas of the legislation:

- Help youth transition from dependency to self-sufficiency.
- Help youth receive education, training and services necessary to obtain employment.
- Help youth prepare for, enter and succeed in post-secondary training and educational institutions.
- Provide personal and emotional support to youth through mentor type relationships and the promotion of interactions with dedicated adults.
- Provide financial, housing, counseling, employment, education, and other appropriate support services to former foster care youth ages 18-21 to complement their own efforts to achieve self-sufficiency and to ensure that program participants recognize and accept their personal responsibility for preparing for and then making the transition to adulthood.
- Make ETV funds for education and training, including post-secondary education, available to youth who meet eligibility requirements.
- Provide services to youth who, after attaining age 16, have left foster care for kinship guardianship or adoption.
- Ensure that children who are likely to remain in foster care until age 18 have regular, on-going opportunities to engage in age or developmentally appropriate activities.

The Massachusetts Department of Children and Families, using stakeholders' input, has focused Chafee programming on assisting youth and young adults build strong foundations for success. We address their needs for permanency, safety and the many facets of well-being. Educational achievement and life skill mastery with permanent connections to family and/or other caring enduring relationships with adults are the goals for our youth.

Description of Program Design and Delivery

The Department has designed programming to address the varied service needs of the youth and young adults in the agency's care and/or custody.

Adolescent Outreach Program

The Adolescent Outreach Program has been using a strength-based approach to service delivery since implementation approximately 19 years ago. Services provided include intensive, individualized life

skill assessment and training to current foster youth and young adults ages 14-21 from across the state to assist them in developing necessary skills and supports to achieve their potential. Per grant guidelines, program services are also available to youth who were guardianed or adopted from DCF after attaining age 16 and to former foster youth who discharged from DCF between ages 18-21, and in some instances youth who discharged from agency care at age 17 and request services. This extension has provided a safety net for those young adults who are in need of additional transitional services. This extension will continue as program funds allow.

Outreach services seek to address each of the purpose areas of the Chafee legislation assisting youth with life skill development, access to education, training and other services necessary to obtain employment, support through connections to family, including siblings and life long supports.

The services provided are specific to the needs of each individual, including LGBTQ youth and young adults. Staff members have participated in trainings (and continue to do so) to ensure that our services are affirming the sexual orientation and gender identities of our youth/young adults. Advocacy on behalf of LGBTQ students, especially with schools and colleges has been necessary. Dorm room assignments, school or camping trips all require knowledge of the needs of the individual, particularly when the youth/young adult identifies as transgender.

The Outreach staff members also assist youth with planning for and succeeding in post-secondary educational settings as well as vocational training programming.

Strength-Based Approach

Feedback from the youth and young adults served by the Outreach Program confirms the staffs' belief that the relationship model is a significant factor in the program's success. Since its development in the late 90's, the program's strength-based approach and focus on youth engagement with a youth development base has inspired the employment program, internship program, our ETV support model, etc. We hold true to the principle that youth and young adults are essential partners in their own goal setting, service planning, and life skill training, a key factor which facilitates their successful transitions into the community. Youth and young adults are encouraged to practice newly acquired skills and utilize problem-solving techniques effectively - within a safety net of adult supervision and support. Youth are continually empowered to establish goals, make decisions and practice newly acquired skills. Youth are also supported in handling mistakes, disappointments and failures. The ultimate goal is to equip youth to live interdependently within the community, become self-supportive and able to advocate for themselves, as necessary. Through focused discussions around decision-making/problem solving, community-based activities and goal-focused skill building tasks, youth work to develop the skills necessary to cope with the challenges of adulthood and live self-sufficiently in their communities. The staff work closely with the DCF primary case managing social workers, foster parents, congregate care providers, community service providers and adults important to the youth to offer opportunities for youth and young adults to learn life skills through practical activities and achievements in their communities – making efforts to normalize their experiences. Assisting youth identify their educational/vocational goals and develop strategies to realize their potential are critical tasks for program staff.

The Department's Foster Child Bill of Rights (2009) and the Sibling Bill of Rights (2012) support these goals.

The Department's revisions to the Permanency Planning Policy in 2013 align with the Fostering Connections law encouraging permanency, sibling connections, extended voluntary care for transition age youth to support optimal goal achievement. The staff of the Adolescent Support Services Unit have

continued to provide focused trainings, pre-service trainings to new staff and technical assistance to agency staff, providers and foster parents to strengthen understanding and practice of the policy as it addresses youth and transition age young adults. These opportunities for training and technical assistance will continue. Adolescent Support Services staff members also have modified the PAYA (Preparing Adolescents for Young Adulthood) Life Skills training to reflect the revised policy.

Youth Served

From July 2015 to May 2016, the Outreach staff served 1464 youth and young adults. Of these, 472 youth and young adults received or are presently receiving intensive, weekly individualized life skill assessment to identify their strengths, life skills training to address their needs, as well as assistance for youth in developing and strengthening life long connections to caring adults. These services support the youth in mastering the skills they will need to live successfully in the community upon discharge from agency care. During this same time period, 992 youth received assistance from Outreach staff to assist with job search, education, financial aid/college applications, housing support, Mass Health applications, and referral/resource information. The outcome statistics are derived from the 465 youth/young adults served in the program this past year. Additionally, another 7 youth/young adults have begun working with an Outreach worker this May 2016; however, as their participation is so recent, their progress is not calculated in the outcomes.

The Outreach Program focuses its work with youth/young adults in Departmental foster care, kinship care, those who are receiving Young Adult Support Payments and youth eligible through guardianship/adoption. It is expected via contract requirements that youth/young adults in Comprehensive Foster Care or congregate care are provided similar life skill preparatory services in their placements. To avoid duplication of services, the Outreach workers generally do not work intensively with youth while they are in these placements. Also, youth/young adults who received Outreach services in a previous year may return for services – intensive or short-term focused at any time prior to age 21 – per Chafee Program guidelines.

Youth/young adults are referred generally to the Outreach Program by the primary case managing social worker. Outreach workers also identify prospective clients by reviewing the report of youth in placement. Current programming/staffing focuses primarily on youth/young adults ages 16 and older for two reasons: youth younger than age 16 have in the past not demonstrated sustained engagement for weekly life skills meetings and present staffing levels would not currently support the expansion of services to youth ages 14 and 15. However, the Outreach staff do serve 15 year olds when their needs may be met by the program. The PAYA life skills curriculum is available to all youth in DCF placements age 14 and older and is now offered on a flash drive.

As in previous years, the majority of youth served in the program are age 17 to 21. The vast majority, 99% of the youth on the active caseload as of May 2016, were open for case management and placement services with DCF; 5% of these youth had previously discharged from DCF and later returned to placement. These young adults include self-referrals and those referred to the program by community service agencies, homeless shelters, former foster parents, DCF social workers, etc. Given the updated Permanency Planning Policy, we expect to see a continuation in the high numbers of youth who choose to sign a voluntary placement agreement with DCF when they reach age 18. One percent of the active Outreach cases were closed with DCF –no longer in DCF placement (3 cases.) At the time of the case review, 3% or 6 youth/young adults in the active caseload were youth who left care after age 16 for guardianship or adoption.

There are no differences in how youth/young adults would be served whether they are open with DCF for placement, former foster youth who left DCF after attaining age 18 or left DCF placement after age 16 for guardianship or adoption. The referrals to the Outreach Program for the youth in guardianship or adoptions are less frequent, however.

Staffing and Service Overview

The program is presently staffed by 20 Outreach workers and 5 (full and part-time) Supervisors. Overall program management is provided by the Director of Adolescent Support Services. The Outreach workers are assigned to an area office. In some instances of smaller offices, the Outreach worker covers 2 offices. The Outreach supervisors cover an assigned region.

The Outreach staff provide weekly service to the youth and young adults on their Active Caseload and contact with the youth/young adults who have moved from the Active Caseload to Tracking for 6 months – to provide any additional support needed. Outreach workers also provide resource information to youth, staff, providers and foster parents. Often Outreach workers will provide short term services to youth around education, housing, and life skills or any number of other issues that may arise. Since implementation, the program has categorized this work as contact services and has not included these youth in the active or closed caseload count. However, given the extent of the services provided during these contacts – sometimes as much as weekly meetings that continue for many weeks, we are reporting these numbers to capture the full extent of support provided.

This past year staff provided 992 youth with such support. This number is most likely under reported as the Outreach staff members have assisted many youth with completing the NYTD survey this year and in the process have connected them to DCF support services, educational programs, etc.

Determining Eligibility for Benefits and Services (section 477 (b) (2) (E) of the Act)

Massachusetts DCF uses the Chafee Program guidelines and criteria for program participation to determine which youth and young adults are eligible for services. The Department's Permanency Planning Policy mirrors the Fostering Connections guidelines for continuation in voluntary care.

DCF also provides Chafee services for eligible youth/young adults from other states who are temporarily living in Massachusetts or attending college here as well as those who have moved to MA after discharging from another state at or after age 18.

Outcomes

Two of the principal objectives of the Adolescent Outreach Program services are permanency and self-sufficiency for current and former foster youth. This relational model of programming provides a highly individualized approach and accommodates youth with a variety of clinical issues and cognitive functions. Enhancing the agency's capacity to better prepare youth, age 14-21 for moving from agency care to permanence and strengthening their chances of leading productive lives within the community after discharge are goals for this work.

Since its implementation, the Adolescent Outreach Program has continued to assist youth reach their life skill goals. Highlights of the most recent statistical review in May 2016 are presented below. The percentages are based on a total of 237 youth/young adults ages 16-21 who had received program services this year, but have been discharged from the program. Most of these youth (77%) are open with DCF; of

these youth 3% had left agency care at or after attaining age 18 and returned for services. Twenty-three percent (23%) were closed cases.

The achievements over the last few years have been fairly consistent. The youth/young adults who engage in Outreach services are generally successful in reaching their educational and employment goals as well as attaining permanency connections with family and community.

Education

- 78% attained a high school diploma
- 5% attained a GED/HiSET certificate
- 8% were still enrolled in high school
- 3% were enrolled in a HiSET program
- <1% enrolled at Job Corps
- 4% of youth dropped out of high school with no other educational services in place

Among these 198 youth who completed high school or a GED/HiSET ----

- 26% were enrolled in a 2 year college
- 21% were enrolled in a 4 year college;
- 5% completed a post-secondary vocational training program
- 4% were enrolled in a post-secondary vocational training program
- 6% have been accepted to a 2 year college to begin in the fall;
- 3% have been accepted to a 4 year college to begin in the fall;
- <1% completed a vocational training program at Job Corps

Employment*

- 22% of the youth were employed full-time
- 50% part-time
- 6% were working part-time during school year and full time in the summer
- 5% have secured jobs for the summer
- 1% were in internships or volunteer work
- 3% were not working due to pregnancy or parenting responsibilities
- 3% were not working due to educational commitments
- 2% were not working due to placement issues
- 2% were not working due to documented disability
- <1% were at Job Corps
- <1% were in the military
- 5% unknown

Additional Information

- 1% were participating in an internship or volunteer position in addition to employment
- 18% were enrolled with a Career Center
- 3% had applied to WIA for employment assistance

****The employment statistics reflect the fact that 83% of these youth were still attending high school, HiSET classes, college or vocational training at the time of reporting.***

Other Source of Income

- 2% were receiving Social Security disability benefits
- 56% were receiving state funded Young Adult Support payments
- 4% were receiving TANF
- 14% were receiving SNAP benefits
- 41% received ETV payments this year
- 35% used the MA Tuition and Fee Waiver
- 24% received state Foster Child Grant funds for full time post-secondary education
- 3% had utilized a Family Unification Housing Voucher through the Outreach Program.

Placement

- 38% were living in their own apartments with or without roommates
- 16% had returned to live with their immediate or extended family
- 11% were living in college dorms
- 10% were living in DCF foster homes
- 7% were living in a kinship foster home
- 5% were living with friends & paying rent
- 3% were living in an independent living program or group care
- 2% were unknown
- 2% were renting a room
- 2% were living with former foster parent – paying rent
- 1% were living in a contracted Comprehensive Foster Care placement
- 1% were living with friends-not paying rent
- 1% were at Job Corps
- 1% were living in a Young Parents Program
- <1% were living at a DMH Program
- <1% were living at a DYS Program

Other Services

- 8% of the youth were taking psychotropic medications as prescribed
- 5% were prescribed psychotropic medications but were not taking them
- 5% were receiving services from the MA Rehabilitation Commission
- 1% were on probation through the courts
- 1% were receiving substance abuse services
- <1% of youth were receiving services from the Dept. of Mental Health

Additional Outcomes

- 88% had a connection their birth parent(s)
 - ❖ 9% were in touch via telephone/social media only
 - ❖ 79% were visiting with parents
- 98% of youth have a community support system
- 99% of youth have an identified life long connection

- 96% of the youth who had siblings were connected with them; of these youth:
 - ❖ 8.5% *through phone calls only*
 - ❖ 87% *were visiting or living with their siblings*
- 90% of the youth have a connection with their extended birth family; of these youth:
 - ❖ 7% *through phone calls only*
 - ❖ 83% *are visiting with extended family*

Practice and Tools for Teaching Life Skills

Life Skill Curriculum

The Department's own life skill curriculum, Preparing Adolescents for Young Adulthood (PAYA) has been successfully used by the foster parents, residential and congregate care programs and comprehensive contracted foster care agencies for more than 20 years to help ensure continuity in the life skills training for youth in out-of-home placement. The components of the PAY A curriculum include five (5) life skills modules, each of which incorporates a number of related skill areas as described below:

Module 1: Money, Home and Food Management

Module 2: Personal Care, Health, Safety and Decision-Making

Module 3: Education, Job Seeking and Job Maintenance

Module 4: Housing, Transportation, Community Resources, Laws and Recreation

Module 5: Young Parents Guide – Sexuality, Reproduction, Decision-Making, Pre-Natal Care, Pregnancy, Child Development, Child Safety, Physical Care, Education and Career Planning and Housing

This year DCF updated Modules 2 and 3 and has made the full curriculum and activities available on a flash drive for providers, foster parents and staff. Plans are underway to make the curriculum available on the DCF website.

The Adolescent Services staff provided life skills and youth development trainings statewide this past year. There were 11 PAYA certification trainings across the state this year and 5 trainings on supporting foster youth in post-secondary education. All DCF staff, contracted and state agencies, community partners, and foster parents are invited to attend these trainings which address the use of the curriculum and the implementation of the program services. The training presents strategies for working with adolescents around readiness for community living and teaching specific life skills. Transition planning and the after-care needs of youth are also addressed.

The Department's revised Permanency Planning Policy (effective July 1, 2013) requires all Comprehensive Foster Care (IFC) contracted providers and congregate care providers to complete the Youth Readiness Assessment Tool for the same population of youth and young adults specified above. Foster parents, providers, and staff are encouraged to integrate the information and activities suggested in the modules into the daily learning opportunities for youth in their care. The PAYA incentive program is also available to these youth.

DCF staff met with the Caring Together Documentation Group to discuss possible minor revisions to the Youth Readiness Assessment – particularly for youth served only by the Department of Mental Health. The recommendations for the changes are under consideration by DCF legal staff.

PAYA Incentive Program

Since the implementation of the PAYA Program, the Department has utilized incentives to reward adolescents for their successful completion of a skill module, encourage their development of self-esteem, and empower them to continue their efforts of enhancing their life skills. The youth also learn to set goals for themselves and work toward their achievement – as well as the tangible reward. In order to qualify for an incentive, a youth must master the skills addressed in the individual life skill module. Youth may request \$50 for a life skill related item or a one time payment of \$300 toward driver education training. From June 2015 to May 2016, DCF processed 374 PAYA incentive requests: 259 for \$50 and 115 requests for the \$300 for driver education. The total amount awarded was \$47,450.

PAYA Life Skill Groups

Boston Region

A PAYA Group was held in the Boston Region during April school vacation this year. The group covered two PAYA Modules including the topics of Education, Employment, Housing, Transportation, Community Resources, Recreation and Understanding the Law. Youth who completed the three day group will receive a \$100 incentive. Three male foster youth and five females ranging from ages 15-19 participated in the group.

Topics addressed included reviews of educational benefits through DCF and the financial aid process as well as housing, transportation, community resources, and understanding the law. The DCF Housing Stabilization Unit Supervisor spoke with the youth. Some of the topics included affordable housing programs, credit and CORI information, roommates, tenant rights, leases, and how to find and budget for an apartment.

Additionally, youth learned how to get their driver's permit, the benefits of attending a driver's education program, how to get their license, and all about car insurance. Youth also learned about resources and recreational activities in the area as well as how to register to vote and be active in their community.

Another focus of the group was employment including job searching, interview skills, job maintenance, resumes, and cover letters. A member of the Dimock Street Area Office interviewing team came to speak with the youth about his experience with interviewing potential candidates including first impressions, what is/is not appropriate to wear, being on time and prepared for an interview, having a professional resume and cover letter, the importance of body language and speaking professionally, and common pet peeves of employers during interviews.

Eight youth completed the group and were offered the opportunity for a paid internship at a local nursing home. This internship will help the youth build their resumes and explore career interests.

Efforts to Provide Developmentally Appropriate Activities for Foster Youth

Life Skills Support Program

The Department staff understand the importance of providing access for foster youth to developmentally appropriate activities and is committed to facilitating youths' connection to school and community activities. DCF utilizes Chafee Program funds as well as state funds for this purpose. The Chafee program funds are used for a variety of activities such as team athletics/uniforms, senior class expenses, SAT prep courses, high school activity fees, short term transportation, computers, etc. Chafee eligible foster youth including youth adopted or guardianship with kin after age 16 and those youth who discharged from placement at or after age 18-21 may be awarded funds to support their life skill development and transition needs. Between June 2015 and May 2016, DCF awarded 580 foster youth and young adults a life skills payment for a total of \$326,313.

DCF Internship Program

The Department's continuing partnership with private businesses and community-based organizations provides internship opportunities for DCF youth with the goal of assisting youth gain beneficial work experience and exposure to careers in which they have expressed an interest. Such access to internships is certainly a developmentally appropriate resource for foster youth, particularly as the Outreach staff provide the support in helping the youth/young adult identify their area of interest as well as potential placement sites. The Outreach staff provide on-going supervision – meeting with the youth/young adult weekly -assessing the youth's current employment skills and providing support around job readiness in areas such as appropriate dress, workplace ethics, time management and transportation. Outreach workers can also support the internship supervisors to address any needs or concerns that may arise during the placement. Staff use the PAYA Life Skill Curriculum Module 3 to assist youth with employment readiness skills.

These internships give youth a chance to explore potential career opportunities and encourage youth to set educational and vocational goals, form natural mentor connections with employers and employees in a career/field they are interested in and gain experience in a professional work setting.

DCF youth are paid a stipend by the Department (Chafee funds) for their participation in this program. The average youth initially works 40 hours with an opportunity for a 40 hour extension. The youth receives a \$7 an hour stipend. The stipend payment is managed by the Outreach Worker and given to the youth when the employer verifies that the hours have been completed. Some youth go on to be hired by the employer and/or form lasting mentoring relationships. The internship program has been a great way to introduce youth to a vocational or professional work setting and motivate them to continue with their educational goals.

In FY 16, 50 youth were matched with internship placements. Of these, 18 youth have completed their internships and 32 youth have ongoing internships.

Of the 18 completed internships:

33% of youth were hired by the employer following the internship;
28% of participating youth have reported a continued mentor relationships with their employer; and
11% of youth continue to volunteer at their internship placement.

Some of the internships this year included:

- MSPCA
- Northeast Animal Shelter
- Saint Anne's Hospital
- Skye Computer
- Windsor Place Nursing
- Malden TV
- YMCA
- Lech Auto
- Kelley Furniture
- Heritage Senior Center
- Photography Workshop
- American Nursing
- BMB Computer
- Camp to Belong
- Transitions Farm

The Department has continued to reach out to employers in the local areas to promote interest in learning more about our internship possibilities. A Boston financial firm has recently hired a foster youth in college for a summer internship. The firm has chosen to pay the intern directly.

Based on feedback from our foster youth focus group last year, we have extended the time period for some of the internships, as needed, to allow sufficient time to establish connections that could build into a mentoring relationship and for the youth to gain more experience in their work.

Employment Efforts

- Assisting our youth develop employment skills - including readiness, search and maintenance - is one of the fundamental goals of the Outreach Program. As of May 2016, 357 youth or 77% of the 465 youth who are receiving or had received Outreach services during this fiscal year were known to be employed at this writing. An additional 40 youth (9%) had secured summer jobs and are scheduled to begin summer employment soon. There were also 20 youth (4%) who were participating in an internship or were volunteering. The Outreach staff will continue to assist youth develop work readiness skills and facilitate access to job placement services.
- The relationships that Adolescent Support Services/Outreach staff continue to develop with the local career centers is directly benefiting the youth they serve with improved access to job training programs and funding for vocational training programs. This access to WIA funding of vocational training programs is particularly beneficial to youth who attend a post-secondary school that is not Title IV eligible, and, therefore, not covered by the federal Education and Training Voucher or the MA State Foster Child Grant Program. As of May 2016, 84 youth or 18% of the youth who are presently being served or were served by the Outreach Program in FY 16 were also receiving services or funding from the Career Center. An additional 18 youth (4%) applied for summer employment through WIA.

Youth and Young Adults Participation in CFCIP Planning and Service Improvements

On an ongoing basis, the Department seeks input in planning and refining CFCIP services from the members of the Regional Youth Advisory Boards and the Massachusetts Network of Foster Care Alumni.

Youth Advisory Boards

The Department's Youth Advisory Board has been active for more than 16 years. Presently, there are 35 members of the Regional Youth Advisory Boards who are committed to promoting change for future foster youth through their voice, advocacy, and action. They provide recommendations to the Department on services, policy and practice. Additionally they want to ensure that foster youth are known for their strengths, achievements, goals and not labeled negatively.

The Regional Youth Advisory Boards generally meet monthly, providing a medium for youth in out-of-home placement to voice their concerns and offer suggestions to the agency on issues facing youth in care. Delegates from each Regional Board sit on the Central Office Advisory Board; they are statewide representatives for their peers' interests, concerns, and questions. The agenda topics for each meeting are jointly developed by the Board members based upon their own ideas/concerns or those of the youth they represent and by DCF administration – often seeking youth input on policy, programming, etc.

- The youth leadership achievements this year and future planned activities are described below:
- 1. The Youth Advisory Boards are often asked to offer feedback on a number of issues relevant to the Department. This year they were asked to provide feedback on the issue of youth running from care. Members offered suggestions to the agency to help prevent running and lessen run time.
- 2. Board members provided feedback for Millbrook Scholars Program and for the DCF Handout on Student Debt.
- 3. Board members participate on the Youth Panels at the area offices to review applications from former foster youth wishing to return to agency care.
- 4. Board members assisted in the planning for the Youth Leadership Institute last July and are working now on this year's Youth Leadership Academy and Youth Summit to be held on July 20 and 21.
- 5. The Southern Region Youth Advisory Board members met with the DCF Area Board. The Area Board recruited two of the youth sit on their Area Office Board. The Youth Advisory Board members were asked to assist the Area Board in designing and redecorating two DCF visiting rooms.
- 6. The Central Region Board members are working on a project to develop drawstring bags for adolescents when they come into care. They are identifying funders/donations and expect to have 30 bags for each Central Region office soon.
- 7. Northern Region Board members presented at a training of staff on the importance of permanency and life-long connections for foster youth.
- 8. DCF maintains its participation in the New England Youth Collaborative – a regional youth group dedicated to improving the services/resources and outcomes for foster youth. Each New England state has 3-4 youth representatives. This year the group has been working on normalcy rights for youth in congregate care.
- 9. DCF Youth Advisory Board members participated in the production of the annual graduation video that was presented at the Jordan's Furniture Youth Achievement Celebration this May 15th, 2016. The video is also used for training new social work staff, foster parents and as a recruitment tool for adoptive and foster parents.

10. Members of all the regional Boards continue to participate in MAPP trainings and regional recruitment events, sharing their experiences to help train and recruit Foster and Adoptive families. Board members also participated in the DCF Adoption Option event this past September to assist in recruiting foster/adoptive homes for transition age youth.
11. Members spoke at Area office legislative breakfasts to present the youths' perspective on foster care.
12. Members assisted with the Education Open Houses at the area offices for younger foster youth interested in post-secondary education.
13. Youth continue to participate in trainings, including CORE training, for social workers and supervisors to talk about the needs of youth in DCF care/custody.
14. Again this year, Board members have given back to their communities by volunteering at homeless shelters and hosting food drives.
15. Board members have been very helpful in assisting DCF with strategies for reaching out to foster youth regarding the NYTD surveys.
16. Again this year members planned activities with a local nursing home - craft projects with the elderly residents around the Halloween, Christmas, and Easter holidays. This intergenerational project was a rewarding experience for both the youth and the residents, and the youth look forward to continuing similar projects in the future.
17. Board members also planned and hosted an Easter Egg Hunt at one of the Boston area offices for foster children.
18. The Department's teen newsletter, *The Wave*, has continued to provide a voice for youth in care and is an effective means of informing youth of the opportunities/services available to them both in the agency and the community. THE WAVE is available on the DCF Intranet.

The Massachusetts Network of Foster Care Alumni

- The Massachusetts Network of Foster Care Alumni, initiated and funded through DCF, has continued to grow this past year. Its purpose is to illuminate the diverse needs of alumni of foster care in the state by advocating for appropriate services and supports, by promoting a healthy peer community, and by developing opportunities for service and leadership. The Network's Advisory Board has strong representation of foster care alumni. The Board has obtained its 501c3 certification. This past November the fourth annual Thanksgiving Dinner was held to provide members and interested young adults the opportunity to network with one another and learn more about the opportunities the Massachusetts NFCA offers.

CFCIP Services across the State

The services funded with the Chafee Foster Care Independence Grant funds are available to eligible youth and young adults across the state – life skills training, internships, discharge support, etc. In the area offices where there is not an Adolescent Outreach worker assigned, the regional Outreach Program Supervisor will provide the access to Chafee funded services and supports.

The Chafee funded services are the same in each of the 5 regions of the state. The particular focus of the services is based on the individual youth/young adult's needs.

The state funded services are comparable across the state – again with the focus on the unique needs of the individual youth to be served in each area/region. Former foster youth ages 18-21 are offered the same Chafee services as foster youth under age 18. Former foster youth who leave DCF care after

attaining age 18 may access Outreach services and other Chafee Program funded services, i.e. internships, discharge support, assistance with educational services.

Housing Support, Room and Board Assistance, Homelessness Prevention

Many of the young adults reaching age 18 in DCF custody/care choose to sign a Voluntary Placement Agreement with the agency to continue in care. Therefore, the state provides the funding for placements for youth/young adults ages 18 and older – from foster care, to Comprehensive Foster Care (contracted) to independent living programs. In addition, the DCF utilizes the state funded Young Adult Support Payments to directly provide room and board funding to young adults who are determined by DCF to be responsible and able to safely manage these funds. As of May 2016, there were 1798 young adults age 18 and older in agency voluntary care.

As the Chafee Program funds cannot be used to support the room and board costs for foster youth in agency custody/care, Massachusetts uses less than 30% of its allotment of the federal Chafee Foster Care Independence Program for room and board payments. The Department, however, uses the Chafee funds for the Discharge Support Program.

The Discharge Support Program is managed by the Adolescent Support Services Unit of DCF using Chafee grant funds. The program supports start-up costs (i.e. first month's rent, security deposit, essential furniture, household items, bedding, etc.) for young adults who have left agency care and are in need of such support. These are the expenses that DCF considers room and board payments for former foster youth. Transportation expenses are also included in the discharge support category. This past year from June 2015 to May 2016 (to date) – 64 young adults received discharge payments for housing and related expenses totaling \$64,550. Funds may be paid directly to the young adult **or** to the landlord. If necessary, the checks may be written to the young adult and mailed to the DCF area office so that the Outreach worker or social worker can assist the young adult in paying the rent and other living expenses. If the young adult's behaviors are such that providing money without his/her willingness to work with Outreach staff as described above would likely jeopardize safety, then the young adult is informed of the program and given contact information so that he/she may call at any time and request assistance.

Given the Department's focus on achieving permanency for our children and youth, many youth are leaving care/custody to return home prior to age 18 –making them ineligible for the Discharge Support funds. Also, in July 2013 the DCF modified its Permanency Planning Policy to broaden the criteria for youth/young adults to remain in voluntary care beyond age 18 – up to age 22, we are seeing more young adults leave care at or after age 21 – making them ineligible for the Chafee Discharge Support funds. An increase in the age for eligibility for Chafee funds would be beneficial to these young adults as they transition into the community.

With the Department's Foster Care Reviews for youth age 17 and older in DCF custody/ care, there are opportunities for the youth to be informed of this resource. Further efforts to inform youth, staff and providers of this transition benefit include training of staff in the area offices and at the pre-service/CORE training for all new staff; training of providers at PAYA trainings and technical assistance meetings. Outreach workers review the agency's monthly report of youth in placement to identify youth ages 17 and older who may be discharging from care. Outreach workers regularly inform youth at Youth Advisory Board meetings of the resources and request that they share the information with other foster youth.

As our Outreach staff contact young adults for the NYTD surveys, they are also discussing the Discharge Support Program as well as all the other Chafee funded services and higher education funding that is available to them.

Below is a summary of the housing supports offered through state and federal housing funds, DCF, as well as donated supports.

- **VOLUNTARY PLACEMENT AGREEMENT AND OPTIONS** - DCF encourages youth who attain age 18 in custody or care to request continued care with the Department to pursue their educational and/vocational training and access the services they need to reach their potential as participating citizens. The Voluntary Placement Agreement (VPA) that both the youth and the agency staff must sign has been modified to allow for agreements between the young adult and DCF and to specify the expectations of continued care. The service plan details the goals that the youth and the agency have agreed upon as well as the tasks for all parties who will assist the youth achieve the identified goals. This new form also includes reference to the Health Care Proxy and the annual credit reviews.

As of May 2016, there were 1798 young adults age 18 and older in DCF placement settings. In addition to foster care and congregate care placements for youth ages 18 and older, the Department provides Young Adult Support Payments directly to young adults that DCF staff believe are responsible and able to live in an approved placement (i.e. college dormitory, apartment with or without roommates). Via this provision, young adults receive a stipend to fund their living costs and daily expenses. These youth are most often either attending an educational program or are training for a job/career. DCF social workers provide case management services. The area office Adolescent Outreach Worker may assist with supervision and support. As of May 2016, there were 849 young adults statewide who were receiving Young Adult Support Payments.

The supports available for post-secondary education and vocational training from both the federal government and the state are certainly an incentive for youth to pursue their educational goals. Youth are encouraged to stay in school to achieve their diplomas, HiSET certificates or to pursue post-secondary education or vocational training. At this same time, the agency has been working to re-connect youth to their families when safe and appropriate to do so and to ensure that youth have identified enduring relationships with caring and responsible adults prior to their discharge. Eighty-eight (88) percent of the youth served and discharged from in the Outreach Program this year have connections with their birth parents (phone, social media or visits) and 90% were connected with their extended families. Their connections with siblings were even higher at 96%. More details of this contact are available on pages 7 and 8 of this report.

- DCF has continued its partnership with the Sisters of Charity for more than 12 years to provide housing accommodations for female students age 18 and older who are currently or formerly in the care of DCF and are now pursuing post-secondary studies. The Bachand Residence for Girls is an ideal example of collaboration and the valuable support that caring members of the community can offer to young adults preparing to transition to adulthood. The Sisters are responding to the community need for safe, stable housing for DCF post-secondary students who are attending community college or vocational training programs which do not offer housing accommodations. The Sisters of Charity rent DCF students private rooms in a previously vacant wing of their building. In addition to their own rooms, the young women have a kitchen and dining area, a lounge, computer room, laundry and storage area. The Department provides a monthly stipend to these students to assist

with their rent and living expenses. An assigned staff person works closely with the residents and the Sisters as the program changes/adapts to fit the needs of these adolescents. This past year, 19 young women have been residents at Bachand Hall. The students are only accepted as referrals from the DCF. Presently, 12 young women are residing there.

- The Lowell Area office of DCF has also collaborated with community housing advocates and a developer to create a housing program for young men in the Lowell area, Paige Street Apartments. The program includes 10 one bedroom apartments. Nine of the apartments are reserved for DCF young adults ages 18 and older in voluntary care and receiving Young Adult Support Payments, and one room is for the Resident Advisor (RA). The apartments are very affordable as the group was able to secure project based Section 8 vouchers for the units. The young adults pay 30% of their income for rent. They are responsible for their own use of electricity and cable. The building also has a common area in the basement for the residents to gather and a space for the young adults to meet with their social workers. The expectation is that the residents will attend college or a vocational training program. The program has been successful with an ongoing waiting list.
- Outreach staff members maintain contact with local/regional transitional living programs and shelters, including those funded via the federal Runaway and Homeless Youth grants to identify youth/young adults who may be eligible for our Chafee funded services.
- Since 2009, DCF and the MA Dept. of Housing and Community Development have jointly applied to HUD for Family Unification Program (FUP) vouchers— a portion of which have been assigned for “transition age” youth. These vouchers are limited to an 18 month period, unlike the standard FUP vouchers. As the young adults awarded the 18 month FUP vouchers are required to work with an Adolescent Outreach worker, the program is referred to as the FUP-AOP. Since 2009, we have maintained 28 vouchers for the transition age youth. Outreach staff are assigned to work with each recipient to support them with educational pursuits, money management, employment, housing and other needs that may arise. The young adults do not have to be in the voluntary care of DCF to be eligible for the FUP vouchers, just Chafee eligible.
- The DCF is collaborating with the Department of Housing and Community Development to discuss options through the HUD FSS program to modify the DCF FUP-AOP timeframe for the vouchers – extension beyond 18 months.

Below is an overview of the details for the young adults with FUP vouchers as of May 2016.

FUP Program Summary – 2016

This year the program has served 39 young adults. Presently 15 young adults are in their apartments using their vouchers, and 6 additional young adults are in the process of securing housing.

Twelve young adults completed their time with the FUP Program and moved on to secure housing.

Another six of the young adults who completed the Family Unification Program this past year moved on to participate in the Youth Transitioning to Success Housing Program. *

FUP Participants - 21

Employment

5 working full time

16 working part-time

Education

- | | |
|----|---|
| 1 | Enrolled in High School |
| 17 | Enrolled in College |
| 1 | Enrolled in a Vocational Training Program |
| 2 | not in school (working) |

An additional 5 referrals are in process.

*After successfully completing their 18 month FUP voucher, six young adults have moved from the FUP-AOP into the DHCD/DCF Youth Transitioning to Success Program. Description follows.

Youth Transitioning to Success Program (YTTSP)

The Department of Housing and Community Development and DCF partnered to develop the Youth Transitioning to Success Program (YTTSP) following feedback from focus groups of young adults who participated in the Family Unification Program (FUP) for transition age youth as well as input from DCF Outreach staff. This program was implemented in 2011 and designed to assist youth who have been successful with their FUP voucher. The model includes many of the principles of the Moving to Work Program. Some of the features are subsidized rent, a special needs account for approved emergency expenses as well as an escrow account to assist youth to save for the future. The participants are required to be enrolled in a post-secondary degree program/vocational training program and to work at least 12 hours weekly. This YTTSP Program also includes assigned Outreach workers to assist the young adults with managing the responsibilities of money management, education, employment and housing.

This year the program served 14 young adults. Seven young adults presently remain in the program. All are working and in school.

Of the 7 young adults who completed the YTTSP Program FY 16:

- 1 reached age 23 and continues in college
- 2 mutually terminated from the program and moved into other long term housing with roommates
- 4 completed Bachelor degrees and successfully completed the program.

Two additional young adults have been referred to the program and are in the process of transitioning from the FUP-AOP to the YTTSP Program.

The YTTSP Program has been very successful for our foster youth. The collaboration between DCF and DHCD continues to be excellent. Whenever questions/challenges arise, both agencies discuss alternatives, and resolutions are readily agreed upon.

The model works for many young adults as the fixed percentage of the rent subsidy (depending on the year of their participation) is not determined by their income as it is in the Family Unification Program. This allows a youth adult to work and save money without the worry of an increase in their monthly rent.

Extension of IV-E Foster Care Assistance to Young Adults 18-21

- MA has a long history of extending voluntary care to young adults ages 18 and older. As of May 2016, there were 1795 youth age 18 and older in the voluntary care of the DCF. The conditions under which they can remain in DCF care after age 18 mirror the recommended conditions for extended care under the Fostering Connections Law.
- With the revised DCF Permanency Planning Policy, the agency assumes that youth turning 18 will sign a Voluntary Placement Agreement to continue in care – unless they are returning home, adopted or unwilling to work collaboratively with DCF toward their service plan goals. Youth who choose not to participate in the treatment services that DCF assesses to be necessary for them may leave care to avoid these supports. Young adults who leave DCF care before reaching age 21 most often do so to return to family – especially the youth who are age 18. The older the young adult is the more likely they will transition from DCF care after having completed an educational/vocational program. A significant benefit for DCF young adults is the agency's policy that they may return to request voluntary services after discharging at age 18 or older. Planning for discharge is a fundamental part of service delivery. DCF provides a Discharge Support Program with Chafee funds. The program supports start-up costs (i.e. first month's rent, security deposit, essential furniture, household items, bedding, etc.) for young adults who have left agency care and are in need of such support. These are the expenses that DCF considers room and board payments for former foster youth. (More detail on pages 15 and 16.)
- The placement settings available to youth and young adults in the agency's care after age 18 are the same settings that are available for youth under age 18 with the exception of the Young Adult Support Payments which are available to youth age 18 and older who have demonstrated their ability to manage a budget. These young adults may reside in a college dormitory or an apartment.
- The Department's Adolescent Outreach Program (supported with Chafee grant funds) provides individualized support to youth and young adults seeking or maintaining employment. Employment readiness services including practice with job applications, resumes, interview prep and practice, and job search as well as employment support on the young adult secures a job. Additionally, the Internship Program provides placements for youth/young adults in employment settings of interest to them. Young adults are also referred to the Career Centers across Massachusetts for career interest counseling, resume writing and job search.
- The Department provides specialized services to youth and young adults with special service needs. DCF contracts for teen living programs for teen mothers and their children to receive parenting skills training and life skills training. These services are available with a housing component or as stand alone services.

Collaboration with Other Private and Public Agencies

- DCF has been collaborating with the state Department of Housing and Community Development for the last few years to manage the Family Unification Program Vouchers (FUP) for housing for transition age youth and the newer program, the Youth Transitioning to Success Program (YTTSP). (Fuller descriptions can be found under the housing section.) To date we have served or are presently serving 148 young adults with FUP housing vouchers and 54 young adults in the YTTSP.

- DCF participates in the Advisory Board of the STAY (Success for Transition Age Youth and Young Adults) Project of the MA Department of Mental Health, which is funded through a SAMHSA Grant. The purpose of this grant is to engage youth/young adults with a serious mental health disturbance (SED) and to promote age appropriate services.
- The Worcester County District Attorney's Office and the Worcester County Sheriff's Office have provided training to our foster youth and staff for a number of years on the topics of distracted driving and the dangers of substance abuse.
- The Outreach Program staff routinely refers youth/young adults to community based agencies for health care, pregnancy prevention and STD prevention and treatment. Staff members receive trainings from the state Department of Public Health, Planned Parenthood League, and other specialists on how to help youth/young adults care for themselves and make informed decisions about their sexual behaviors.
- DCF Adolescent Services staff members have continued to work collaboratively with staff at the Board of Higher Education, the state universities, the 2-year public colleges as well as the staff of the campuses of the University of MA. These collaborations have been very helpful in resolving issues on behalf of our shared students. DCF Adolescent Support Service staff have continued their presence on campuses and work in partnership with higher education (in the areas of support services, financial aid, registrar, etc.) to enhance the availability of and access to needed resources for our students. Outreach to the private colleges and post-secondary vocational training programs our youth attend has been ongoing. Thirty-four (34) college advising events were held on 22 campuses and two DCF area offices this past academic year. More detail is provided in the ETV section.
- DCF also works closely with the state Department of Transitional Assistance to assist transition age youth access SNAP benefits when appropriate and AFDC for parents whose children are not in the custody/care of DCF.
- DCF works collaboratively with the state Department of Mental Health (DMH) and the Department of Public Health to facilitate access to services for youth and young adults with mental health and/or substance abuse histories. This collaborative working relationships are in addition to the services that DCF provides directly to foster youth through treatment programs (residential or community based). The Department's Caring Together Initiative allows DCF to contract for congregate care and support services jointly with DMH. DCF has also extended this partnership model to contracting for comprehensive foster care with the Department of Youth Services.
- DCF Outreach social workers are continuing their communications with local shelters in an effort to identify any young adults who may qualify for DCF and/or Chafee services. Outreach workers reach out to local shelter programs to ask staff to call them if they identify a young adult who identifies as a former foster youth. Our goal is to connect with the young adult to offer Outreach services and other services as appropriate.
- The state Department of Elementary and Secondary Education has continued its data sharing with DCF providing a range of demographic and educational information (SIMs data) which is visible for workers on iFamilyNet, including the SASID (State Assigned Student Identification Numbers), language, country of origin, enrollment information, truancy days, grade, school attending, special

education status. The agencies continue to work to improve the timeliness of the data. DCF also receives the MCAS scores on students who were in agency custody when they took the exam. All this educational data is essential to social workers as they support youth in reaching their educational potential.

- The Department's recent update of the education policy provides a consistent message of the importance of promoting educational stability, continuity and engagement from birth through post-secondary education or career for all children and youth involved with the Department. Training was provided to the field staff to support the policy implementation.
- DCF's 29 Education Coordinators are affiliated with each of our geographical area offices to provide assistance, training and support to workers and families for all education and special education related concerns that impact our children and youth. Their focus includes school enrollment, school engagement and supporting transitions for youth who are hospitalized or returning from congregate care placements. They fulfill a critical role in fostering educational stability and progress for our youth.
- DCF youth have continued their involvement with the New England Youth Collaborative this year and have shared the progress that Massachusetts has made with growing the MA Network of Foster Care Alumni. Plans are underway for the annual youth conference in August this year where DCF Outreach staff will present a workshop on money management in higher education –“Know Before You Owe.”
- DCF Outreach Program staff members have continued their efforts to strengthen connections with WIA funded agencies and career centers with the goal of accessing services and supports for our foster youth. This year 23% of the youth/young adults on the Active Outreach caseload and 21% of the youth/young adults on the Tracking/Closed Outreach caseloads were enrolled at a Career Center or had submitted an application to the local WIA employment center as of May 2016.
- The Department of Children and Families' partnership with Jordan's Furniture has grown significantly over the last 5 years. One of the programs assists youth who are transitioning into their first apartments. In an effort to support these youth, Jordan's Furniture provides stipends in the form of gift cards for needed furniture. Eligible youth are between the ages of 17-23 who are leaving placement or who will move into unfurnished housing in order to pursue an educational or vocational goal. Referrals are made to the Outreach Program by DCF outreach workers or social workers. Youth must write a letter stating their needs and goals in support of the request. In FY 16, Jordan's Furniture assisted 14 youth each with \$800 in gift cards for a total donation of \$11,200. Youth were then able to go to Jordan's Furniture store with their outreach worker or social worker to buy new furniture.
- This year's Youth Achievement Celebration honoring youth who graduated from high school, college, a vocational training program or received a HiSET certificate was held on May 15th once again at Jordan's Furniture Store in Reading, MA. More 500 graduates and their guests were invited to celebrate their educational achievements, to share food, activities and a movie. The graduates were also given gifts to commemorate their accomplishments. The DCF Regions will also celebrate their graduates during the months of May and June at local events.
- The MA Department of Youth Services (juvenile justice) and DCF have continued the collaboration to identify transitioning youth connected with both agencies who are eligible for

Chafee and/or state funded resources, such as Discharge Support funds, Tuition and Fee Waivers, Education and Training Vouchers, etc. Joint meetings have been held to discuss transition planning for youth served by both agencies.

- The MA Network of Foster Care Alumni has continued its development of members and held the fourth annual Thanksgiving Dinner Celebration on November 19, 2015 in Worcester, MA. More than 100 alumni of foster care, ranging in age from 18 to 80, gathered to share a turkey dinner with all the trimmings. They enjoyed connecting with old friends and making new ones. Also in attendance were foster parents, state legislators, and DCF personnel, all members of MASS NFCA as allies of young adults in foster care. The Network provides a valuable resource to adults age 18 and older who have experienced foster care, adoption or guardianship. Its goals are to illuminate the diverse needs of alumni of foster care in Massachusetts by advocating for appropriate services and support, by promoting a healthy peer community, and by developing opportunities for service and leadership.
- More than 200 foster youth, foster/adoptive parents, providers and staff attended this year's statewide College Fair on April 20th in Westborough, MA. Attendees learn about the opportunities of post-secondary education as well as the state and federal financial support available. Representatives from more than 28 colleges and post-secondary educational programs attended along with a representative from MEFA (Massachusetts Educational Financing Authority) and the Massachusetts Education and Career Opportunities, Inc. Also invited were a select group of private colleges that have committed to providing supportive services to foster care students. Colleges and programs were able to highlight courses of study as well as support programs available to foster youth.

Mass Health – Chafee Foster Care Independence Program and the Affordable Care Act

The Department of Children and Families and the MA Department of Medical Assistance have continued their partnership to support Massachusetts' utilization of the federal Chafee Provision allowing states to provide Mass Health coverage for youth who discharge from placement at or after age 18. This benefit is provided up until their 21st birthday and, here in MA annual re-application has not been required. This is a collaborative effort among federal and state government with DCF, the Department of Medical Assistance (DMA), the Executive Office of Health and Human Services and the state legislature working to improve health care access for these young adults. Youth who remain in DCF care under a Voluntary Placement Agreement after age 18 will continue to receive the same Mass Health coverage as before through DCF. An informational sheet which explains the benefit in English and in Spanish has been shared with youth, DCF staff and providers.

DCF and the Department of Medical Assistance have been working to facilitate the continuation of Mass Health - Medicaid to eligible young adults so that they do not experience a gap in coverage from "in placement" Mass Health to the coverage under the Affordable Care Act eligibility. Additionally, DCF and Mass Health staff work closely to facilitate access to FFC Mass Health for former foster youth over age 21 who lost coverage after attaining age 22. DCF and the office of Medicaid are working on a flyer to share with young adults, DCF staff, foster parents and providers/advocates that will assist in streamlining the application process. The CIP Youth website: <http://www.masscip.org/content/chapter-nine> is also a useful resource. DCF has provided and will continue to provide outreach and education to foster parents, young adults, staff, providers regarding this benefit to identify young adults who are eligible but no longer in agency care.

DCF has provided information about the FFC eligibility in its Youth Newsletter, Higher Education Newsletter, and foster parent newsletter. Outreach staff also share this information with young adults as

they administer the NYTD survey. As these individuals are identified, DCF Outreach staff members follow their applications through the approval process. The Department of Medical Assistance has identified two staff to facilitate processing of these applications and address any problems that arise.

DCF area offices will soon have additional medical social worker to assist with care coordination.

Massachusetts has also selected the option to cover former foster youth from other states, as well.

Human Trafficking

The Department in partnership with the Justice Resource Institute (JRI), the applicant organization, was awarded a Child Welfare Trafficking Grant. The goal of this program is to develop within the state's child welfare system sustainable methods for preventing minor trafficking, identifying trafficking victims and connecting them with support and services. The process will include data gathering, infrastructure development awareness-raising and cross-systems collaboration and outreach. The collaboration with DCF includes the My Life My Choice Program of JRI which works with at risk youth and youth who have experienced trafficking and the Support to End Exploitation Now (SEEN) Program, a multi-disciplinary response addressing human trafficking in the Boston area. The Massachusetts Juvenile Court and a number of other stakeholders have committed to active roles in the project. Additional objectives are to educate DCF and provider staff on the identification and responses to CSEC and to assist counties across the state in establishing a CSEC Multi-Disciplinary Teams.

The first Training of Trainers on the Commercial Sexual Exploitation was presented to agency trainers of new social workers and specialists who will be able to train other DCF staff statewide with the intended outcome of social workers/supervisors better able to understand the issue, identify those youth/young adults possibly at risk, know the statute and related policy (51 A and DA referral) and facilitate access to appropriate services.

One of the Chafee Outreach Program supervisors worked with staff of My Life My Choice to develop a toolkit specifically for transition age youth. (Not yet published.) The Department's PAYA Life Skills curriculum addresses the dangers of the domestic violence, dating violence, victimization and human trafficking. The focus on self esteem building, self care and personal goal setting is also the approach that the Adolescent Outreach staff use with their youth.

NYTD

The Department contracts with the Judge Baker Children's Center to assist with the NYTD surveys. The DCF Outreach staff locate and survey the youth and young adults who are in agency custody/voluntary care as well as young adults who are no longer in agency placement, but whose contact information is known to DCF. The Judge Baker staff search for young adults ages 19 and 21 who are no longer in agency placement and whose contact information is not current. To date, DCF has been able to reach the required percentages of youth and young adults to survey.

Baseline Population Highlights from NYTD Survey

There were a total of 673 foster youth reaching age 21 who were in the NYTD baseline group in FFY 15. DCF selected the sample option which was 288 youth. Seventy foster youth in the sample did not participate for the following reasons:

Declined to respond	17
Incapacitated	1
Death	1
Unable to locate	51

There were 218 young adults who did participate.

There were 385 who were not included in the sample.

Total Baseline Population was 673.

Highlights of Survey Responses of 218 Youth Turing Age 21 in FY2015

- 90% of the youth responded that they had at least one adult in their lives (other than their DCF social worker) to whom they could go to for advice and emotional support;
- 50% of the youth reported that they were enrolled in an educational program;
- 29% of the youth reported that they had a part-time job;
- 18% of the youth reported that they had a full-time job;
- 16% of the youth reported that they were receiving Social Security payments;

Discussions

- DCF has shared the NYTD data with statewide managers to continue assessment of the implementation of the Permanency Planning Policy and our efforts to support permanency for all foster youth. DCF has shared the NYTD information with the Massachusetts Alliance for Families (MAFF), the foster/adoptive advocacy association that is dedicated to enhancing the quality of life for foster children and foster families. The areas noted as strengths – school enrollment and permanency connections were shared as well as other survey outcomes. Discussions continue on strategies to maintain focus and positive outcomes for permanency, education, employment readiness/work experience and overall well being for our foster youth.
- NYTD outcome data has been shared with the members of the Youth Advisory Boards. Staff has asked these youth leaders for their suggestions for strategies for engaging youth/young adults to complete the surveys. They have also helped staff determine which survey questions needed more explanation to avoid misunderstanding and incorrect responses. The feedback from the members of the Youth Advisory Boards has been valuable –from their recommendations that youth need better education around Mass Health eligibility and coverage to recommendations that more vocational training options be available to foster youth who struggle with academics. Outreach staff members are addressing these issues: 1. Collaboration with the staff at Mass Health to develop a brochure for

foster youth; and 2. Continued advice/support to youth and young adults to identify their post-secondary path. Outreach staff are working closely with the community colleges, local high schools/night schools, and local resources to identify all vocational training programs.

- Discussions of the NYTD requirement and agency efforts to collect information on all the services delivered to youth ages 14 and older have been ongoing with staff, managers, providers, foster parents, youth leaders and other stakeholders. Greater emphasis on the data entry of services delivered to youth – documentation in the NYTD Window on the Family Net system is in the planning phase. The current data is not capturing all the support services delivered to the adolescents in the federally designated “served population.” Efforts will continue to increase the entry of all services provided.

Post-Secondary Education

- Massachusetts awarded 485 Education and Training Vouchers in academic year 2015-2016 current to May 31, 2016. (A more detailed report on the ETV Program follows in a separate section.)
- For more than 10 years the Department has hosted Statewide and Regional Youth Recognition Dinners to acknowledge the achievements of foster youth who graduated from high school, college, a vocational training program or received a GED/HiSET. This year the academic/vocational achievements of 552 youth were recognized (401 graduating from high school, 42 youth achieving their HiSET certificate, 29 youth receiving a post-secondary vocational certification, 38 youth graduating with a Bachelor’s degree and 12 with an Associate Degree. The Jordan’s Furniture Store is a primary sponsor providing the space for the largest recognition event – statewide - with gifts for all the youth and a free movie in the IMAX Theater. Private local donors also help to sponsor the event.
- As of May 2016, the Department has issued 5309 State College Tuition and Fee Waivers to current or former DCF foster youth - 256 waivers in the last 12 months. In June 2008 the MA legislature expanded the waiver program to cover fees in addition to tuition. The eligibility for the waiver was also expanded in 2008 so that DCF foster youth who are or were in agency custody and were not able to return home by age 18 are eligible for this benefit at the Massachusetts state two and four year colleges and the University of Massachusetts- all campuses with the exception of the medical school. Youth who were adopted or placed in a guardianship home through the Dept. of Children and Families are also eligible for the same waiver of tuition and fees.
- Adolescent Support Services Unit staff again presented Educational/Vocational Fairs in 26 of 29 area office for youth, foster parents, congregate care providers, and DCF staff. Outreach staff presented information on financial aid – state and federal grant programs, assisted youth in completing their FAFSA applications and discussed the many options of college/vocational training opportunities available to foster youth. Foster youth who were currently attending college were also present to answer youths’ questions. This is a resource that has been provided for more than ten years and will continue. The area offices that did not host an Educational/Vocational Fair chose to provide individual appointments with foster youth to assist with their educational/financial questions/needs.
- Young adults who leave DCF care after age 18 but prior to age 21 are eligible for the Chafee funded services and the Education and Training Vouchers described throughout this report. The vast majority

are also eligible for the state funded Tuition and Fee Waivers. The Adolescent Outreach workers are fundamental in assisting these young adults to access the needed services including those to address their educational/vocational needs.

- Information on scholarships for transition age foster youth was made available to social workers and internal youth partners via the DCF Social Intranet and an electronic shared resource file available to staff via an internal shared drive. Through this technology updates can be made in real time as scholarship information and other information relative to post-secondary planning and support becomes available.
- In academic year 2015-2016, DCF referred 510 youth to the Massachusetts Board of Higher Education for consideration of the Foster Child Grant Program to assist financially with their college/vocational training needs. The Board makes the final determination of eligibility. Awards are based on financial need and student status, including full-time attendance, MA residency, and eligible educational program. The Massachusetts Foster Child Grant is limited to students whose custody status was protective. *Youth in state custody via a Child Requiring Assistance Petition are not eligible for this grant.*
- The DCF website, www.mass.gov/dcf, provides an online public resource for students and foster parents and partners to access up to date post-secondary and higher education financial benefits and support programs. The information is found under the Adolescent Support Services tab. ETV social workers update and maintain the education information provided via the website.

Education and Training Voucher Program

Accomplishments

- Massachusetts awarded 485 Education and Training Vouchers in academic year 2015-2016. This reflects a decrease of <6% from the 516 recipients in academic year 2014-2015. However, this year there were 79 students who applied for ETV awards and had to be denied as they were age 23 and 11 foster youth who applied at age 21 and were also not eligible. There were 219 new vouchers and 266 ongoing vouchers this year; 54% of the vouchers awarded this year were for returning students. DCF staff continue to support students in persisting with their education.

(A chart is presented on the next page with these same numbers.)

- The slight decrease in enrolled students reflects data that shows fewer eligible participants in the Massachusetts foster care population and a shift in practice where youth are provided more opportunity to participate in the workplace prior to college enrollment. Youth are also encouraged, when appropriate, to utilize alternative work readiness programs prior to college as allowed with the Massachusetts DCF Permanency Planning Policy.
- The students who received an ETV award this year attended 99 different colleges, universities and vocational programs in 16 states. Of the 485 recipients, 406 (83%) students were enrolled full-time, and 79 students (16%) were enrolled part-time.

The ETV Program funding is particularly helpful to the DCF foster youth who were not in protective custody (as they are not presently eligible for the state-funded Foster Child Grant) and to those youth who were adopted from foster care or youth who were placed in a guardianship with kin after attaining age 16. The Education and Training Voucher Program has provided significant post-secondary assistance to eligible foster and adopted youth and has assisted them with making more manageable and safer transitions to adult living.

2015-2016 ETV Program Information	
Total Recipients for 2015-2016	485
Breakdown of Total Recipients for 2015-2016	
Show New Recipients and Ongoing Recipients	
2016 (NEW)	219
2015, 2016	111
2014, 2015, 2016	73
2013, 2014, 2015, 2016	42
2012, 2013, 2014, 2015, 2016	13
2014, 2016	9
2013, 2015, 2016	4
2013, 2014, 2016	4
2013, 2016	3
2011, 2012, 2014, 2015, 2016	2
2012, 2015, 2016	1
2012, 2014, 2016	1
2012, 2014, 2015, 2016	1
2012, 2013, 2015, 2016	1
2011, 2012, 2013, 2014, 2015, 2016	1
Total	485
Number of Universities/Colleges/Vocational attended	
by # ETV Recipients	99
Number of States	16
Enrollment Status of # ETV Recipients	
Full-Time	406
Part-Time	79
4 Year Public	162
2 Year Public	225
4 Year Private	76
2 Year Private	10
Vocational Training	12

Students enrolled not awarded ETV @ age 23	79
Applied after age 21, not awarded	11

The goals for the ETV Program are as follows:

- Capturing all eligible Massachusetts students from foster care and providing these students with support via the Education and Training Voucher Program and other means of assistance. Providing academic and personal support to foster youth pursuing post-secondary education;
- Maximizing all state and federal academic and financial resources available to students involved with DCF;
- Incorporating initiatives to connect youth with adult and peer mentors at academic institutions and with support staff on campus and at DCF;
- Educating DCF social workers and partners that serve adolescents on the importance of adequate college planning and preparation as well as the need for intensive support while youth are attending post-secondary educational programs;
- Increasing education and capacity of college staff who work in student support services to help foster youth achieve post -secondary education;
- Encouraging participants of the ETV Program to join the DCF Youth Advisory Board and the MA Network of Foster Care Alumni;
- Continuing focus groups of ETV recipients to obtain feedback on program services and recommendations for improvements, and
- Developing a Youth Advisory Board specific to the ETV program comprised of college students from foster care.

DCF efforts toward the above goals are documented on the following pages:

Direct Service/Mentoring

- Thirty-four College Advising events were held on 22 campuses and two DCF Area Offices this past academic year. More than 240 foster youth were served through these events via either direct meetings with ETV staff or through advocacy on their behalf to college financial aid or student support personnel. Students were assisted with financial planning, housing, academic progress and social/emotional needs. These events also provided an opportunity for interested students to meet peer mentors from foster care who attend the same academic institutions.
- ETV staff provided a Post-Secondary Success Workshop at the 2015 DCF Youth Summit. First year post-secondary students were assisted in mapping out their long-term educational and career goals and defining short-term goals that will lead to their desired achievements. Current college level juniors and seniors from foster care helped staff the workshop and provided insight and tips for success.
- The Department hosted its 10th annual statewide College Fair on April 20, 2015. The event was attended by over 200 participants including foster youth, foster parents, agency and congregate care program staff. There were representatives from more than 30 colleges/universities, and vocational trainings programs as well as organizations that included the MA Educational Finance Authority (MEFA), the Massachusetts Network of Foster Care Alumni and the Massachusetts Education and Career Opportunities Inc. Also invited were a select group of private colleges that

have committed to providing supportive services to foster care students. Colleges and programs were able to highlight courses of study as well as support programs available to foster youth.

- The DCF continues to publish a newsletter for ETV student recipients which invites input from college students and educates readers on resources and events geared toward post-secondary success. Guidance from the Youth Advisory Board members and DCF college students will continue to be solicited to ensure the information is relevant to the needs of the students and presented in a manner that will engage students.
- In person meetings and conference calls of Advisory Board Members and other college students who are interested in providing guidance and feedback to the ETV program are scheduled through the summer of 2016.

Collaboration

- DCF has maintained and will continue its membership on the Massachusetts Department of Education's Financial Aid Advisory Board to ensure that foster care youth are represented when financial aid policy and practice is developed at Massachusetts colleges.
- ETV staff met on campus with financial aid staff of 22 Massachusetts public colleges for the purposes of programmatic planning as well as review of current financial aid packaging for enrolled foster youth.
- This year ETV staff partnered again with TRIO staff at 6 community colleges across Massachusetts to develop processes to increase referral to Trio and collaboration between the DCF and TRIO programs.
- ETV staff continued to provide significant support to the University of Massachusetts Boston UAccess Program. This office is designed to provide support and referral for students who are facing social, emotional, and financial challenges at the university. ETV staff work to facilitate services offered by the UAccess Program to foster care students enrolled at UMASS. UAccess held its third annual conference; this year the theme was Trauma informed support for homeless post -secondary students. ETV staff served on the planning committee for the conference and provided 3 workshops on effective support models for the foster care population and how to utilize child welfare resources for qualified students.
- ETV staff continues to serve as advisory board members on the Statewide Network on Homeless College Students and the Massachusetts Board of Higher Education Financial Aid Advisory Board. On these Boards ETV staff ensure that current state programming and resources are inclusive of the needs of foster youth.
- The two ETV staff have developed and maintained partnerships with state community colleges to identify housing and educational support resources and have presented at numerous informational meetings for DCF staff and providers to share information on these resources.

Training and Technical Assistance

- ETV staff again this year assisted in the production of a video highlighting the accomplishments of youth graduating from high school and college. The theme of this year's video was encouragement. The photographs of many of the current graduates and graduates of years past were included in the video – a very impressive message to all foster youth about the possibilities for educational achievement. The video is utilized by Adolescent Outreach Workers as well as recruitment and training staff of the Department.
- ETV staff presented at six regional trainings sponsored by UMass UAccess and the Massachusetts Education Financing Authority on transitional needs of foster care students.
- DCF staff continued to assist in financial aid coordination for The Home for Little Wanderers ASCL (Academic Support for College and Life) Program. This residential program is located on campus at Bridgewater State University and serves youth with life skills training while they are earning college credits.
- The ETV and Outreach staff provided technical assistance this year statewide to the Department's contracted foster care agencies, group homes and independent living programs in order to increase competency of care providers in assisting youth plan for, pursue and persist in post-secondary education and vocational training.
- On a regular basis, Adolescent Services staff provided life skills and youth development trainings statewide. There were eleven PAYA certification trainings across the state this year and three trainings on supporting foster youth in post-secondary education. All DCF staff, contracted and state agencies (DMH, DYS, DMR among others), community partners, and foster parents are invited to attend these trainings.
- ETV staff issue a newsletter for professionals and supporters of college age foster youth. The publication includes training opportunities and dates; resource and referral information for professionals supporting youth in post-secondary education.
- Again this year ETV staff partnered with the Massachusetts Child Welfare Training Institute to train new DCF social workers. The agency sought to provide a pre-service training about a cradle to career approach for child consumers through a trained and empowered workforce. ETV staff spoke to the issues of helping foster youth with planning for and executing a post-secondary plan for education, work, or vocational training. There were 4 follow up trainings for participating staff where ETV staff provided support on case specific issues and challenges.
- ETV staff is collaborating with Ascentria Care Alliance to assist DCF youth who have immigration/refugee status with post-secondary education needs.
- ETV staff provided a presentation about child welfare resources for post-secondary education at a student transfer conference for state college financial aid and admissions staff. The goal of the conference was to develop connection between public colleges in order to facilitate successful transfers on behalf of students.

- Higher Education Workshops were provided to agency staff and partners 5 times throughout the year in each region of the Commonwealth by ETV staff.
- In March 2016, ETV staff provided an updated webinar to the Massachusetts Education Financing Authority. The webinar is posted to the organization's website for future reference.

Program Adjustments

No changes have been made with the ETV Program this year.

Massachusetts State Financial Aid Programs for Foster Youth

DCF coordinates the ETV Program with other Massachusetts state-funded education and training programs currently offering financial assistance to eligible foster and adopted youth including the State College Tuition and Fee Waiver Program, the Foster Child Grant Program and the William Warren Scholarship Program.

The ETV staff work with the MA Board of Higher Education – Office of Student Financial Assistance around the Foster Child Grant. ETV staff review all ETV applications, Foster Child Grant Applications, William Warren Scholarship applications and financial aid award statements in an effort to prevent duplication of benefits and determine that the amount of assistance from any Federal sources combined with ETV funds does not exceed the “cost of attendance” as outlined in 477 (b) (3) (J).

Foster Child Tuition and Fee Waiver Program

The Foster Child Tuition and Fee Waiver Program provides waivers for undergraduate tuition and fees for state-supported classes at the in-state rate to foster children at any one of Massachusetts' 29 state universities and community colleges. Initially approved by the Board of Higher Education in June of 2000 for tuition waivers, this program was expanded to include fees in July of 2008. Youth eligible for the state college undergraduate or certificate tuition and fee waivers include:

- A current or former foster child who was placed in the custody of the Department of Children and Families and remained in custody through age 18 without subsequently being returned home. The youth must have been in custody for at least six months immediately prior to age 18;
- Youth adopted through the Department of Children and Families; and
- Youth who have been in the custody of the Department of Children and Families and whose guardianship was sponsored by the Department of Children and Families through age 18.

To date (May 2016), the Department has issued 5309 State College Tuition and Fee Waivers to current and former foster and guardian DCF youth, 256 waivers in the last 12 months. DCF also

grants state college tuition and fee waivers to children and youth who were adopted through the agency.

MA Foster Child Grant Program

The Foster Child Grant Program was developed in January 2001 and provides up to \$6000 of financial aid for current and former DCF youth (in custody via a C&P) who have left care at age 18 or older without returning home. This aid may be used at any IV- E eligible public or private college. The MA Board of Higher Education manages these grants, determining the level of funding per student. This academic year (2015-2016) the Department referred 510 youth to the Massachusetts Board of Higher Education for consideration of the Foster Child Grant Program to assist financially with their college/vocational needs.

William Warren Scholarship Program

- The Department issued 7 William Warren Scholarships this year to youth served by the agency who were attending four year colleges and who demonstrated need beyond financial support programs available at the state and federal level. These scholarships were financed with donated funds and nominally by the State Ward account. Many of the youth who apply for the program are also eligible for the Massachusetts Tuition and Fee Waiver and other higher education support programs such as ETV. Applicants who qualify for other forms of student aid are supported by ETV workers to access such aid.

Hope Worldwide Dr. Martin Luther King Essay Contest

- Once again this year DCF has continued its partnership with Hope Worldwide, an agency that sponsors an essay contest annually to celebrate the birthday of Dr. Martin Luther King. College students from foster care are invited to compete in an essay contest where they reflect on their public service. More than \$3500 in scholarships was awarded to foster youth enrolled in college. The winners were honored at a service dedicated to Dr. King.

Consultation with Tribes (section 477(b)(3)(G))

A representative of the Adolescent Outreach Program has been in contact with the Catherine Hendricks, ICWA Director for the Mashpee Wampanoag Tribe. Catherine has been apprised of adolescent services and funding available to Tribal youth in placement and how to obtain services and funding. All the forms and applications to access funds and services have been provided.

At this time there is one tribal youth age twenty in placement who is working with an Adolescent Outreach Worker and residing in her own apartment through the Family Unification Program. This youth also attends Bristol Community College and receives all educational funding available. Catherine also stated that a former DCF youth, who was also served by the Outreach Program and graduated from University of Massachusetts at Dartmouth is now working for the Tribe as an Indian Child Welfare Program Assistant.

Currently, there are 12 youth between the ages of 14-17 years old in placement. A representative from the Adolescent Outreach Program is coordinating with the Director to provide training to all Tribal case managers on services and funding available to Wampanoag foster youth.

A representative from the Adolescent Outreach Program has also been in communication with Bonnie Chalifoux, Director of Human Services, Aquinnah Wampanoag Tribe on Martha's Vineyard. Ms. Chalifoux has also been apprised of Adolescent Outreach services and funding available to Tribal youth who are Chafee eligible. All the forms and applications to access funds and services have been provided. Ms. Chalifoux reported that at this time the Aquinnah Tribe does not have any youth age 14-21 in placement.

The Outreach Program will continue to work with Tribal officials from both the Aquinnah Wampanoag Tribe and the Mashpee Wampanoag Tribe to identify Tribal adolescents in placement and assist them in accessing services and funding available to them.

CFCIP Program Improvement Efforts

The following DCF Strategic Plan Goal Objective is related to the CFCIP Program Improvements:

Goal 2.0: Strengthen Case Practices and Processes

Strategic Initiative 2.1: Strengthen Core Functions and Innovations in Case Practice

Progress has been achieved in the following:

Objective 2.1.6: Strengthen Engagement with Youth Adults

- Foster Care Review (FCR) Policy/strengthen our FCR process with youth ≥ 18 years old
 - *The role of the Department's Foster Care Reviewers continues to be significant to the process of transition planning for foster youth reaching age 17+ in agency custody/care. With the revisions to the agency's Permanency Planning Policy, the Foster Care Reviews for youth at age 17+ must review the Youth Readiness Assessment and discuss the transition plan for the youth as he/she reaches age 18. Foster Care Review staff alert the area office staff and Adolescent Services staff if concerns are identified with transition planning, completion of the Youth Readiness Assessment Tool, etc. Identification of training or technical assistance needed prompts response from staff of Adolescent Support Services Unit.*
- Permanency Hearings for youth ≥ 18 years old
 - *The Department continues to work with the courts and agency staff to increase the attendance of youth at their permanency hearings.*
- Youth Panels in each area office to address any concerns with youth ≥ 18 continuing in agency care
 - *Adolescent Outreach staff have been included on the area office youth panels in most area offices. Progress continues as offices integrate the role of the panels with ensuring that transition and educational planning is happening for youth reaching transition age in agency care.*
- Support the MA Network of Foster Care Alumni to become self-sustaining
 - *Progress has been made with the continuing development of the Board of Directors of the MA Network of Foster Care Alumni. Two new members have joined the Board. Fundraising has not been as successful as hoped; however, donations to offset some of the costs of the annual Thanksgiving Dinner were received. The organization's application for an AmeriCorps/Vista staff person was approved this year. The staff person should begin work in the near future and will assist with membership development and fundraising.*

Regional events to bring the members together for learning and community support will continue. The next event, a cooking class, is planned for June. A larger event, Family Fun Day is planned for this summer.

- Develop placement supports for youth ≥ 18 years and older
 - *The Adolescent Outreach Program continues to provide direct support to youth in foster care around life skills development, transition planning, education planning, and permanency connections. Outreach staff provide technical assistance and training to foster parents, congregate care and contracted foster care providers.*
- Develop additional educational supports
 - *The Department's data exchange with the state Department of Elementary and Secondary Education continues to offer vital information on foster youths' status in the schools. More timely data sharing is being pursued.*
 - *Funding for the state supported Tuition and Fee Waivers and Foster Child Grant is stable.*
- Continue to strengthen the NYTD program.
 - *The Department has continued to successfully reach the targets for the NYTD surveys of current and former foster youth. Adolescent Outreach staff and contracted staff through Judge Baker Children's Center continue the joint outreach to foster youth. When a youth/young adult is contacted for the survey and has identified needs, the Outreach staff workers respond appropriately to address those needs.*

CFCIP (Chafee Foster Care Independence Program) Training

Training Provided

- On an ongoing basis, Adolescent Services staff provided life skills and youth development trainings statewide. There were eleven PAYA certification trainings across the state this year to present the PAYA life skill curriculum and strategies to help youth develop and practice needed life skills. A videotape of foster youth speaking about the importance of permanency and life skills is incorporated into these trainings. All DCF staff, contracted and state agencies (DMH, DYS, DMR among others), community partners, and foster parents are invited to attend these trainings.
- The Adolescent Support Services staff also presented 3 trainings for staff, foster parents and providers on post-secondary educational support programs that are available to DCF foster youth and strategies for assisting students achieve their goals.
- The Adolescent Services staff also continued to provide training and technical assistance to congregate care programs and contracted comprehensive foster care agencies to assist their staff with utilization of the PAYA (Preparing Adolescents for Young Adulthood) life skill curriculum and transition planning for foster youth. With the increase in new DCF social work staff, trainings addressing the Department's updated Permanency Planning Policy, including the Youth Readiness Assessment Tool and transition planning practice have been presented. There will continue to be local and regional trainings focusing on these topics.

- As has been the ongoing practice, Outreach staff have provided resource information and technical assistance to all 29 DCF area offices, many congregate care and independent living programs, foster parent support groups and youth advocacy agencies, including a review of all the available adolescent resources and youth development activities such as the expansion of Mass Health coverage for youth discharging from DCF after age 18 to age 26 through the Affordable Care Act, the Life Skills Support Program, Discharge Support Program, Foster Child Tuition Waivers, the ETV Program, transitional living options and subsidized housing through the FUP-AOP, Peer Leadership trainings, statewide and regional Youth Recognition Dinners, the MA Network of Foster Care Alumni and other support services.
- Adolescent Services staff are available to respond to training needs as requested.

Attachment A

JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM

(1) **RESPONSIBLE STATE AGENCY**

The Massachusetts Department of Children and Families (DCF) is the state agency responsible for administering the Title IV-E program; DCF will also administer the Independent Living Program under section 477 (section 477 (b) (2)). DCF will cooperate in national evaluations of the effects of the programs implemented to achieve its purposes.

CFCIP FUNDS REQUESTED

Federal Funds Requested	\$3,143,968	
State Match Amount	\$785,992	Source: Account 4800-0041 RESG02 Independent Living/Congregate Care Programs

Amount of Federal Funds to be Used for Room and Board: \$100,000

Education and Training Voucher Program Funds Requested: \$1,020,225

Annual Reporting of State Education and Training Vouchers Awarded

Name of State: Massachusetts

<u>Final Number:</u>	Total ETVs Awarded	Number of New ETVs
2013-2014 School Year (July 2013 to June 2014)	516*	223
2014-2015 School Year	514**	227
2015-2016 School Year	485***	219

* In the 2013-2014 academic year there were 55 additional students who were enrolled in post-secondary education and applied for ETV awards but had to be denied as they were age 23.

** In the 2014-2015 academic year there were 75 additional students who were enrolled in post-secondary education and applied for ETV awards but had to be denied as they were age 23.

*** In the 2015-2016 academic year there were 97 additional students who were enrolled in post-secondary education and applied for ETV awards but had to be denied as they were age 23 or had not applied prior to age 21.

Commonwealth of Massachusetts

Department of Children & Families

Update on Assessment of Performance

States that have completed their CFSR Statewide Assessment in 2015 or 2016 may choose to reference that assessment – the Department completed its Statewide Assessment in September 2015, in preparation for participating in its Round 3 CFSR in September 2015. At present the Department is in negotiations with the Regional Office of the Department of Health and Human Services to develop a Program Improvement Plan to address areas in need of improvement cited in the CFSR report. An initial draft was submitted to DHHS earlier this year and subsequent meetings have been held, and continue, to revise the initial submission.

The DCF 2015 Statewide Assessment follows.



Child and Family Services Reviews

Statewide Assessment Instrument

April 2014



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Introduction

The Child and Family Services Reviews (CFSRs), authorized by the 1994 Amendments to the Social Security Act (SSA), are administered by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The goals of the CFSR are to:

- Ensure substantial conformity with title IV-B and IV-E child welfare requirements using a framework focused on assessing seven safety, permanency, and well-being outcomes and seven systemic factors;
- Determine what is happening to children and families as they are engaged in child welfare services; and
- Assist states in helping children and families achieve positive outcomes.

The CFSR Process

The CFSR is a two-phase process, as described in 45 CFR 1355.33. The first phase is a statewide assessment conducted by staff of the state child welfare agency, representatives selected by the agency who were consulted in the development of the Child and Family Services Plan (CFSP), and other individuals deemed appropriate and agreed upon by the state child welfare agency and the Children's Bureau.

The second phase of the review process is an onsite review. The onsite review process includes case record reviews, case-related interviews for the purpose of determining outcome performance, and, as necessary, stakeholder interviews that further inform the assessment of systemic factors. The onsite review instrument and instructions are used to rate cases, and the stakeholder interview guide is used to conduct stakeholder interviews.

Information from both the statewide assessment and the onsite review is used to determine whether the state is in substantial conformity with the seven outcomes and seven systemic factors. States found to be out of substantial conformity are required to develop a Program Improvement Plan (PIP) to address the identified areas out of substantial conformity. States participate in subsequent reviews at intervals related to their achievement of substantial conformity. (For more information about the CFSRs, see the *Child and Family Services Reviews* at <http://www.acf.hhs.gov/programs/cb>.)

Integration of the CFSP/APSR and CFSR Statewide Assessment

The CFSR process is intended to be coordinated with other federal child welfare requirements, such as the planning and monitoring of the CFSP. We are encouraging states to consider the statewide assessment as an update to their performance assessment in the state's most recent CFSP and/or Annual Progress and Services Report (APSR) rather than a separate assessment process and reporting document. Most of the content for the statewide assessment overlaps with the CFSP/APSR and the same expectations for collaboration with external partners and stakeholders exist across all planning processes. States can use the statewide assessment process to re-engage these partners and stakeholders in preparation for the CFSR.

The Statewide Assessment Instrument

The statewide assessment instrument is a documentation tool for states to use in capturing the most recent assessment information before their scheduled CFSR. Each section, as outlined below, is designed to enable states to gather and document information that is critical to analyzing their capacity and performance during the statewide assessment phase of the CFSR process.

- Section I of the statewide assessment instrument requests general information about the state agency and requires a list of the stakeholders that were involved in developing the statewide assessment.
- Section II contains data profiles for the safety and permanency outcomes. These include the data indicators, which are used, in part, to determine substantial conformity. The data profiles are developed by the Children's Bureau based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS), or on an alternate source of safety data submitted by the state.
- Section III requires an assessment of the seven outcome areas based on the most current information on the state's performance in these areas. The state will include an analysis and explanation of the state's performance in meeting the national standards as presented in section II. States are encouraged to refer to their most recent CFSP or APSR in completing this section.
- Section IV requires an assessment for each of the seven systemic factors. States develop these responses by analyzing data, to the extent that the data are available to the state, and using external stakeholders' and partners' input. States are encouraged to refer to their most recent CFSP or APSR in completing this section.

We encourage the state to use this document "as is" to complete the assessment, but the state may use another format as long as the state provides all required content. The statewide assessment instrument is available electronically on the Children's Bureau website at <http://www.acf.hhs.gov/programs/cb/resource/round3-cfsr-statewide-assessment>.

Completing the Statewide Assessment

The statewide assessment must be completed in collaboration with state representatives who are not staff of the state child welfare agency (external partners or stakeholders), pursuant to 45 CFR 1355.33 (b). Those individuals should represent the sources of consultation required of the state in developing its title IV-B state plan and may include, for example, Tribal representatives; court personnel; youth; staff of other state and social service agencies serving children and families; and birth, foster, and adoptive parents or representatives of foster/adoptive parent associations. States must include a list of the names and affiliations of external representatives participating in the statewide assessment in section I of this instrument.

We encourage states to use the same team of people who participate in the development of the CFSP to respond to the statewide assessment. We also encourage states to use this same team of people in developing the PIP. Members of the team who have the skills should be considered to serve as case reviewers during the onsite review.

How the Statewide Assessment Is Used

Information about the state child welfare agency compiled and analyzed through the statewide assessment process may be used to support the CFSR process in a range of ways. The statewide assessment is used to:

- Provide an overview of the state child welfare agency's performance for the onsite review team;
- Facilitate identification of issues that need additional clarification before or during the onsite review;
- Serve as a key source of information for rating the CFSR systemic factors; and
- Enable states and their stakeholders to identify early in the CFSR process the areas potentially needing improvement and to begin developing their PIP approach.

THE PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104–13)

Public reporting burden for this collection of information is estimated to average 240 hours for the initial review and 120 hours for subsequent reviews. This estimate includes the time for reviewing instructions, completing the assessment, and reviewing the collection of information.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Statewide Assessment Instrument

Section I: General Information

Name of State Agency: Massachusetts Department of Children and Families

CFSR Review Period

CFSR Sample Period: October 1, 2014-May 15, 2015

Period of AFCARS Data: 2012A – 2014B

Period of NCANDS Data: FY 2013 and 2014

(Or other approved source; please specify if alternative data source is used):

Insert other approved data source

Case Review Period Under Review (PUR): October 1, 2014-September 24, 2015

State Agency Contact Person for the Statewide Assessment

Name: Ruben A. Ferreira

Title: Assistant Commissioner, Continuous Quality Improvement

Address: 600 Washington Street, Room 6321, Boston, MA 02111

Phone: 617-748-2165

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E-mail: ruben.ferreira@state.ma.us

Statewide Assessment Participants

Provide the names and affiliations of the individuals who participated in the statewide assessment process; please also note their roles in the process.

State Response:

Special thanks to the following for their contributions:

Virginia A. Peel, Senior Counsel, DCF

Rosalind M. Walter, Director of Data Management, DCF/EHS IT

Joy Cochran, Director of Foster Care Support Services, DCF

Andrea Cosgrove, Director of Program Operations, DCF

Vivian Davidovich, Director Foster Care Review, DCF

Leo Farley, Director of Adoption Support Services, DCF

Mary Gambon, Assistant Commissioner, Adoption, Foster Care & Adolescent Support, DCF

Andrew Todd Rome, General Counsel, DCF

Liz Skinner-Reilly, Federal Grants Coordinator, DCF

Susan Tucke, Director of Foster Care and Adoption Recruitment, DCF

John Vogel, Associate Director, Massachusetts Child Welfare Institute, DCF

Section II: Safety and Permanency Data

State Data Profile

Statewide data indicators – Summary of performance and potential program improvement goals

Table 1 shows, for each statewide data indicator, the periods of data used, the state's risk-standardized performance relative to the national standard, and the initial determination of whether the state must include the indicator in its Program Improvement Plan (PIP).

Table 1. Summary of performance against the National Standards

Indicator	State's Risk-Standardized Performance, National Standards (NS), and Children's Bureau's potential PIP Determination													
	using data submitted to the Children's Bureau as of July 10, 2014 (dataset used in initial NS determination)							using most recent data submitted as of April 16, 2015						
	12-month period ^a	Data used ^b	RSP ^c	95% interval ^d	National Standard ^e	Perform- ance relative to NS ^f	PIP	12-month period ^a	Data used ^b	RSP ^c	95% interval ^d	National Standard ^e	Perform- ance relative to NS ^f	PIP
Perm in 12 months (entries)	11B12A	11B – 14A	46.8	45.4 - 48.2	40.5%	Met	No PIP	12AB	12A – 14B	46.0	44.7 - 47.4	40.5%	Met	No PIP
Perm in 12 months (12-23 mos.)	13B14A	13B – 14A	40.0	37.8 - 42.2	43.6%	Not met	PIP	14AB	14A – 14B	34.2	32.2 - 36.3	43.6%	Not met	PIP
Perm in 12 months (24 + mos.)	13B14A	13B – 14A	24.7	23.2 - 26.3	30.3%	Not met	PIP	14AB	14A – 14B	24.2	22.6 - 25.7	30.3%	Not met	PIP
Re-entry to foster care in 12 mos.	11B12A	11B – 14A	14.0	12.6 - 15.5	8.3%	Not met	PIP	12AB	12A – 14B	13.6	12.3 - 15.1	8.3%	Not met	PIP
Placement stability ⁱ	13B14A	13B – 14A	5.37	5.22 - 5.51	4.12	Not met	PIP	14AB	14A – 14B	6.23	6.08 - 6.38	4.12	Not met	PIP
Maltreatment in foster care ^j	13AB, FY13	13AB, FY13	27.0 2	24.89 - 29.33	8.50	Not met	PIP	14AB, FY14	14AB, FY14	34.4 0	32.12 - 36.84	8.50	Not met	PIP
Recurrence of maltreatment	FY12-13	FY12-13	14.3	13.7 - 14.9	9.1%	Not met	PIP	FY13-14	FY13-14	22.4	21.8 - 23.1	9.1%	Not met	PIP

For indicators that must be included in a PIP, Table 2 shows the state's baseline performance and the potential PIP goal for the indicator based on the specified baseline period. If the indicator has a companion indicator, the table shows the state's baseline performance and threshold for the companion indicator.

Table 2. PIP Baselines, Goals and Thresholds (if applicable)

Indicator	Primary Indicator				Companion Indicator (if applicable)		
	12-month period used for Baseline	Baseline ^g	Adjusted Improvement Factor	PIP Goal	Baseline ^g	Adjusted Threshold Factor	Threshold ^h
Perm in 12 months (entries)	12AB						
Perm in 12 months (12-23 mos.)	14AB	33.1	1.082	35.8		Not applicable	
Perm in 12 months (24 + mos.)	14AB	24.3	1.091	26.5		Not applicable	
Re-entry to foster care in 12 mos.	12AB	13.4	0.891	11.9	46.3	.966	44.7
Placement stability ⁱ	14AB	6.53	0.904	5.90		Not applicable	
Maltreatment in foster care ^j	14AB, FY14	24.15	0.812	19.61		Not applicable	
Recurrence of maltreatment	FY13-14	17.6	0.903	15.9		Not applicable	

For descriptions of the indicators, including denominators, numerators, and exclusions, see the CFSR 3 Data Dictionary at the end of this document. For details about statistical terms and the Children's Bureau's approach to calculating the national standards, states' risk-standardized performance, and PIP baseline and goals, see the Federal Register notice, Statewide Data Indicators and National Standards for Child and Family Services Reviews published on 10/10/2014, the revisions published on 5/13/2015, and the amended Child and Family Services Technical Bulletin #8A published on 5/13/2015.

Table Footnotes

^a **12-month period:** The 12-month period specified in the denominator for this indicator. The FY periods (e.g., FY 12) refer to NCANDS data, which span the 12-month period Oct 1st – Sept 30th. All others refer to AFCARS data: 'A' refers to the 6-month period Oct 1st – March 31st. 'B' refers to the 6-month period April 1st – Sept 30th. The two-digit year refers to the calendar year in which the period ends (e.g., 13A refers to the 6-month period Oct 1st 2012 – March 31st 2013).

- ^b **Data used:** Refers to the initial 12-month period and the period(s) of data needed to follow the children to observe their outcome.
- ^c **RSP:** State's risk-standardized performance. The RSP is derived from a multi-level model and reflects the state's performance relative to states with similar children and takes into account the number of children the state served, the age distribution of these children, and, for some indicators, the state's entry rate.
- ^d **95% interval.** The 95% interval estimate reflects the amount of uncertainty associated with the RSP. For example, the Children's Bureau is 95% confident that the true value of the RSP is between the lower and upper limit of the interval.
- ^e **National Standard.** The observed performance for the nation as described in the aforementioned Federal Register notices.
- ^f **Performance relative to NS.** Indicates whether the state's 95% interval showed that the state met, did not meet, or was no different than the national standard (NS). "No Different" means the interval includes the NS. For indicators assessing permanency in 12 months, "Met" is used when the entire interval is above the NS and "Not Met" is used when the entire interval is below the NS. For the remaining indicators, "Met" is used when the entire interval is below the NS and "Not Met" is used when the entire interval is below the NS.
- ^g **Baseline.** Data Profiles may show a preliminary PIP baseline derived from the state's observed performance for the indicator using the most recent 12-month period of available data (shown in the next two tables, *Observed performance on permanency indicators* and *Observed performance on safety indicators*). At the time that a state PIP is due to CB, the baseline period is updated or specified and does not update with subsequent Profiles other than in certain situations when the state resubmits data for the baseline period.
- ^h **Threshold.** If the state must include permanency in 12 months (entries) in its PIP, the state must also not go above the threshold shown for re-entry to foster care. If the state must include re-entry to foster care in its PIP, the state must not go below the threshold shown for permanency in 12 months (entries).
- ⁱ Performance on **placement stability** is expressed as the number of moves per 1,000 days in care.
- ^j Performance on **maltreatment in foster care** is expressed as the number of victimizations per 100,000 days in care.

Observed performance on permanency indicators

	Denominator			Numerator			Percentage		
	11AB	11B12A	12AB	11AB	11B12A	12AB	11AB	11B12A	12AB
Permanency in 12 months (entries)	5138	4871	5101	2508	2282	2363	48.8%	46.8%	46.3%
Age at entry									
0 – 3 mos	479	464	461	155	152	146	32.4%	32.8%	31.7%
4 – 11 mos	218	223	237	104	94	92	47.7%	42.2%	38.8%
1 – 5 yrs	1180	1114	1174	584	501	507	49.5%	45.0%	43.2%
6 – 10 yrs	716	639	737	345	288	334	48.2%	45.1%	45.3%
11 – 16 yrs	2307	2209	2229	1250	1187	1209	54.2%	53.7%	54.2%
17 yrs	238	222	263	70	60	75	29.4%	27.0%	28.5%
Re-entry to care in 12 months	2500	2275	2350	313	305	314	12.5%	13.4%	13.4%
Age at exit									
0 – 3 mos	44	37	24	1	1	2	2.3%	2.7%	8.3%
4 – 11 mos	115	113	113	15	17	13	13.0%	15.0%	11.5%
1 – 5 yrs	623	543	553	60	66	65	9.6%	12.2%	11.8%
6 – 10 yrs	352	302	350	32	36	37	9.1%	11.9%	10.6%
11 – 16 yrs	1140	1069	1102	194	173	187	17.0%	16.2%	17.0%
17 yrs	226	211	208	11	12	10	4.9%	5.7%	4.8%

Observed performance on permanency indicators (continued)

	Denominator			Numerator			Percentage or Rate		
	2013AB	2013B14A	2014AB	2013AB	2013B14A	2014AB	2013AB	2013B14A	2014AB
Permanency in 12 months (12-23 mos.)	1904	1811	1961	766	701	649	40.2%	38.7%	33.1%
Age on 1 st day									
1 – 5 yrs	723	734	808	362	359	334	50.1%	48.9%	41.3%
6 – 10 yrs	362	333	362	144	135	119	39.8%	40.5%	32.9%
11 – 16 yrs	626	573	617	219	179	175	35.0%	31.2%	28.4%
17 yrs	193	171	174	41	28	21	21.2%	16.4%	12.1%
Permanency in 12 months (24+ mos.)	2613	2468	2430	727	599	590	27.8%	24.3%	24.3%
Age on 1 st day									
2 – 5 yrs	493	441	469	276	238	240	56.0%	54.0%	51.2%
6 – 10 yrs	509	497	507	200	169	169	39.3%	34.0%	33.3%
11 – 16 yrs	1192	1134	1050	222	173	152	18.6%	15.3%	14.5%
17 yrs	419	396	404	29	19	29	6.9%	4.8%	7.2%
Placement stability	766550	926482	993299	4513	5322	6483	5.89	5.74	6.53
Age at entry									
0 – 3 mos	81799	97420	125951	225	339	460	2.75	3.48	3.65
4 – 11 mos	41632	53292	54273	220	260	313	5.28	4.88	5.77
1 – 5 yrs	181916	246312	268019	1050	1501	2030	5.77	6.09	7.57
6 – 10 yrs	129336	155487	166938	819	901	1164	6.33	5.79	6.97
11 – 16 yrs	302924	337929	336586	2012	2118	2236	6.64	6.27	6.64
17 yrs	28943	36042	41532	187	203	280	6.46	5.63	6.74

Observed performance on safety indicators

	Denominator			Numerator			Rate		
	FY 2012	FY 2013	FY 2014	FY 2012	FY 2013	FY 2014	FY 2012	FY 2013	FY 2014
Maltreatment in foster care	3074546	3033398	3378310	530	568	816	17.24	18.72	24.15
Age at entry or on 1 st day									
0 – 3 mos	109880	118882	176664	12	24	46	10.92	20.19	26.04
4 – 11 mos	133835	142389	166192	19	36	38	14.20	25.28	22.87
1 – 5 yrs	771092	791886	949399	129	140	249	16.73	17.68	26.23
6 – 10 yrs	520706	546449	640144	130	111	176	24.97	20.31	27.49
11 – 16 yrs	1362051	1257757	1262248	227	236	281	16.67	18.76	22.26
17 yrs	176982	176035	183663	13	21	26	7.35	11.93	14.16
	Denominator			Numerator			Percentage		
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14	FY 2011-12	FY 2012-13	FY 2013-14
Recurrence of maltreatment	19942	19350	20427	1564	2147	3597	7.8%	11.1%	17.6%
Age at initial victimization									
0 – 3 mos	1418	1429	1621	140	222	354	9.9%	15.5%	21.8%
4 – 11 mos	998	1062	1149	80	129	257	8.0%	12.1%	22.4%
1 – 5 yrs	6671	6640	6811	622	750	1397	9.3%	11.3%	20.5%
6 – 10 yrs	5233	4985	5367	419	569	908	8.0%	11.4%	16.9%
11 – 16 yrs	5103	4729	4963	292	459	658	5.7%	9.7%	13.3%
17 yrs	484	491	514	11	18	23	2.3%	3.7%	4.5%
Missing	35	14	2	0	0	0	0.0%	0.0%	0.0%

Permanency context data

- Entry rates are calculated using Census population estimates as of July 1st of each year. Rates are shown in the 12-month period that includes July 1st, and uses the number of entries for that 12-month period as the numerator.
- Please note that the context data for entries, exits and children in care on the first day may not match the numbers shown in the section, “Observed performance on permanency indicators.” There are methodological differences in calculations of observed performance on the statewide data indicators that are not applied to the context data (e.g. data from additional periods used, records excluded due to data quality issues, exclusion of children with length of stay in care less than 8 days and youth age 18 and older). Additional information regarding differences are described in the Data Dictionary beginning on page 15 of this Profile.
- Context data provided below correspond with the data periods used in calculating observed performance on the statewide data indicators. Data periods that do not correspond to an indicator on this Profile are grayed out.

	Number							Percentage or Rate						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
Entry Rate														
Entry rate per 1,000 in child population								3.8	3.6	3.8	3.7	1.9	2.2	
Entries to Foster Care														
Number of children entering	5334	5079	5268	5151	5378	6269	6587							
Age at entry														
0-3 mos	473	460	461	475	526	674	781	8.9	9.1	8.8	9.2	9.8	10.8	11.9
4-11 mos	238	237	249	256	298	334	351	4.5	4.7	4.7	5.0	5.5	5.3	5.3
1-5 yrs	1241	1183	1231	1212	1282	1622	1766	23.3	23.3	23.4	23.5	23.8	25.9	26.8
6-10 yrs	764	694	782	822	883	1059	1140	14.3	13.7	14.8	16.0	16.4	16.9	17.3
11-16 yrs	2363	2260	2261	2110	2092	2226	2184	44.3	44.5	42.9	41.0	38.9	35.5	33.2
17 yrs	254	242	282	275	294	348	360	4.8	4.8	5.4	5.3	5.5	5.6	5.5
18 yrs and older	1	3	2	1	3	5	4	0.0	0.1	0.0	0.0	0.1	0.1	0.1
Missing	0	0	0	0	0	1	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Placement setting at end of report period														
Pre-adoptive home	56	67	53	60	80	74	98	1.0	1.3	1.0	1.2	1.5	1.2	1.5

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	Number							Percentage or Rate						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
Foster family home (relative)	969	970	1038	993	1150	1457	1489	18.2	19.1	19.7	19.3	21.4	23.2	22.6
Foster family home (non-	1980	1933	2014	1981	2052	2467	2493	37.1	38.1	38.2	38.5	38.2	39.4	37.8
Group home	678	708	689	690	703	760	741	12.7	13.9	13.1	13.4	13.1	12.1	11.2
Institution	153	143	139	159	155	176	204	2.9	2.8	2.6	3.1	2.9	2.8	3.1
Supervised independent living	17	15	14	11	16	21	28	0.3	0.3	0.3	0.2	0.3	0.3	0.4
Runaway	75	60	80	73	93	85	72	1.4	1.2	1.5	1.4	1.7	1.4	1.1
Trial home visit	1395	1174	1234	1177	1121	1218	1442	26.2	23.1	23.4	22.8	20.8	19.4	21.9
Missing	11	9	7	7	8	11	20	0.2	0.2	0.1	0.1	0.1	0.2	0.3
Number of removals														
1	4005	3802	3959	3865	4076	4867	5199	75.1	74.9	75.2	75.0	75.8	77.6	78.9
2	965	914	947	953	979	1053	1034	18.1	18.0	18.0	18.5	18.2	16.8	15.7
3	279	268	268	247	241	250	258	5.2	5.3	5.1	4.8	4.5	4.0	3.9
4 or more	85	95	94	86	82	99	96	1.6	1.9	1.8	1.7	1.5	1.6	1.5
Missing	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Exits from Foster Care														
Number of children exiting	5450	5473	5120	5075	5108	4984	5055							
Discharge reason														
Reunification	3181	3163	2873	2927	2940	2838	2961	58.4	57.8	56.1	57.7	57.6	56.9	58.6
Live with other relative(s)	218	211	197	157	173	250	296	4.0	3.9	3.8	3.1	3.4	5.0	5.9
Adoption	707	806	824	763	798	693	584	13.0	14.7	16.1	15.0	15.6	13.9	11.6
Guardianship	330	320	336	346	332	307	312	6.1	5.8	6.6	6.8	6.5	6.2	6.2
Emancipation	947	922	858	855	822	842	856	17.4	16.8	16.8	16.8	16.1	16.9	16.9
Transfer to another agency	64	48	28	25	43	52	42	1.2	0.9	0.5	0.5	0.8	1.0	0.8
Runaway	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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	Number							Percentage or Rate						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
Death of Child	3	3	4	2	0	2	4	0.1	0.1	0.1	0.0	0.0	0.0	0.1
Not applicable	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Length of stay in care														
Less than 8 days	220	225	186	124	159	227	246	4.0	4.1	3.6	2.4	3.1	4.6	4.9
8 days to 5 mos	1126	1080	1009	1015	1046	1118	1252	20.7	19.7	19.7	20.0	20.5	22.4	24.8
6 – 11 mos	1302	1288	1143	1199	1188	1120	1168	23.9	23.5	22.3	23.6	23.3	22.5	23.1
12 – 17 mos	649	704	714	695	709	697	669	11.9	12.9	13.9	13.7	13.9	14.0	13.2
18 - 23 mos	493	511	498	536	604	548	477	9.0	9.3	9.7	10.6	11.8	11.0	9.4
24 - 29 mos	397	379	380	378	314	300	290	7.3	6.9	7.4	7.4	6.1	6.0	5.7
30 – 35 mos	279	273	282	264	245	214	212	5.1	5.0	5.5	5.2	4.8	4.3	4.2
36 - 41 mos	259	230	188	196	190	175	181	4.8	4.2	3.7	3.9	3.7	3.5	3.6
42 mos or longer	725	783	720	668	653	585	560	13.3	14.3	14.1	13.2	12.8	11.7	11.1
Missing	0	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Children in Care 1 st day of 12-month period														
Number of children in care 1 st day					8230	7945	8318							
Length of stay in care (as of the 1 st day)														
Less than 6 mos					2323	1938	2498					28.2	24.4	30.0
6-11 mos					1431	1752	1448					17.4	22.1	17.4
12-23 mos					1871	1789	1936					22.7	22.5	23.3
24 mos or longer					2605	2466	2436					31.7	31.0	29.3
Missing					0	0	0					0.0	0.0	0.0
Children in Care 1 st day of 12-month period (12-23 mos.)														

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	Number							Percentage or Rate						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
Number of children in care 1 st day (12-23 mos)					1871	1789	1936							
Age on 1 st day														
1-5 yrs					714	730	793					38.2	40.8	41.0
6-10 yrs					360	329	360					19.2	18.4	18.6
11-16 yrs					607	555	605					32.4	31.0	31.3
17 yrs					190	171	174					10.2	9.6	9.0
18 yrs and older					0	4	4					0.0	0.2	0.2
Missing					0	0	0					0.0	0.0	0.0
Placement setting at end of report period														
Pre-adoptive home					202	183	189					10.8	10.2	9.8
Foster family home (relative)					446	446	493					23.8	24.9	25.5
Foster family home (non-					594	558	589					31.7	31.2	30.4
Group home					111	129	155					5.9	7.2	8.0
Institution					101	83	82					5.4	4.6	4.2
Supervised independent living					15	22	29					0.8	1.2	1.5
Runaway					43	37	38					2.3	2.1	2.0
Trial home visit					359	331	360					19.2	18.5	18.6
Missing					0	0	1					0.0	0.0	0.1
Number of removals														
1					1382	1327	1432					73.9	74.2	74.0
2					348	327	365					18.6	18.3	18.9
3					103	100	94					5.5	5.6	4.9
4 or more					38	35	45					2.0	2.0	2.3

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	Number							Percentage or Rate						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
Missing					0	0	0					0.0	0.0	0.0
Case plan goal														
Reunify					543	517	540					29.0	28.9	27.9
Live with other relative(s)					98	76	66					5.2	4.2	3.4
Adoption					769	755	817					41.1	42.2	42.2
Guardianship care					30	21	39					12.7	13.1	14.7
Long-term foster					238	235	284					1.6	1.2	2.0
Emancipation					192	185	190					10.3	10.3	9.8
Missing					1	0	0					0.1	0.0	0.0
Children in Care 1st day of 12-month period (24 + mos.)														
Number of children in care 1 st day (24+ mos)					2605	2466	2436							
Age on 1 st day														
2-5 yrs					492	440	469					18.9	17.8	19.3
6-10 yrs					508	494	506					19.5	20.0	20.8
11-16 yrs					1176	1127	1042					45.1	45.7	42.8
17 yrs					419	395	402					16.1	16.0	16.5
18 yrs and older					10	10	17					0.4	0.4	0.7
Missing					0	0	0					0.0	0.0	0.0
Placement setting at end of report period														
Pre-adoptive home					312	273	284					12.0	11.1	11.7
Foster family home (relative)					419	412	414					16.1	16.7	17.0
Foster family home (non-					1011	963	900					38.8	39.1	36.9
Group home					258	286	286					9.9	11.6	11.7

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	Number							Percentage or Rate						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
Institution					242	220	215					9.3	8.9	8.8
Supervised independent living					47	55	75					1.8	2.2	3.1
Runaway					62	68	58					2.4	2.8	2.4
Trial home visit					254	189	203					9.8	7.7	8.3
Missing					0	0	1					0.0	0.0	0.0
Number of removals														
1					1860	1759	1709					71.4	71.3	70.2
2					558	531	536					21.4	21.5	22.0
3					140	132	148					5.4	5.4	6.1
4 or more					47	44	43					1.8	1.8	1.8
Missing					0	0	0					0.0	0.0	0.0
Case plan goal														
Reunify					342	315	325					13.1	12.8	13.3
Live with other relative(s)					360	356	343					13.8	14.4	14.1
Adoption					1032	971	981					39.6	39.4	40.3
Guardianship care					304	282	282					11.7	11.4	11.6
Long-term foster					114	111	108					4.4	4.5	4.4
Emancipation					453	431	397					17.4	17.5	16.3
Missing					0	0	0					0.0	0.0	0.0

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Safety context data

	Number				Percentage or Rate			
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2011	FY 2012	FY 2013	FY 2014
Referrals received by CPS	73,294	75,439	75,560	77,974				
Screened-in	37,799	37,678	37,867	47,591	51.57	49.94	50.12	61.03
Screened-out	35,495	37,761	37,693	30,383	48.43	50.06	49.88	38.97
Children referred to CPS (duplicate)	123,813	126,623	126,722	136,511				
Screened-in	73,358	73,312	74,169	94,949	59.25	57.90	58.53	69.55
Screened-out	50,455	53,311	52,553	41,562	40.75	42.10	41.47	30.45
Screened-in rate (per 1,000 in child population)					43.92	44.06	44.76	55.09
Children screened-in (unique)	61,804	61,659	62,395	76,790				
Population of children 0-17	1,407,240	1,399,417	1,393,946	1,393,946				
Re-reported within 12 months (unique)	6,870	9,370	12,616	NA	15.60	22.37	32.74	NA
Children screened in, by dispositions (unique)								
Victims	20,221	19,191	20,261	31,825	32.71	31.11	32.46	41.42
Substantiated + Indicated	20,221	19,191	20,261	31,825	32.71	31.11	32.46	41.42
Alternative response victim								
Non-Victims	41,598	42,493	42,155	45,002	67.29	68.89	67.54	58.58
Alternative response non victim	19,028	21,222	20,041	13,883	30.78	34.40	32.11	18.07
Unsubstantiated	12,061	10,529	10,718	17,974	19.51	17.07	17.17	23.40
Other	10,509	10,742	11,396	13,145	17.00	17.41	18.26	17.11
Victimization rate (per 1,000 in child population)					9.72	9.31	14.53	22.82
Substantiated + Indicated (unique)	13,672	13,027	20,255	31,816				
Population of children 0 – 17	1,407,240	1,399,417	1,393,946	1,393,946				

Section III: Assessment of Child and Family Outcomes and Performance on National Standards

Instructions

Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance on each of the seven child and family outcomes. Review the information with the statewide assessment team and determine if more recent data are available that can be used to provide an updated assessment of each outcome. If more recent data are not available, simply refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each outcome. Analyze and explain the state's performance on the national standards in the context of the outcomes.

A. Safety

Safety Outcomes 1 and 2

Safety outcomes include: (A) children are first and foremost, protected from abuse and neglect; and (B) children are safely maintained in their own homes whenever possible and appropriate.

- For each of the two safety outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the two federal safety indicators, relevant case record review data, and key available data from the state information system (such as data on timeliness of investigation).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Safety Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the safety indicators.

State Response:

Children Are First And Foremost, Protected From Abuse And Neglect

The safety of children and families must be a primary focus for the Department of Children and Families (DCF or Department) in its role as the Commonwealth's child protection agency. Children and families experiencing risk of harm as a result of physical or sexual abuse, serious and ongoing neglect, or domestic violence, deserve our attention, compassion and intervention.

Research has shown that the safety of children and families is significantly enhanced when families and their broader familial, social and community network are engaged in the efforts to promote safety and mitigate the risk of harm. The Department has incorporated Andrew Turnell's, *Signs of Safety*, to ground efforts in this area; including the use of Safety Mapping. This approach encourages an emphasis on assessing the imminent safety and danger for a child and family, and identifying those factors/actions which may immediately restore safety and ameliorate risk of future harm.

While the Department has a unique and vital role in promoting the safety of children and families, it is not an exclusive role. Schools, community agencies, other service providers and community partners, must each be vigilant to indications that a child or family may be in danger. Further, they all must work collaboratively to address that risk. Only through these collective efforts will the occurrence of maltreatment be effectively reduced.

Following a high profile safety-related incident, Massachusetts enlisted the Child Welfare League of America (CWLA) to conduct a thorough, independent review of the Department to help inform DCF policies and practices and identify areas for action in the short-and long-term. Recommendations included:

- **Staffing and Budget** – a comprehensive workforce strategy including adequate allocation of frontline, supervisory, and managerial staff to stabilize the caseload; the use of specialized substance abuse, health, mental health and domestic violence staff in each area office; along with credentialing, training, hiring and workforce supports.
- **Technology** – support for the Department's initiative to provide workers with mobile technology, allowing them the ability to have immediate contact with supervisors and

emergency personnel, document visits in real-time and upload photos of children to the Massachusetts SACWIS.

- **Policy and Practice (ICPM)** – the Department's Integrated Case Practice Model (ICPM) rolled out in 2009, is at a crossroads in its development and use. The Department will address inconsistencies in implementation and concerns regarding DCF's case practice model.
 - DCF should develop clear protocols for evaluating risks to children living at home using Structured Decision Making tools & safety assessments to assist workers.
 - ICPM Re-tool and re-launch.
- **Policy and Practice (0-5 year olds)** – continuation of the Department's directive to screen in for investigations any report alleging abuse or neglect of a child five years old or younger with young parents or any parent with a history of substance abuse, domestic violence, mental health issues, or unresolved trauma.
 - Screening and assessing according to the directive should continue until such time as safety and risk assessment protocols and the case practice model have been implemented consistently across the state, and a quality improvement plan has been developed.
- **Medical Services** – the addition of medical staff to area offices. At each DCF area office, staff should be responsible for conducting a medical triage within 24-hours of each child's entry into care to identify any significant medical needs.
- **Substance Abuse** – recognizing the significant challenges posed by the opioid abuse epidemic, CWLA recommends DCF, Department of Public Health (DPH), lawmakers, substance abuse programs, and other community partners should work together to develop a plan to increase the funding for and availability of substance abuse programs in the Commonwealth to parents and expectant parents.
- **Quality Improvement** – build on existing protocols to implement a comprehensive quality improvement process.

Chart S1. STATE DATA PROFILE
CA/N Reports & Children In Placement

	FY2013		FY2014	
Total CA/N Reports Disposed	37,867		47,591	
Substantiated	14,071	37.2%	22,282	46.8%
Unsubstantiated	8,161	21.6%	13,771	28.9%
Other	15,635	41.3%	11,538	24.2%
*Children Served in Placement	13,609		14,907	

**Children in Placement on last day of year + discharges during year.*

Data Source: ACF Data Profile May 19, 2015

Significant year-over-year increases are evident when comparing total CA/N reports disposed between FY2013 and FY2014 (25.7% increase). During the same time period a significant increase in substantiation rates was also observed (25.8%). The number of children served in placement increased 9.5%.

Timeliness of Initiating Investigations of Reports of Child Maltreatment

Safety Outcomes 1 and 2 include timeliness of initiating investigations of reports of child maltreatment. The initiation of timely CPS responses and face-to-face contacts with children involved in screened-in reports of alleged maltreatment is a primary means of ensuring the safety of children. The 2007 Child and Family Services Review identified timely initiation of investigations of reports of child maltreatment as an area needing improvement. With a strength rating of 64.0%, DCF exceeded the 2007 PIP Negotiated Improvement Goal of 58.2% for two (2) consecutive quarters following its baseline review.

Performance on this indicator was assessed utilizing a PIP case review instrument developed by the Massachusetts DCF and approved by the Children's Bureau. The Department contracted with the *Center for the Support of Families* (CSF) to conduct its PIP case reviews. The following findings relative to timeliness of initiating investigations of reports of child maltreatment came out of CSF's reviews:

Highlights of Quality Case Practice

- DCF was found to have a general strength in the timely initiation of response reports across all PURs and response types.
- Emergency responses were found to be consistently initiated timely and reported children were seen within the required 24-hour window.
- Investigations were found to generally be both initiated in a timely manner and were thoroughly completed with sound, well-reasoned judgment.
- Response reports with allegations of neglect, the most common allegation, were found to be relative strengths compared to other allegation types.

Areas for Improvement in Case Practice

- Non-emergency response reports lacked the strength and consistency of practice of emergency responses, and to a lesser extent initial assessments (differential response), particularly as it relates to seeing reported children within three (3) business days of assignment.
- On some reviewed cases, workers neglected to see all reported or non-reported children listed in the response report.

While the Department met its 2007 PIP Negotiated Improvement Goal on timely initiation and seeing children involved in responses to reports of alleged child maltreatment, DCF recognizes this as an area requiring additional focus. Toward this end, focused safety and risk-related case reviews were conducted on behalf of the Department during the months of March through June of 2014. These case reviews included both a quantitative and qualitative assessment of timeliness of initiating investigations (see *Safety And Risk-Related Case Reviews* at the end of this section for additional details). Findings from these case reviews, indicate that 84.7% of investigations of reports of child maltreatment were completed in a timely manner. The Department is utilizing findings from this safety and risk-related review to highlight trends and identify barriers to meeting the response timeframes; with the goal of improving timeliness.

SAFETY OUTCOMES: Maltreatment in Foster Care & Recurrence of Maltreatment

Reducing the incidence of maltreatment in foster care and recurrence of maltreatment is an important measure of the Department's success in promoting the safety of children and families and identified as areas needing improvement in the 2007 Child and Family Services Review. The Department monitors maltreatment in foster care and recurrence of maltreatment on open and closed cases on a monthly/quarterly/annual basis as a component of its performance management and accountability system.

Chart S2.

Indicator	State's Risk-Standardized Performance, National Standards (NS), and Children's Bureau's potential PIP Determination						
	using most recent data submitted as of April 16, 2015						
	12-month period ^a	Data used ^b	RSP ^c	95% interval ^d	National Standard ^e	Performance relative to NS ^f	PIP
Maltreatment in foster care ^j	14AB, FY14	14AB, FY14	34.40	32.12 - 36.84	8.50	Not met	PIP
Recurrence of maltreatment	FY13-14	FY13-14	22.4	21.8 - 23.1	9.1%	Not met	PIP

The Department of Children and Families has historically fallen below the national standard for *Maltreatment in Foster Care* and *Recurrence of Maltreatment*. As evidenced in Chart S2 above, children in the care and custody of DCF are experiencing more *Maltreatment in Foster Care* than the recalculated national standard of 8.50 per 100,000 days in care. Further, the Department is evidencing increasingly more incidences of *Recurrence of Maltreatment* than the recalculated national standard of 9.1%. Both of these safety indicators necessitate PIP Goals, which for the baseline time period specified in the CB generated State Data Profile are:

- Maltreatment in Foster Care – 14AB, FY14 = 19.61 per 100,000
- Recurrence of Maltreatment – FY13-14 = 15.9%

The Department has identified maltreatment in foster care and recurrence of maltreatment as priority areas of focus and has thus far enumerated the following strategies to more effectively assess risk and reduce maltreatment:

1. Provide additional training using the "Signs of Safety" approach for staff.
2. Fully implement safety and risk assessment tools.
3. Develop critical pathways to support consistent decision-making in casework practice.
4. Increase collaboration with fellow state agencies, community partners, law enforcement, and the schools to identify additional strategies for reducing maltreatment and promoting the safety of children and families.

The commitment to promote safety and reduce maltreatment requires a systemic approach and the Department has integrated the following additional strategies into its strategic plan:

- Training that is targeted across the agency for social workers, supervisors and management to support a commonly held framework of best case practice.
- Supporting community connected practice that includes relationship building with District Attorney offices, mandated reporters and police departments.
- Improving ties with the community to reduce repeat maltreatment by preventing crises and supporting earlier responses.

- Sharing information and replicating effective practice about successful engagement through maximized use of regularly scheduled and ad hoc meetings within DCF and with community partners.
- Disseminating learning from critical incidents and investigations regarding best case practices and opportunities for improvement.
- Supporting the critical role of supervisors in setting expectations and promoting quality case practice.
- Expanding communication and collaboration with collaterals to ensure independent verification of family perceptions.
- Communicating DCF's role as a preventive social service agency – not solely the agent of child protection – through community resource building.
- Empowering parents to have a real voice in decision making in family meetings at the outset of their involvement with DCF.
- Establishing a practice approach and implementing structures/tools necessary to proactively support families in addressing factors that contribute to risk of harm, and thereby minimize the need for reactionary and crisis oriented responses.

Children Are Safely Maintained In Their Own Homes Whenever Possible And Appropriate

Assuring the safety of children and mitigating risk to the safety of children is a cornerstone of child welfare practice. One aspect was assessed in the Department's 2007 Child and Family Services Review: Services to Protect Children and Prevent Removal or Re-Entry into Foster Care. This item was identified in the 2007 CFSR as an area needing improvement. With a strength rating of 96.3%, DCF met and exceeded the 2007 PIP Negotiated Improvement Goal of 94.2%% for two (2) consecutive quarters following its baseline review.

The case review conducted by CSF for the Department's 2007 PIP looked at several aspects of this area of practice; including services provided to families to protect children maintained in their homes and prevent removal. This item measures the extent to which child welfare agencies access necessary services and supports for families to either prevent removal or prevent re-entry. Specifically, this item asks whether the agency made efforts to provide or arrange for these services and, if children did in fact need to be removed from their home, was it done to ensure their safety.

CSF's 2007 PIP case review findings revealed that the Department showed a significant strength when it came to providing services to families to protect children and prevent removal or re-entry into foster care. DCF achieved a strength rating on this item early on during its PIP. Case reviews revealed that safety-related and crisis services were regularly provided or accessed for children and their families to meet the immediate or emerging danger for children. More recent focused case reviews on in-home cases suggest that there is currently room for improvement (e.g., matching services to needs and monitoring services provided to families).

As described in the *Service Array* section of this statewide assessment, Massachusetts has re-designed and re-procured its residential (congregate care) service system. This service system, *Caring Together* integrates congregate care treatment and home or community based treatment under a single service model. *Caring Together* allows providers to serve children and families on a continuous basis regardless of where the child is living. If a child meets the criteria for a residential level of service, it does not preclude providing that intensity of service in the child's

home. It also allows for eligible programs to be primarily a community based model with placement as an adjunct service, or to primarily be an out of home treatment model with services that follow the child back into the community. For some families it will be possible for children to remain at home or have a very brief episode of out of home placement.

Risk Of Harm To Child

This was identified in the 2007 CFSR as an area needing improvement. With a strength rating of 82.3%, DCF exceeded the 2007 PIP Negotiated Improvement Goal of 59.4% for two (2) consecutive quarters following baseline review. The following findings came out of the PIP case reviews conducted by CSF on behalf of the Department utilizing a case review instrument (limited to record review) agreed upon by the Children's Bureau and Massachusetts DCF:

Highlights of Quality Case Practice

- DCF does a credible job at the beginning of a case, particularly as it relates to upfront or initial assessment of safety and risk; whether formalized tools are utilized or not.
- Providing services to both keep children safe in their home and prevent removal/re-entry and to respond to children in crisis were noted as strong practices.
- Though consistent use of the formalized Assessment of Danger and Safety tool is not present, when implemented, these tools were generally accurate and timely; leading to better decision making. This finding is further supported by recent focused case reviews on in-home cases.
- Once assigned, investigations were found to be initiated in a timely manner.

Areas for Improvement in Case Practice

- While initial assessments of safety and risk were found to be practice strengths, ongoing assessments of safety and risk were done on a more inconsistent basis; possibly due to the reliance on informal as opposed to formal methodologies.
- The Assessment of Safety and Danger tool was found at times to be inaccurately used by staff, inadequately identifying risk and safety factors, and safety and risk factors and decisions were not well described in the instruments reviewed.
- Inconsistent initiation of safety planning in cases where domestic violence was present.
- Quality of visitation with both children and their parents was most often an area needing improvement; mainly due to lack of engagement.
- Children were often not the focus of visits and documentation was lacking regarding workers' individual interactions with children during visits.
- Though initiation of investigations was found to be a strength, timely interviewing of victim children at the initiation of a response was found to be an area needing improvement. This finding was supported in the Department's focused case reviews on in-home cases.

While the Department met its 2007 PIP Negotiated Improvement Goal on *Risk of Harm to Child*, DCF recognizes this as an area requiring additional focus. Toward this end, the findings from focused safety and risk-related case reviews (see below for additional details) are being utilized to address and improve practices related to risk of harm to children.

Safety And Risk-Related Case Reviews

As a correlate to its foster care review system which assesses the safety and quality of care provided to children/youth in out-of-home care, the Department enlisted the *Center for the Support of Families* (CSF) to conduct safety & risk-related case reviews on children and families in the DCF in-home population. These case reviews provided insight into safety and risk-related practice issues present in DCF's work with children and families. Because DCF is able to supplement its review of outcomes and certain performance indicators through aggregate data reports, this review was designed to explore the "practice behind the numbers" in order to provide insight into which practices are working well and which merit attention for improvement.

The Department worked with CSF to develop a case review instrument that systematically guided these in-home safety and risk-related case reviews. Review instrument development was informed by findings relating to child safety and risk from case reviews conducted by CSF in 2008 on behalf of the Department. These findings sort into the following thematic categories:

- A need for improved use of the Safety and Risk Assessment Tool, including identification of parental protective capacities;
- A need for attention to caseworker visits with children and parents;
- A need for improved engagement of family members;
- A need for timely initiation of CPS responses and face-to-face contacts with children involved in screened-in reports of alleged maltreatment; and
- A need to identify and consider underlying issues within families contributing to maltreatment of children.

The Department's Safety and Risk-Related Review Instrument probed the quality of safety and risk-related activities for each of the thematic categories identified above. Safety and risk-related reviews were conducted in ten (10) area offices on two-hundred (200) randomly selected in-home cases. The Department's leadership team reviewed the report during September of 2014 and incorporated findings into its performance management and accountability system.

CPS Referrals Received by DCF

As found in the CB generated CFSR Round 3 Data Profile and indicated in Chart S3 below, CPS referrals increased between FY2011 and FY2014. This 6.4% rise in referrals tracks with the occurrence of several high profile child fatalities during the same time period. CPS referrals are tracked at the state/region/area office level and have continued to rise through FY2015; albeit less steeply.

Chart S3.

	Counts of Referrals Received by DCF			
	FY2011	FY2012	FY2013	FY2014
Referrals received by CPS	73,294	75,439	75,560	77,974

Screen-in Rates

As found in the CB generated CFSR Round 3 Data Profile and indicated in Chart S4 below, screen-in rates have risen significantly between FY2011 and FY2014. This 25.4% rise in screen-in rates, which tracks with the occurrence of several high profile child fatalities during the same time period, climbed at a greater rate than referral rates. Screen-in rates are tracked at the state/region/area office level and have begun to stabilize in FY2015.

Chart S4.

	Rate per 1,000 in Child Population per CB CFSR Round 3 Data Profile			
	FY2011	FY2012	FY2013	FY2014
Screen-in rate	43.92	44.06	44.76	55.09

Victimization Rates

As found in the CB generated CFSR Round 3 Data Profile and indicated in Chart S5 below, victimization rates have risen significantly between FY2011 and FY2014. This dramatic 134.8% rise in screen-in rates, which tracks with the occurrence of several high profile child fatalities during the same time period, rose at a greater rate than screen-in rates. Victimization rates are tracked at the state/region/area office level and have begun to stabilize in FY2015.

Chart S5.

	Rate per 1,000 in Child Population per CB CFSR Round 3 Data Profile			
	FY2011	FY2012	FY2013	FY2014
Victimization rate	9.72	9.31	14.53	22.82

Entry Rates

As indicated in Chart 1, the number of children served in placement increased 9.5% between FY2013 and FY2014, and has continued through FY2015. As evidenced in Chart S6 below, the Department's rate of entry per 1,000 children had been lower than the national average through FY13B14A, but is presently on the rise.

Chart S6.

Entry Rate	Rate per 1,000 in Child Population per CB CFSR Round 3 Data Profile						
	11AB	11B12A	12AB	12B13A	13AB	13B14A	14AB
All Ages	3.8	3.6	3.8	3.7	1.9	2.2	missing
0-3 months	8.9	9.1	8.8	9.2	9.8	10.8	11.9
4-11 months	4.5	4.7	4.7	5.0	5.5	5.3	5.3
1-5 years	23.3	23.3	23.4	23.5	23.8	25.9	26.8
6-10 years	14.3	13.7	14.8	16.0	16.4	16.9	17.3
11-16 years	44.3	44.5	42.9	41.0	38.9	35.5	33.2
17 years	4.8	4.8	5.4	5.3	5.5	5.6	5.5
18 years and older	0.0	0.1	0.0	0.0	0.1	0.1	0.1

B. Permanency

Permanency Outcomes 1 and 2

Permanency outcomes include: (A) children have permanency and stability in their living situations; and (B) the continuity of family relationships is preserved for children.

- For each of the two permanency outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the four federal permanency indicators and relevant available case record review data.
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Permanency Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the permanency indicators.

State Response:

PERMANENCY OUTCOME 1:

Children Have Permanency And Stability In Their Living Situations

Every child is entitled to a safe, secure, appropriate and permanent home. Permanency is achieved when a child is living successfully in a family that the child, parents and other stakeholders believe will endure throughout their lifetime. Permanency, identified as meaning "family" suggests not only a stable setting, but also stable parents and peers, continuous supportive relationships and parental commitment and affection.

Any change in a child's family is disruptive of established relationships and the comforts, familiar rhythms and normal routines of life. Continuity in caring relationships and consistency of settings and routines are essential for a child's sense of identity, security, attachment, trust and optimal social development.

The Department of Children and Families (DCF or Department) has historically placed the emphasis for permanency on the processes of adoption or guardianship that begin after stabilization and reunification have failed. In the areas of adoption and guardianship, the Department has developed the expertise to effectively expedite those complicated legal and clinical processes. Our more recent focus has been expanded to revitalize our efforts to *stabilize and preserve families, or to reunify families*. This focus requires that the Department, and our partners, include permanency as a central component at all junctures in working with a family. Recent revisions to the Department's Permanency Planning Policy highlight that the responsibility for permanency starts upon initial contact with the family and continues throughout the agency's involvement. It is the role of *all* DCF staff to pursue permanency for families; regardless of the function to which a staff person is assigned.

The Department's work on improving permanency for children and families involved with DCF is grounded in the following tenets.

- Permanency is the work of the entire agency.
- Stabilization and reunification are successful permanency outcomes.
- The Department values and includes the voice of families.

- Respect for the connections amongst and to family is incorporated into the Department's expectations for case practice.
- The Department honors the cultural and linguistic identities of families.
- Enhanced tools and technology support permanency activities.
- Resource development and capacity building is connected to achieving permanency.

The Department has made significant progress on a number of indicators related to permanency. Despite these improvements, DCF has not yet achieved the national standards on each of the permanency composite indicators. Massachusetts anticipates that fidelity to its revised Permanency Planning Policy will result in improved outcomes.

Chart P1.

State's Risk-Standardized Performance, National Standards (NS), and Children's Bureau's potential PIP Determination							
using most recent data submitted as of April 16, 2015							
Indicator	12-month period ^a	Data used ^b	RSP ^c	95% interval ^d	National Standard ^e	Performance relative to NS ^f	PIP
Perm in 12 months (entries)	12AB	12A – 14B	46.0	44.7 - 47.4	40.5%	Met	No PIP
Perm in 12 months (12-23 mos.)	14AB	14A – 14B	34.2	32.2 - 36.3	43.6%	Not met	PIP
Perm in 12 months (24 + mos.)	14AB	14A – 14B	24.2	22.6 - 25.7	30.3%	Not met	PIP
Re-entry to foster care in 12 mos.	12AB	12A – 14B	13.6	12.3 - 15.1	8.3%	Not met	PIP

In order to support the strengths of children and families and address the needs that brought them to the attention of the Department, effective service delivery and permanency planning is critical to ensuring that children are returned to their homes as quickly and safely as possible and that caregivers have the capacity to ensure the safety and well-being of their children. As noted in Chart P1 above, the Department has been meeting the national standard of moving children to permanency within 12 months of entering care. This notwithstanding, the Department is challenged to meet the national standards for those children who remain in care longer than 12 months. Both of these permanency indicators necessitate PIP Goals, which for the baseline time period specified in the CB generated State Data Profile are:

- Permanency in 12 Months (12-23 mos.) – 14AB = 35.8%
- Permanency in 12 Months (24 + mos.) — 14AB = 26.5%

The Department contracted with the *Center for the Support of Families* (CSF) to conduct its 2007 PIP case reviews. The following recommendations were made by CSF as part of the Department's 2007 PIP focused case reviews:

- Ensure provisions are included in contracts with provider agencies that are continuously monitored by DCF staff to focus on completed and appropriately filled out documentation,
 - including treatment plan progress updates, and updated treatment plans as case circumstances change;
- Develop policy and practice guidance supporting the engagement of youth in achieving permanency when the goal involves independent living; including services, placement, education and income planning, at an earlier age.

- A trigger for this could be the moment the goal changes to APPLA, or as soon as the child turns 14, whichever comes first; and
- For youth who are struggling to maintain stability in their placements, develop policy, training and guidance regarding when to convene meetings to determine the most appropriate placement for meeting the youths' presenting needs; even if that means a step up in care to stabilize behaviors.

These recommendations were incorporated into the Department's new Permanency Planning Policy. The Department's recently established CQI Unit (see *Quality Assurance* section of this document) will conduct systematic case reviews to assess practice fidelity to this new policy.

Though the Department recognizes that performance on *Permanency in 12 Months for Children Entering Care* has improved, performance on *Re-entry to Foster Care in 12 Months* has trended upward in each of the past five (5) years. The Department acknowledges that these paired measures are interrelated and that successful reunification necessitates that services be in place to stabilize exits to permanency and mitigate factors leading to reentry. Toward this end, DCF anticipates improvement on both sets of measures as a planned outcome of Caring Together (see *Service Array* section of this document). The Department's performance on *Re-entry to Foster Care in 12 Months* necessitates a PIP Goal, which for the baseline time period specified in the CB generated State Data Profile is:

- Re-entry to Foster Care in 12 Months – 12AB = 11.9%

Placement Stability

Stability of children who are in out-of-home care is an important indicator of the Department's efforts to achieve permanency for children and families. Multiple moves disrupt a child's ability to maintain connections with family and to develop the connections needed for positive emotional and social growth. Furthermore, instability in placement significantly impacts a child's educational achievement. Research has also shown that the more frequently a child moves subsequent to a home removal, the longer the timeframe for reunification.

Chart P2.

State's Risk-Standardized Performance, National Standards (NS), and Children's Bureau's potential PIP Determination							
using most recent data submitted as of April 16, 2015							
Indicator	12-month period ^a	Data used ^b	RSP ^c	95% interval ^d	National Standard ^e	Performance relative to NS ^f	PIP
Placement stability	14AB	14A – 14B	6.23	6.08 - 6.38	4.12	Not met	PIP

Placement Stability is another indicator where the Department did not meet the national standard as shown in Chart P2. This permanency indicator necessitates a PIP Goal, which for the baseline time period specified in the CB generated State Data Profile is:

- Placement Stability – 14AB = 5.90 per 1,000 days in care

Placement stability was identified as an area needing improvement in the 2007 CFSR. As such, the Department worked with the *National Resource Center for Data and Technology* (NRCDT) to analyze DCF data; to identify specific opportunities for improving placement stability. When NRCDT's analysis was complete, a Placement and Educational Stability Steering Committee

was convened to establish the following set of recommendations and to guide the following steps:

- **Kin First.** NRCDDT's findings strongly suggested that placement stability would be improved through a focused effort to increase the use of kinship placement as a first placement whenever a child needed to be removed from home. To this end, the Department initiated a "kin first" strategy.
- **Intensive Foster Care.** Following additional NRCDDT findings which highlighted placement *instability* within Intensive Foster Care (IFC), the Department worked with its IFC providers to identify and implement strategies for improving stability.
- **Supportive Child Care.** Another important component of the Department's work included the establishment of a Memorandum of Understanding (MOU) with the Department of Early Education and Care (EEC). The MOU sought to improve access to supportive child care slots for foster parents, and to extend supportive child care for up to six (6) months after a child returned home and the DCF case closed.

Placement with Kin

The Department has increased efforts to identify kin as a placement alternative when out of home placement is necessary. These efforts have resulted in significantly increasing the ratio of kinship placements compared to non-kinship. The Department had observed a subsequent improvement in placement stability, but the revised indicator shows increased instability.

	DCF Target	SFY'08	SFY'09	SFY'10	SFY'11	SFY'12	SFY'13	SFY'14	SFY'15
Kinship Care Rate Kinship as a % of all children in out-of-home placement	≥ 28.5%	19.2%	22.6%	22.7%	24.5%	26.0%	26.9%	29.4%	31.5%

Data Source: MA DSSRP210 – Children in Placement

At the end of SFY2015, 31.5% of all children in out-of-home placement were placed with kin. This represents a 64.1% increase over SFY2008. In an effort to identify disproportionality in utilization and address disparity in outcomes, this indicator is tracked by race/ethnicity.

	DCF Target	SFY'10	SFY'11	SFY'12	SFY'13	SFY'14	SFY'15
Kinship Care as a % of Departmental Foster Care*	≥ 55.0%	46.4%	48.1%	51.4%	52.1%	53.1%	56.3%

*Departmental Foster Care = foster family

Data Source: MA DSSRP210 – Children in Placement

At the end of SFY2014, 56.3% of all children in Departmental Foster Care (i.e., foster family home) were placed with kin. This represents a 21.3% increase over SFY2010. In an effort to identify disproportionality in utilization and address disparity in outcomes, this indicator is tracked by race/ethnicity.

PERMANENCY OUTCOME 2:

The Continuity Of Family Relationships And Connections Is Preserved For Children

As part of its 2007 CFSR PIP, the Department developed practice expectations for engagement of fathers. Toward this end, a number of activities to promote *Father Engagement* throughout DCF involvement with a family – from screening through ongoing case management, have been undertaken. Toolkits on *Father Engagement* serve as a resource for social workers and supervisors. Area office social workers consult the *Tip Sheets* for ideas on how to approach specific topics as they develop approaches to more effectively engage fathers. Supervisors also utilize the *Tip Sheets* during supervision to assist in guiding the course of casework practice.

Similar to *Father Engagement*, the Department committed to expanding its effort on the identification of kin before the comprehensive assessment and service planning process. As such, identification of kin has been incorporated into the Department's revised intake guidance. The identification of kin is now incorporated into screening activities, as well as during Investigation or Initial Assessment responses. In addition, the Department developed a *Kinship Fact Sheet* that can be completed by families during their initial contact with the agency.

C. Well-Being

Well-Being Outcomes 1, 2, and 3

Well-being outcomes include: (A) families have enhanced capacity to provide for their children's needs; (B) children receive appropriate services to meet their educational needs; and (C) children receive adequate services to meet their physical and mental health needs.

- For each of the three well-being outcomes, include the most recent available data demonstrating the state's performance. Data must include relevant available case record review data and relevant data from the state information system (such as information on caseworker visits with parents and children).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Well-Being Outcomes 1, 2, and 3.

State Response:

A child and family's well-being is directly related to their safety and permanency, and encompasses a range of other factors that contribute to quality of life. The Department of Children and Families (DCF or Department) is committed to the well-being of the children and families it serves. As such, DCF has been focusing attention on assisting families in the identification and development of the skills, connections and self-identity that contribute to a positive sense of personal worth.

Well-being for individuals begins with a strong self-identity, a purpose in life and emotional connections. A family's well-being is reflected in the ability to function as a unit in the home and community with satisfaction/enjoyment. Family well-being is enhanced through the ability to function independently; without the support of an external structured/formal system. Like family well-being, a child's well-being is reflected in the ability to function successfully in home, school and the community with satisfaction/enjoyment. A child's well-being is dependent upon physical health, mental/behavioral, social/emotional and educational needs being met. Every child and family deserves to experience a sense of well-being that includes the opportunity to grow and to develop a sense of mastery in their home, school and community.

The following approaches are the focus of the Department's efforts to improve the well-being of children and families:

- A trauma informed clinical practice model guides casework practice.
- Positive Youth Development approaches are integrated into casework practice.
- Domestic violence, substance abuse and mental health are assessed/addressed.
- Children receive needed medical and dental services.
- Access to appropriate educational services and achievement of educational/vocational goals are promoted.
- Parents and children are actively engaged in identification of strengths and needs and in service planning.
- A child's relationship with his/her father is actively supported.

- The cultural identity of child and family is recognized and supported.

These approaches are reaffirmed in the Department's strategic plan and through the implementation of priority activities integrated throughout casework practices.

WELLBEING OUTCOME 1:

Families Have Enhanced Capacity To Provide For Their Children's Needs

In order to best serve children and their families, it is critical for child welfare agencies not only to assess the strengths and needs of children/parents and access services based on those assessments, but also to engage and empower the family to enhance capacity to ensure the safety, permanency and well-being of their children.

Assessment and Service Planning with Parents

As part of its 2007 CFSR PIP, the Department utilized case reviews to assess the extent to which the agency conducts an initial/ongoing informal or formal assessment of children, parents, and foster parents' strengths and needs, as well as whether appropriate services are put in place to address the identified needs based on these assessments. With a strength rating of 76.2%, DCF exceeded the PIP Negotiated Improvement Goal of 46.6% for two (2) consecutive quarters following baseline review.

Child and Family Involvement in Service Planning

As part of its 2007 CFSR PIP, the Department utilized case reviews to assess whether DCF makes concerted efforts to actively involve children, birth mothers and birth fathers in the entire case planning process. With a strength rating of 69.3%, DCF exceeded the PIP Negotiated Improvement Goal of 49.1% for two (2) consecutive quarters following its baseline review.

Performance on the above two indicators was assessed utilizing a PIP case review instrument developed by the Massachusetts DCF and approved by the Children's Bureau. The Department contracted with the *Center for the Support of Families* (CSF) to conduct its 2007 PIP case reviews. The following findings came out of CSF's reviews:

Highlights of Quality Case Practice

- Demonstrated strength in conducting assessments of strengths/needs and subsequent provision of needed services for children and parents involved with the agency.
- Practice reflects the importance of engaging case members and maintaining/developing connections for children in out of home care.
- Active preparation of children and their out-of-home caregivers for placement; oftentimes ensuring that prior meetings were held to promote a smooth transition/appropriate fit.
- Effective work connecting all case members with culturally competent services when cultural differences are identified.
- Tasks in service plans and referred/provided services are tailored to reflect the individual strengths and needs of the family and in particular, the parents.
- Service coordination and communication with providers.

Areas for Improvement in Case Practice

- Trend of lack of involvement of ALL key case members. While most key case members are involved in case activities, oftentimes one key case member is not involved.

- Failure to consistently involve children and birth fathers in case planning activities—for in-home cases.
- Although service plans are generally tailored to the needs of the family, plans often inadequately address child-specific tasks.

Caseworker Visits with Child

As part of its 2007 CFSR PIP, the Department utilized case reviews to assess the extent to which both the frequency and quality of case worker visits with children was sufficient to ensure their safety, permanency and well-being. With a strength rating of 82.3%, DCF exceeded the PIP Negotiated Improvement Goal of 75.6% for two (2) consecutive quarters following its baseline review

Caseworker Visits with Parents

As part of its 2007 CFSR PIP, the Department utilized case reviews to assess the extent to which case workers have sufficient frequency and quality of visits with both mothers and fathers to ensure the safety and well-being of children. With a strength rating of 68.7%, DCF exceeded the PIP Negotiated Improvement Goal of 54.4% for two (2) consecutive quarters following its baseline review.

Social Worker Contacts – Jun-2015

Research demonstrates that regular visits from social workers significantly improve positive outcomes for children and families; including permanency. Contact with children and with families is tracked on a monthly basis in the Department's *Worker Contact with Consumers Monthly Report*. While not reflected in the Department's summary data below, many children and families, particularly during periods of crisis, are seen more frequently than once per month.

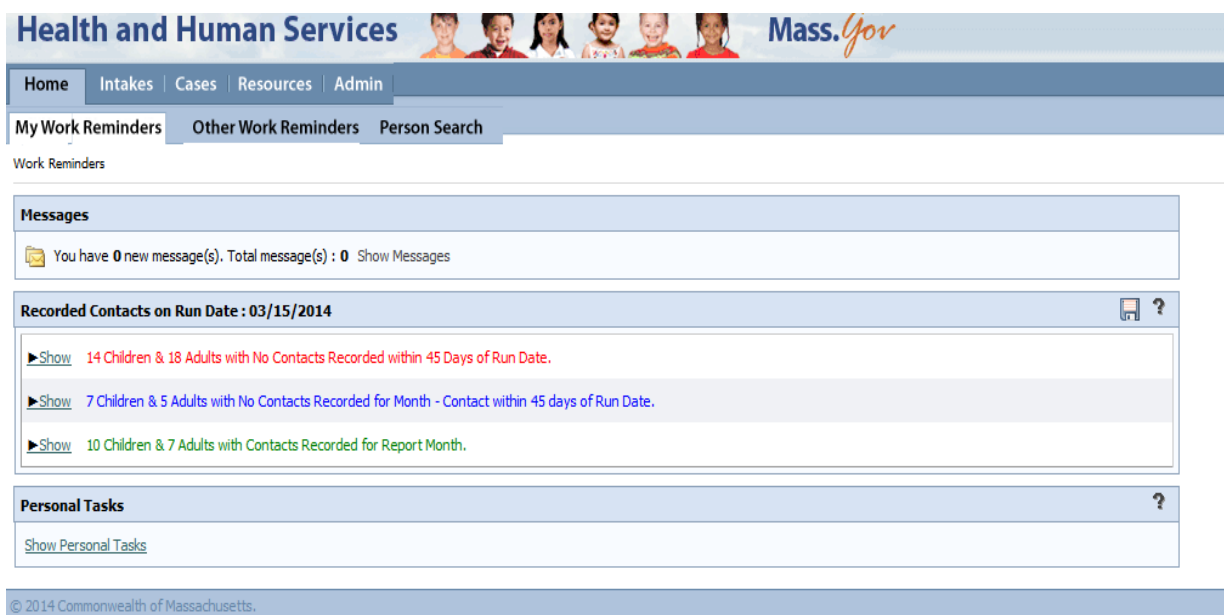
SOCIAL WORKER CONTACT WITH...	June 2015	
	Within 30 days	Within 45 days
ADULTS (parents)	55.3%	62.4%
CHILDREN & YOUNG ADULTS	85.0%	91.4%
Young Adults Age 18+	81.2%	88.6%
Children Age 0-17	85.2%	91.6%
Children Age 0-5	87.8%	93.3%
Children Age 6-11	85.1%	91.6%
Children Age 12-17	82.0%	89.3%
PLACED CHILDREN	88.4%	NA

Data Source: MA(DSSRP097 – Worker Contact with Consumers Monthly Report

The Department prioritized and implemented the following in its ongoing efforts to affirm the importance of social worker contacts as a core function of the agency:

- Developed and deployed **Promoting Quality Visits and Contacts with Families: A Field Guide for DCF Staff**—which includes protocols to assist workers with engaging, assessing safety and risk, observing and documenting contact.

- Enforced expectations for visit documentation within thirty (30) calendar days of contact and implement mandatory real-time time data entry of visits.
 - ACTION STEP: Deployed mobile devices (iPads) to all field staff and supervisors—for real-time documentation and tracking.
 - ACTION STEP: Developed real-time dashboard report on status of visits for social workers, supervisors and managers (screenshot below).



WELLBEING OUTCOME 2:

Children Receive Appropriate Services To Meet Their Educational Needs

Education is critical to a child's healthy growth and development and sense of well-being. The Department's efforts to ensure that children are receiving appropriate education services were identified as an area of strength in the 2007 CFSR Report. Ongoing focus in this area continues to support children's academic achievement. Recognizing that educational achievement is impacted by CPS involvement, the Department proactively works with teachers and school departments to ensure that children in its care or custody receive appropriate educational services and are making progress toward achievement of educational or vocational goals.

The Department tracks a number of education related indicators:

- High School Four-Year & Five-Year Cohort Graduation Rates
- Massachusetts Comprehensive Assessment System (MCAS) Passage Rates
- Attendance Rates
- High School Equivalency Testing Program (HSE) Rates (formerly GRE)

High School Four-Year & Five-Year Cohort Graduation Rates

Massachusetts Department of Elementary & Secondary Education (ESE) calculates and reports on graduation rates as part of overall efforts to improve educational outcomes for students in the

Commonwealth. Reporting graduation rates is required by the federal *No Child Left Behind Act* (NCLB) and by a National Governors Association compact signed on behalf of Massachusetts. The Department tracks these graduation rates for children in its custody utilizing the same methodology utilized by ESE.

Adopting ESE's methodology to calculate the four-year graduation rate, the Department tracks a cohort of students in custody from 9th grade through high school and then divides the number of students who graduate within four (4) years by the total number in the cohort. This rate provides the percentage of the cohort that graduates in four (4) years or less.

Recognizing that many students need longer than four (4) years to graduate from high school, and that it is important to recognize the accomplishment regardless of the time it takes, the Department (and ESE) calculates a five-year graduation rate.

	DCF Target*	2011	2012	2013	2014
Four-Year Graduation Rate	≥ 67.0%	52.0%	50.3%	54.5%	54.0%
Five-Year Graduation Rate		62.8%	53.0%	62.4%	na

*DCF Target of 67% reflects the MA ESE population which most resembles DCF students (LEP, SPED & Low Income).

Data Source: MA data exchange between DCF and ESE

While the *Four-Year Graduation Rates* between academic years 2011 and 2014 are below the established target, extending the timeframe to graduation by one (1) year results in an additional 8% of cohort students receiving *acknowledgment* for graduating in 2013.

Massachusetts Comprehensive Assessment System (MCAS) Passage Rates

MCAS is designed to meet the requirements of the *Education Reform Law of 1993*. This law specifies that the testing program must

- Test all public school students in Massachusetts, including students with disabilities and *English Language Learner* students;
- Measure performance based on the Massachusetts Curriculum Framework learning standards; and
- Report on the performance of individual students, schools, and districts.

As required by the Education Reform Law, students must pass the grade 10 tests in English Language Arts (ELA), Mathematics, and one of the four high school Science and Technology Engineering tests as one condition of eligibility for a high school diploma (in addition to fulfilling local requirements). Recognizing the importance of this metric, the Department tracks *MCAS Passage Rates* for students in its custody utilizing an automated data exchange with ESE.

MCAS tests three (3) broad subject areas:

- English Language Arts (ELA)
- Mathematics
- Science and Technology/Engineering

	DCF Target	2011	2012	2013
MCAS OVERALL DCF PASSAGE RATE	≥ 40.0%	26.9%	26.7%	25.9%
ELA Passage Rate		47.3%	63.7%	68.2%
Mathematics Passage Rate		32.9%	42.5%	43.0%
*Science/Tech./Eng. Passage Rate			76.6%	78.9%

**Science and Technology/Engineering subject area was adopted in academic year 2012 .*

Data Source: MA data exchange between DCF and ESE – 2014 is not yet fully tabulated

MCAS overall passage rates for children in the custody of DCF between academic years 2011 and 2013 are below the established target. While the 2013 MCAS overall passage rate is 64.8% of the established target, performance on each of the MCAS subject areas exceeded the overall target of 40.0%. This indicates that while children in DCF custody demonstrate relative strength in specific subject areas, positive performance in one subject area does not necessarily correspond to positive performance on other subject areas.

WELLBEING OUTCOME 3:

Children Receive Adequate Services To Meet Their Physical And Mental Health Needs

While there is no singular measure that reflects a child or family's well-being, there are a number of indicators that provide insight into how effectively the Department promotes the wellness of children and families. One such indicator is access to medical and dental care. DCF has identified access to quality medical and dental care of children as opportunities for improvement. Efforts to increase the Department's performance on medical/dental care are directed to both:

- improve the data collection to document children's medical/dental appointments, and
- collaboration with community partners to improve access to medical and dental care for children in DCF's care or custody.

Initial and Comprehensive Medical Encounters

DCF policy stipulates that children in the Department's custody are to receive an initial medical screening within 7-days and a comprehensive medical examination within 30-days of entry into custody. Acknowledging that the timely recording of these medical encounters in the Department's FamilyNet/i-FamilyNet is somewhat challenged, the Department reached out to *MassHealth* (Medicaid) in order to obtain documented evidence of medical care.

	Jul-2010 through Sep-2012
7-day Rate	50%
30-day Rate	77%
+/- 30-day Rate	90%

Data Source: MassHealth

While there is significant room for improvement, the findings highlight that 90% of children entering the Department's custody receive medical care (including behavioral health services) within a 30-day window of custody (either 30-days pre-entry or 30-days post-entry).

The following action steps were therefore initiated:

- The Department obtained/reviewed data which allowed for the identification of key providers of medical services to children in custody and worked with these providers to strengthen and expand partnerships to ensure timely and quality access to medical care.
- An expert panel of physicians was convened to identify and codify clear medical priorities to ensure that children with the highest medical needs receive priority for screenings and comprehensive medical assessments.
- The Department is designing and staffing a defined infrastructure/medical system within the Department.
 - Interviews are underway for a DCF Medical Director who will report directly to the DCF Commissioner.
- Mobile devices (iPads) have been deployed to field staff in an effort to facilitate the timely recording of medical/dental encounters and to enhance staff access to case records.

Pediatric Behavioral Health Medication Initiative

Recognizing that children in the care of child welfare agencies are disproportionately prescribed psychotropic medications, DCF convened a *Psychopharmacology Workgroup* co-chaired by the Massachusetts Child Advocate. Among several alternatives, the Department partnered with the Office of Medicaid/MassHealth and the Department of Mental Health to explore and initiate a behavioral health medication prior authorization process.

The MassHealth Pharmacy Program, in collaboration with the Department of Children and Families (DCF) and the Department of Mental Health (DMH), developed a *Pediatric Behavioral Health Medication Initiative* (PBHMI) that requires prior authorization to ensure the highest quality and safest care to *pediatric members* less than 18 years of age in the Primary Care Clinician (PCC) Plan who are prescribed behavioral health medications. An expert workgroup convened by the DMH served as an advisory board to the MassHealth Pharmacy Program to create the approval criteria that will be used to evaluate prior authorization requests submitted to the Drug Utilization Review Program.

As part of this initiative the following situations now require a prior authorization:

1. **Behavioral health medication polypharmacy:** pharmacy claims for any combination of four (4) or more behavioral health medications (i.e., alpha₂ agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotic agents, and mood stabilizers) within a 60 day period for members less than 18 years of age;
2. **Antipsychotic polypharmacy:** overlapping pharmacy claims for two (2) or more antipsychotics for at least 60 days within a 90 day period for members less than 18 years of age;

3. **Antidepressant polypharmacy:** overlapping pharmacy claims for two (2) or more antidepressants for at least 60 days within a 90 day period for members less than 18 years of age;
4. **Cerebral stimulant polypharmacy:** overlapping pharmacy claims for two (2) or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for at least 60 days within a 90 day period for members less than 18 years of age;
5. **Benzodiazepine polypharmacy:** overlapping pharmacy claims for two (2) or more benzodiazepines for at least 60 days within a 90 day period for members less than 18 years of age;
6. **Mood stabilizer polypharmacy:** overlapping pharmacy claims for three (3) or more mood stabilizers for at least 60 days within a 90 day period for members less than 18 years of age;
7. Any pharmacy claim for an **antidepressant, antipsychotic, atomoxetine, benzodiazepine, buspirone, hypnotic or hypnotic benzodiazepine, or mood stabilizer** for members **less than 6 years of age**; and
8. Any pharmacy claim for an **alpha₂ agonist or cerebral stimulant** for members **less than 3 years of age**.

As a method for continuous quality assurance, improvement, and transparency, a multidisciplinary Therapeutic Class Management (TCM) workgroup has been created to retrospectively review prior authorization requests that do not meet the required criteria and to provide an increased level of clinical expertise to evaluate outlier cases. The workgroup may also conduct outreach to individual prescribers to discuss clinically appropriate treatment options in certain cases.

Section IV: Assessment of Systemic Factors

Instructions

The statewide assessment information for systemic factors is used in determining ratings for substantial conformity. Therefore, it is imperative that the statewide assessment team ensures that information in this section speaks to how well each systemic factor requirement functions across the state. To complete the assessment for each systemic factor, state agencies should:

1. Review the *CFSR Procedures Manual* (available on the Children's Bureau Web site at <http://www.acf.hhs.gov/programs/cb>), which elaborates on key concepts and provides examples of data that are relevant to the assessment of systemic factor requirements.
2. Respond to each assessment question using the requested data and/or information for each systemic factor item. Relevant data can be qualitative and/or quantitative. Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance for each of the seven systemic factors. Review the information with the statewide assessment team and determine if more recent data is available that can be used to provide an updated assessment of each item. If more recent data are not available, refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each systemic factor item.
3. Emphasize how well the data and/or information characterizes the statewide functioning of the systemic factor requirement. In other words, describe the strengths and limitations in using the data and/or information to characterize how well the systemic factor item functions statewide (e.g., strengths/limitations of data quality and/or methods used to collect/analyze data).
4. Include the sources of data and/or information used to respond to each item-specific assessment question.
5. Indicate appropriate time frames to ground the systemic factor data and/or information. The systemic factor data and/or information should be current or the most recent (e.g., within the last year).

The systemic factor items begin with #19 instead of #1 because items #1 through 18 are outcome-related items covered in the onsite review instrument used during the onsite review. Items related to the systemic factors are items #19 through 36.

A. Statewide Information System

Item 19: Statewide Information System

How well is the statewide information system functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

Please provide relevant quantitative/qualitative data or information that show the statewide information system requirements are being met statewide.

State Response:

The Massachusetts Department of Children and Families (DCF) has operated a Statewide Child Welfare Information System (SACWIS), known as FamilyNet, since February 1998. FamilyNet was extended to the internet in 2006 to support collaboration between DCF, hospitals and placement service providers to help move children out of hospital settings when a less intensive treatment setting is appropriate. Since 2006, DCF has continued to move FamilyNet functionality to the web-based application i-FamilyNet. *See i-Familynet Overview as of 8/18/14c.docx*. FamilyNet, i-FamilyNet and FamilyNetworks (a client/server application used by DCF Lead Agencies) all update and draw data from the same Oracle production database. These applications (collectively referred to as FamilyNet) support approximately 8,000 users.

Starting in July 2014, DCF deployed nearly 2,500 4G enabled iPads with access to i-FamilyNet. DCF clinical and legal staff can now view and update information available in the i-FamilyNet application from anywhere with a cellular or secure Wi-Fi signal. Recent changes to i-FamilyNet allow caseworkers to upload pictures taken with an iPad and documents into the relevant case record.

FamilyNet is the DCF system of record for most case, family resource and subsidy related functions and maintains demographic data for all persons receiving services from DCF. It also retains a history of home, business and placement addresses for children and adults involved with the agency and maintains a placement history for all children in the care or custody of DCF in out-of-home placement.

I. Required information for children in placement

Status: In foster care or no longer in foster care

FamilyNet captures the history of a child's placement status using an explicit home removal episode (HRE) for each period of out-of-home care. An HRE must be started before a referral for a placement service can be activated or a location not requiring a service referral (known as a non-referral location (NRL)) can be recorded for a child in the care or custody of DCF. Data required to be recorded at the start of an HRE include:

- 1) DCF authority to place child (whether child is in DCF care or custody, also referred to as the child's legal status);
- 2) Date of removal from home;

- 3) Caretaker(s) from whom the child was removed;
- 4) Reason(s) for removal; and
- 5) Whether the child was previously adopted, including some details of the prior adoption.

To ensure consistency and improve timeliness of the data entry of HRE end-dates, HREs are end-dated by a weekly batch process. The HRE end-date and end-reason are derived from a combination of the legal status and placement end-dates and end-reasons and the child's age. An HRE has three sets of start and end-dates which can vary depending on the rules applicable to placement episodes for DCF, AFCARS and Title IV-E.

Timeliness errors for the AFCARS 2015A submission were

0.39 -- Element 22 – Removal Transaction Date

7.83 -- Element 57 – Foster Care Discharge Transaction Date

The accuracy of HRE start and end-dates is monitored by the DCF revenue provider as part of their IV-E eligibility determinations. Any problems or errors are reviewed by a DCF staff person and corrected as appropriate. Corrections can include updating legal status types, dates and end-reasons, HRE start or end-dates and end-reasons, as well as adding missing unpaid placements. Because of the tight integration of legal status, HRE and placement data entry, problems with HRE start dates are generally identified by the caseworker or supervisor when recording a child's initial placement. This is reflected in the low number of timeliness errors for the Removal Transaction Date.

Timeliness of service referral activation is monitored using the Service Referral Activation Report DSSRP179.

Location: child physical location

FamilyNet captures a history of the child's placements (name of provider, start-date, end-date, type of placement) and a history of the child's placement addresses. Placement types include paid placements, documented by a service referral, and unpaid placements. Paid placement types are described by a taxonomy which includes a category, program and model. The placement taxonomy provides a fine-grained description of the placement service, in some instances including the staffing level for congregate care placements. Unpaid placements are tracked using less fine-grained categories which nonetheless distinguish between placement in family settings, both kinship and non-kinship, residential, group homes, institutions and hospitals. On-the-run episodes are tracked using non-referral locations. The type of psychiatric hospital placement can also be recorded.

When the service referral for a paid placement is "activated" by recording the actual start date, or a non-referral location is saved, the child's address history is automatically updated with the child's placement address. A placement address is identified as a Full-time Placement, Part-time Placement or NRL address. Placement addresses are automatically end-dated when the actual end-date is added to a service referral or the end-date added to an NRL. If a placement record is data entered retroactively, the placement address is still automatically created.

Paid placements are carefully tracked by area, region and central office financial staff using the AuthoCosts report and other financial reports. Payrolls are closely monitored Department of Administration and Finance (DAF) staff for any unusual activity.

See *Summary of Children in Placement on 5-1-2015.xlsx*

The following data comes from the Service Referral Activation Report (dssrp178 and 179). This report includes all placement service referrals activated during the reporting month. A service referral is “activated” when the date the child entered the placement (“actual start date”) is recorded. The data entry timestamp is also included in the report allowing managers to track both the time between the child’s actual start date and data entry of the service referral and the time between the actual start date and data entry of the actual start date (activation).

	Days between Placement and Data Entry of Service Referral								
Placement Type	0 to 7		8 to 14		15 to 28		29+		Total Count
	Count	%	Count	%	Count	%	Count	%	
Dept FC*	821	85.2%	71	7.4%	41	4.3%	31	3.2%	964
CFCI**	150	90.9%	7	4.2%	4	2.4%	4	2.4%	165
Congregate	424	92.6%	11	2.4%	9	2.0%	14	3.1%	458
Grand Total	1395	87.9%	89	5.6%	54	3.4%	49	3.1%	1587

	Days between Placement and Service Referral Activation								
Placement Type	0 to 7		8 to 14		15 to 28		29+		Total Count
	Count	%	Count	%	Count	%	Count	%	
Dept FC*	632	65.6%	194	20.1%	81	8.4%	57	5.9%	964
CFC**	133	80.6%	21	12.7%	7	4.2%	4	2.4%	165
Congregate	382	83.4%	36	7.9%	21	4.6%	19	4.2%	458
Grand Total	1147	72.3%	251	15.8%	109	6.9%	80	5.0%	1587

Source: DSSRP179 Run 5/4/15

* Departmental Foster Care includes placement with kin and other resources identified by the family.

**Comprehensive Foster Care, formerly known as Intensive Foster Care (IFC). This service purchased from provider agencies

Demographic Characteristics: date of birth, sex, race, ethnicity, disability, medically diagnosed condition requiring special care, ever been adopted

FamilyNet captures

- 1) Actual and estimated dates of birth;
- 2) Sex (female/male);
- 3) Race (any combination of American Indian/Alaskan Native, Asian, Black, Native Hawaiian/Other Pacific Islander, and White; or Declined or Unable to Determine)
- 4) Ethnicity (Hispanic/Latino origin);
- 5) Medically diagnosed conditions
- 6) Whether a child in placement was previously adopted.

Race (12/31/2013)				
Race/ Ethnicity	All DCF Consumers		Children under 18 in Placement	
White ⁽¹⁾	32,840	44%	3,615	47%
Hispanic/Latino ⁽²⁾	19,301	26%	1,983	26%
Black ⁽¹⁾	10,633	14%	1,059	14%
Asian ⁽¹⁾	1,020	1%	86	1%
Native American ⁽¹⁾	145	*	14	*
Pacific Islanders ⁽¹⁾	27	*	1	*
Multi-Racial ^{(1) (3)}	2,127	3%	532	7%
Unable to Determine	3,011	4%	387	5%
Missing	6,286	8%		
Total Consumers	75,390	100%	7,677	100%

⁽¹⁾ Excluding Hispanic/Latino

⁽²⁾ Hispanic/Latino includes all races, ⁽³⁾ Multi-racial = two or more races

Source: Annual Data Profile 2013

Considerable care has been taken in the design and construction of FamilyNet and i-FamilyNet to ensure caseworkers are made aware of critical safety information regarding consumer children. Safety alerts based on medical diagnoses and certain observed behaviors appear wherever case members are listed.

Case workers are required to obtain birth certificates for children in placement. These are used to verify dates of birth and parental relationships. Courts often require newly issued birth certificates at various junctures in the life of a court case to ensure accurate paternal relationships are available.

See *Excerpt from Manage_Person-BR-CM0017 with corrections.docx*.

See *CFSR 3 Data Profile 5-20-15a – MA.docx*, pages 13 and 14 for results of AFCARS and NCANDS Data quality checks.

Goals for permanency: reunification, adoption, guardianship, other planned permanent living arrangement, not yet established.

DCF has the following permanency goals:

- 1) Stabilization
- 2) Reunification
- 3) Adoption
- 4) Guardianship
- 5) Alternative Planned Permanent Living Arrangement (APPLA)

Permanency goals are recorded as part of a child's service plan. Service plans are reviewed and updated at least every 6 months. Part of this review necessarily includes viewing the goal recorded in the service plan. If a child's permanency goal remains the same, FamilyNet retains the original goal start date. Service plans are easily accessible by area and regional office staff who can view the permanency goals for children in placement and in intact families. For children in placement, permanency goals are reviewed every six months as part of the Foster Care Review. The review ascertains whether the correct goal is listed in the service plan being reviewed and determines if the goal is appropriate. Permanency goals are also provided in 6 routinely used monthly reports. Permanency goals are highly visible, affording staff responsible for a child's wellbeing many opportunities in the course of their work to see and act if the permanency goal was erroneously recorded or is no longer appropriate.

Children receiving services at home have a goal of Stabilization. The initial permanency goal for children in placement is generally Reunification. Subsequent goals are set during a Permanency Planning Conference (PPC). A child's first PPC occurs within 9 months of the child's entry into placement. Area office staff are provided with a monthly report to support scheduling timely initial PPCs. A child's initial PPC is used to determine if DCF should pursue termination of parental rights (TPR) on behalf of the child, and if not, to record the reason TPR is not appropriate. If the decision of the initial PPC was not to pursue TPR and the child remains in placement for 15 of the first 22 months, another PPC is required to reconsider the decision not to request TPR. Subsequent PPCs are held at the request of clinical or legal staff or when a foster care review (FCR) determines the child's current permanency goal is inappropriate.

The official record of PPCs and semi-annual FCRs is maintained in FamilyNet. PPCs were recently moved to i-FamilyNet and 6 week placement reviews have also been implemented in i-FamilyNet.

II. Other FamilyNet functionality

Service Referrals

FamilyNet includes referrals for all paid services and interfaces with the Office of the State Comptroller through the MMARS system to initiate payment for most services and to track receivables and collections in the event an overpayment occurs.

See *Sect19 – ACCOUNTS RECEIVABLE PROCESS.doc*

Contracts for DCF paid services are organized according to a taxonomy including a category, program and model. Every service referral references the taxonomy of the service provided. The taxonomy is used for placement and non-placement services. Many reports include the taxonomy or non-referral location representing the child's current placement.

Family Resource Licensing

Family Resource home-studies, annual re-evaluations and license renewals along with required background record checks are recorded on FamilyNet for homes licensed by DCF and DCF contracted providers.

Active Family Resource Homes on 5/2/2015			
FR Home Type	DCF	Contracted	Grand Total
Intensive Foster Care	6	1549	1555
Kinship/Child-Specific	2696	50	2746
Unrestricted*	1919	191	2110
Inquirer/Applicant	1921	874	2795
Grand Total	6542	2664	9206

FR Home Type	With Placements	No Current Placements	Grand Total
Intensive Foster Care	1135	420	1555
Kinship/Child-Specific	2193	553	2746
Unrestricted*	1530	580	2110
Inquirer/Applicant	9	2786	2795
Grand Total	4867	4339	9206

Source: DSSRP 225

*Includes Pre-Adoptive

Foster Care Reviews

FCRs occur every six months for children who have been in placement at least 6 months. FCRs are recorded on FamilyNet and FCR reports can be viewed by any user with access to the case. A batch process automatically creates review records three months prior to the review due date. Batch extracts and ticklers support the review scheduling and invitation process. DCF field staff must review the proposed invitation list and update FamilyNet as needed to ensure required invitees are invited. Invitation letters are sent through an automated process once an FCR has been scheduled. In addition to the determinations and supporting narratives, FCR records include the names of all persons who were invited and who attended the FCR. A report of the FCR is sent to all attendees through an automated process.

See DSS Policy #86-009, Revised 9/6/2000 Foster Care Review Policy

ICPC

ICPC requests were recently moved to i-FamilyNet. 100A and 100B documents received from other states can now be scanned into i-FamilyNet and associated with a child's ICPC request. 100A and 100B documents are generated from i-FamilyNet when Massachusetts is the sending state.

Legal

Court case records moved to i-FamilyNet in November 2014. DCF attorneys can access and update court cases using iPads. This includes entering legal dictation, court dates/actions and court results.

See *CIP Summary Data for ffy2014.xlsx* and *CIP Summary Data for ffy2013_Final v.2.xlsx*

Provider Services

Service providers have had access to portions of the case record in i-FamilyNet since 2006. Providers record Child and Adolescent Needs and Strengths (CANS) assessments, incident reports, treatment plans and treatment plan reviews have been recorded in i-FamilyNet since 2008. This information is available to providers while they are providing services to a particular consumer and to DCF staff through the consumer's case record. Data from the CANS assessments and incident reports will be used to evaluate the Caring Together IV-E waiver project.

During FFY2014, 2397 **CANS** assessments were completed for 1780 children & adolescents

During CY2014 (through 6/14/14), 9481 **Incident Reports** were completed for 1982 children

IV-E Eligibility Determinations

The revenue provider for DCF conducts and documents IV-E eligibility reviews in i-FamilyNet. FamilyNet retains a history of all eligibility determinations including those which were rolled-back when information becomes available which might change an eligibility determination. The IV-E eligibility function has dedicated tables in the FamilyNet database, some of which are copies of the production tables for demographics, court cases, legal status, etc. This allows data to be updated or notes added without altering the source data.

III. Reporting

Data necessary to ensure compliance with DCF policies and document trends are available to DCF staff through on-line queries, batch and warehouse reports. On-line queries are available in FamilyNet and i-FamilyNet and provide information used to assign cases, obtain lists of scheduled activities, view the summary of a court appearance, print case narratives, etc. Batch reports run on a schedule, are less widely available and are distributed to managers and administrative staff. DCF is currently in the process of making batch reports more accessible to administrative and management staff. In July 2014, DCF implemented a user dashboard

available to caseworkers and supervisors in i-FamilyNet. This report provides aggregate counts of the consumer children and adults assigned to a caseworker by the length of time since the last recorded in-person contact during the current month. Caseworkers and supervisors can download a list of assigned consumers including the last in-person contact date using their pc or iPad. An on-line query makes the same consumer contact information available to managers.

Batch reports and batch letters are being moved to a Jasper server as part of a data analytics initiative. Batch reports will be accessed from a central repository based on user security roles. This migration is being used as an opportunity to enhance existing reports, cull reports no longer in use, and ensure reports are easily available in the format most appropriate to the report purpose.

DCF has a data warehouse of purpose-built tables storing summary data extracted from the FamilyNet production database of child placements, financial transactions, AFCARS, NCANDS and NYTD data, title IV-E determination data and more. Data from the warehouse is currently accessed through ad hoc queries and using Oracle Discoverer. Reports available in Discoverer are referred to as the DataMart and include the AuthoCosts report, CFSR child welfare outcome reports, reports for tracking trends in reports of child abuse/neglect and responses, case openings and closings, and to support IV-E eligibility determinations. The AuthoCosts report tracks all payments for DCF-licensed and applicant foster homes, contracted foster homes, family-based services and most congregate care placements. All warehouse tables are designed to hold multiple years of data and are updated on a schedule tied to business reporting needs, generally, weekly, monthly or quarterly. All DataMart reports include aggregated data summaries and support drill-down to detail data in the warehouse tables. See *DCF DataMart Child Welfare Outcomes Reports.doc*. The data warehouse also includes a data set known as “Flow Data” which documents all child placements organized with one row per placement per child. The Flow Data set includes the child’s permanency goal as of the beginning of the placement in focus as well as the child’s demographic data and the placements, if any, immediately prior to and after the placement in focus. This data set is used extensively for analytic purposes. A similar warehouse table is planned for all service referral data, which will provide similar opportunities for analysis of non-placement service data. A proof of concept is underway to migrate DataMart reports to Jasper.

On-line queries, batch and DataMart reports are based on state-wide data and most can be parsed by DCF region, area and unit or provider agency and provider division. This permits comparisons across regions, areas, providers and will enable data level report security to ensure access to confidential data is limited to appropriate users.

New reports are constantly under development to support DCF’s evolving needs. A report to better track youths who are on-the-run is currently in use even as it is being modified to provide better information to discern the patterns and triggers for run-away episodes as well as possible interventions. Reports have been developed and more are planned to evaluate the efficacy of new Caring Together services under a Title IV-E waiver and for permanency planning, legal and fair hearing functionality as they move to i-FamilyNet. Two reports support the qualitative review of non-placement cases; one lists cases with 3 or more reports of child abuse/neglect

within a three month period and the other lists cases which have not had a child in placement or a report of abuse/neglect for at least two years.

A selection of reports supporting various DCF business processes are enumerated in the *Representative List of Management Reports*

IV. Data Quality

DCF provides caseworkers, supervisors, clinical managers, legal managers and family resource licensing staff with many aids and opportunities to verify the accuracy of data contained in FamilyNet. Although DCF has not had a dedicated case review unit for some years, it has worked hard to promote a culture of data accuracy by making pertinent detailed data available in all reports and on windows throughout the FamilyNet/i-FamilyNet application. Routine case management events administrative reports provide opportunities throughout the year for the staff most familiar with a case to review the data recorded in FamilyNet, and to identify and correct inaccurate data. These events and reports include, but are not limited to the following checkpoints.

Checkpoints for Data Accuracy

Activity	Child in Home	Child in Placement
Intake/response: <ul style="list-style-type: none"> Initial data entry of demographics and location 	Applies	Applies if there is an emergency home removal or child is placed during response
Comprehensive Assessment (CA): <ul style="list-style-type: none"> Frequency: <ul style="list-style-type: none"> Currently, at beginning of case opened for services and as desired while case open; After new policy is implemented, at least every 6 months in conjunction with updating the action plan Demographic data is updated. AFCARS edit ensures demographic data needed for AFCARS are data entered before CA is completed. 	Applies	Applies
Service/Action Planning (SP/AP): <ul style="list-style-type: none"> Frequency: At least every 6 months Permanency goal is reviewed and updated if required Demographic data is updated Placements and visitation plans reviewed AFCARS edits must be satisfied prior to completion of new/updated SP The name will change to Action Plan when new policy is implemented. 	Applies	Applies

Caseworker Contact Reports: <ul style="list-style-type: none"> • A dashboard updated daily after the first week of the month indicating which consumers do not have caseworker contacts recorded for the current month • Caseworker Contacts Preview Report (monthly report which lists consumers for whom a contact has not been recorded for the reporting month) 	Applies	Applies
Service Referral for Placement or Non-Referral Location: <ul style="list-style-type: none"> • Each time a new placement is recorded, either by activating a service referral or entering a non-referral location, FamilyNet checks to see if there is a Home Removal Episode and custody record in effect on the start date of the placement. 		Applies
Monthly Clinical Reports <ul style="list-style-type: none"> • Children in Placement (all children with an open HRE) • ASFA Report (children who need a 6 Week Review or Permanency Planning Conference) • Children with a Goal of Adoption/Guardianship • Children with a Finalized Adoption/Guardianship • PACT Report (children for whom supplementary payments are made) • Service Referral Activation Report • Early Intervention (children qualifying for EI referral) 		Applies
IV-E Eligibility Determination: <ul style="list-style-type: none"> • Frequency: Shortly after home removal and every 3 months for children found to be IV-E eligible • What is reviewed and validated? <ul style="list-style-type: none"> ○ Demographic data, ○ court orders, ○ custody and ○ placement records 		Applies
Six Week Placement Review and Permanency Planning Conferences (PPC): <ul style="list-style-type: none"> • Frequency: <ul style="list-style-type: none"> ○ Six Week Placement Review: 6 weeks after start of placement; ○ 9 months after start of placement or as required by changed circumstances or Foster Care Review recommendation • What's reviewed? <ul style="list-style-type: none"> ○ Need for placement ○ Permanency goal ○ Progress toward goal ○ Whether current placement is appropriate ○ Whether TPR is needed 		Applies

<p>Foster Care Reviews (FCRs):</p> <ul style="list-style-type: none"> • Frequency: Every six months while child is in placement • What's reviewed? <ul style="list-style-type: none"> ○ Six weeks prior to review due date: <ul style="list-style-type: none"> ▪ Need for review (is child still in placement) ▪ Whether required invitees are in FamilyNet with current addresses ○ At review: <ul style="list-style-type: none"> ▪ Need for placement ▪ Whether current placement is appropriate ▪ Permanency goal ▪ Progress toward goal ▪ Whether required medical/dental care has been provided 		Applies
<p>Quarterly Adoption Reviews:</p> <ul style="list-style-type: none"> • Frequency: Quarterly for children with a goal of Adoption • What's reviewed? <ul style="list-style-type: none"> ○ Appropriateness of goal (if no, the child is referred for a PPC) ○ Barriers to progress toward goal ○ Status of termination of parental rights (TPR) <ul style="list-style-type: none"> ▪ Whether parental relationships are correctly recorded ○ Whether child is matched to a preadoptive home and whether the fact of a match is recorded ○ Whether child can be adopted within 24 months of placement 		Applies
<p>Monthly Legal Reports:</p> <ul style="list-style-type: none"> • Permanency Hearing Tickler Reports (supports scheduling Permanency Hearings) • Reasonable Efforts Report (supports data entry of Reasonable Efforts and Contrary to the Welfare court results) 		Applies
<p>Permanency Hearings:</p> <ul style="list-style-type: none"> • Frequency: Annual • What's reviewed? <ul style="list-style-type: none"> ○ Need for placement ○ Permanency goal ○ Progress toward goal ○ Whether current placement is appropriate ○ Whether reasonable efforts to reunify have been made or are not required 		Applies

AFCARS Validation Data <ul style="list-style-type: none"> Frequency: Semi-Annual Used by IT to identify data and report coding issues 		Applies
NCANDS Validation Data <ul style="list-style-type: none"> Frequency: Annual Used by IT to identify data and report coding issues 	Applies	Applies
NYTD Validation Data <ul style="list-style-type: none"> Frequency: Semi-Annual Used by IT to identify data and report coding issues 	Applies (served population only)	Applies
Activity	Departmental Foster Care	Comprehensive Foster Care
Foster/Pre-adoptive License Homestudy, Annual Reassessments and License Renewals <ul style="list-style-type: none"> AFCARS edits for resource demographic information must be satisfied prior to completion 	Applies	Applies
Monthly reports: <ul style="list-style-type: none"> Active Family Resources Overdue License Renewals Unapproved Homes with Active Referrals 	Applies Applies Applies	Applies Applies
Periodic reports: <ul style="list-style-type: none"> Primary Caregiver has marital status of Married and there is no Secondary Caregiver 	Applies	Applies

DCF is in the process of staffing a CQI unit with five staff members who will conduct systematic statewide case reviews using a review tool modeled after the CFSR Onsite Review Instrument. This is the final piece needed for a systematic data quality review process.

Data regarding paid placements is generally very good as payment is predicated upon the placement being accurately recorded. Payments for Departmental Foster Care and invoices for other services are generated by FamilyNet using the same service referral data used to create the placement records. If the service referral information is accurate, the placement information is accurate and vice versa. Invoice and payment data is closely monitored by the central office, regional and area office staff responsible for ensuring that budgeted funds are properly spent. If a placement and its corresponding service referral are end-dated in arrears, FamilyNet creates a receivable which is also tracked in FamilyNet. See *Sect19 – ACCOUNTS RECEIVABLE PROCESS.doc*

Data regarding unpaid placements has significantly improved in recent years as a result of the work done to ensure psychiatric hospitalizations are accurately recorded by the Mental Health Specialists closely monitoring these placements and due to the focus on tracking children who are on-the-run from placement.

A monthly batch report lets the Subsidy unit support the timely activation of adoption subsidies once adoptions are legalized. Documenting diagnosed health conditions and the family structure of foster care providers are areas where data entry needs to improve. Health information for medically fragile children is documented by staff nurses and these children are closely

monitored. System edits in FamilyNet and i-FamilyNet ensure demographic information for consumers and family resource providers is data entered at junctures when the information should be known (i.e., at the completion of Comprehensive Assessments, Service Plans and during Family Resource licensing). An ad hoc report is provided to area offices and provider agencies to monitor and support accurate data entry of the marital status of family resource providers. The Permanency Profile Facesheet for the child(ren) being reviewed includes demographic, relationship, health/behavior and education data recorded in FamilyNet so that missing or incorrect information can be updated at the time of the PPC.

See *Permanency_Profile_Facesheet.docx*.

The Hotline Intakes/Investigations Overview is an on-line report designed to monitor data quality and is used to aid in the timely completion of Hotline intakes/investigations.

The comprehensive family assessment and service planning process have been redesigned and new functionality is being built in i-FamilyNet for release early in 2016. The new Comprehensive Assessment and Action Plan will make demographic, medical and education data more visible and include more robust edits to ensure these data are recorded and updated.

Data quality is taken very seriously and data errors which cannot be corrected by the user are logged by the Information Technology unit, reviewed by a business analyst to determine if it is the result of user error or an application bug and corrected to the extent possible. Data extracts are extensively validated and data errors identified when validating reports are similarly logged, analyzed and corrected.

See attached *Data Extract Validation Protocol.doc*.

Providing the detail data represented by the statistics in reports provided to the field is a very effective strategy for identifying inaccurate data. Showing what is being counted allows the people most interested in a report's accuracy to validate their data.

Inaccurate HRE and placement data identified during IV-E eligibility determinations is referred to DCF staff members who research and correct the data when appropriate. The IV-E secondary review conducted during the week of 9/27/12 and covering the period 10/1/11 to 3/31/12 found,

Program Strengths & Promising Practices

The State has a highly-automated system which provides access to demographic information from DCF's Family Net and family financial information through the TANF and Medicaid automated systems operated by other State agencies.

Overall the automated worksheets provide clear documentation of the eligibility decision, basis for the decision, and period of eligibility. As previously stated, there are areas in which additional documentation would be helpful for reviewers. Court documents clearly explained the contrary to welfare and reasonable efforts findings. The removal court orders were completed timely, usually the next day if an emergency removal occurred after hours. All required judicial findings were obtained in the sample cases reviewed. The State has made improvements in the licensing of foster care placements as all foster homes were fully licensed

during the PUR. We also noted the Interstate Compact for the Placement of Children cases in the review sample contained all necessary information to document title IV-E eligibility. This represents a substantial improvement from our prior onsite review where four cases were determined to have ineligible payments due to the lack of documentation that the foster care provider was licensed by the receiving State. Finally, DC has worked with EEC to improve the documentation of criminal background checks for residential facilities. All cases involving a residential placement contained the information necessary to document compliance.

See *Massachusetts Department of Children and Families Title IV-E Foster Care Eligibility - ma2012_secondary*, p7.

DCF looks forward to having a CQI unit with the ability to develop and track metrics for data accuracy. This will enhance, but not replace, the work being done daily by staff at all levels of the agency to promote good quality actionable data.

Attachments:

- 1) i-FamilyNet Overview as of 5-29-15.docx
- 2) Summary of Children in Placement on 5-1-2015.xlsx
- 3) Excerpt from Manage_Person-BR-CM0017 with corrections.docx
- 4) CFSR 3 Data Profile 5-20-15a – MA.docx
- 5) Sect19 – ACCOUNTS RECEIVABLE PROCESS.doc
- 6) DSS Policy #86-009, Revised 9/6/2000 Foster Care Review Policy
- 7) CIP Summary Data for ffy2014.xlsx and CIP Summary Data for ffy2013_Final v.2.xlsx
- 8) DCF DataMart Child Welfare Outcomes Reports.doc
- 9) Representative List of Management Reports
- 10) Permanency_Profile_Facesheet.docx
- 11) Data Extract Validation Protocol.doc
- 12) Massachusetts Department of Children and Families Title IV-E Foster Care Eligibility - ma2012_secondary.pdf

B. Case Review System

Item 20: Written Case Plan

How well is the case review system functioning statewide to ensure that each child has a written case plan that is developed jointly with the child's parent(s) and includes the required provisions?

Please provide relevant quantitative/qualitative data or information that shows each child has a written case plan as required that is developed jointly with the child's parent(s) that includes the required provisions.

State Response:

In Massachusetts, Service Planning is a fundamental component of social work practice and is intended to be a dynamic, interactive process which involves the Department of Children and Families (DCF or Department), family members, substitute care and other service providers. The service plan represents a time-limited agreement between the Department, the family and those providing services to the family, which includes a shared understanding of why the family is involved with the Department and identifies the goal(s), projected date of goal achievement and outcome(s) to be achieved by the Department's intervention with the family. The service plan includes the related change indicator(s) by which family members demonstrate they have achieved the identified outcome(s). The service plan specifies the expectations negotiated with the family regarding participation in services and completion of tasks which support the family member's ability to effect these changes, achieve the service plan goal and eventually close the case; it also includes the tasks for the Department, substitute care and other service providers. The service plan reflects the direction of a case, guides case practice and provides information for decision-making. To the greatest extent possible, the service plan is written in the family's preferred language, in a manner that is clearly and easily understood by the involved parties.

It is the policy of the Department that an initial full service plan is developed within fifty-five (55) working days for every case which will remain open following assessment. To the greatest extent possible, the service plan is developed jointly with the family. In most cases, the service plan involves the parent(s)/guardian(s) or other caretaker(s); the reported child(ren) and/or the child(ren) who is the subject of a voluntary application for services or a court order; other children in the family; DCF; and, in cases where children are in placement, the substitute care providers. Other service providers also may be included in the service plan.

The Department monitors its performance on completing service plans within the mandated timeframes. A monthly case work report (DSSRP071-Statistics for Casework) is available to all staff and is used by supervisors and managers to monitor individual office performance. Historically, the Department had been completing 80% of service plans within the mandated timeframe. Given the significant increase in caseloads over the past two years, meeting this historical performance level has proven to be a particular challenge for the Department.

State Fiscal Year 2016 and Beyond

Family Assessment and Action Planning

The Department's Family Assessment and Action Planning work is intended to be guided by the practice principles and approaches included in the DCF Case Practice Model. The Department has recognized the need and has been actively working over the past several years to update the current written policy and procedures, along with sections of our information technology system used to document/record family assessment information and the case plan work. DCF is currently in negotiations with the union representing its social workers (SEIU local 509) to reach agreement on the new policy and in September 2014 kicked-off the design phase for a new electronic assessment and case plan tool. The Department anticipates that the Family Assessment and Action Planning policy and SACWIS support will be fully in place within state fiscal year 2016.

While the Department has been able to track the quantity and timely completion rates of service plans, the existing FamilyNet service plan tool limits the ability to assess quality of service plans. The planned Family Assessment and Action Planning i-FamilyNet tool should allow for both a quantitative and qualitative assessment of service plans. Along with this, the Department's new CQI Unit will utilize systematic case review methodology and tools to assess service plan quality.

Consistent with the Department's Case Practice Model, family assessment and action planning centers on engaging family members in an integrated and dynamic process of exploring their unique strengths and needs for 2 important and related purposes:

1. determining whether the Department must remain involved with the family and why; and
2. 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.
 - For the young adult who has sustained connection or re-engaged with the Department, the focus of the assessment and action planning is on the identification and relationship development of one or more adults who will maintain a consistent, caring and permanent relationship with the young adult and on assessing preparation for successful adulthood, supporting life skills development and providing resources to promote adult independence.

Family Assessment and Action Planning is:

- integrated by identifying and addressing assessed areas of concern for the parent's capacity to meet the safety, permanency and well-being needs of the child; and
- dynamic in that the gathering of information from multiple sources is a process throughout the life of a case, not a one-time event.

Values and Principles

Family Assessment and Action Planning at the Department is conducted in a manner that aligns with and furthers the Department's Core Values:

- **Child and Youth-Driven:** A child's experiences and perspectives must be heard and understood.
- **Family-Centered:** Family members are partners in assessing strengths and needs, and in planning to address concerns.
- **Community-Focused:** Children, youth and their families are best understood and supported within their natural support systems.
- **Strengths-Based:** Families have the ability, with support, to overcome adverse life circumstances.
- **Committed to Cultural Diversity/Cultural Responsiveness:** Families are diverse and have the right to be respected for their cultural practices, norms, attitudes and beliefs.
- **Committed to Continuous Learning:** Changes in the shared, progressive understanding of a family's circumstances, needs and strengths are revealed and recognized over time.

Outcomes

The Family Assessment and Action Planning process should result in the Department and the family having shared understanding of:

- Everyone's concerns for the child's safety, permanency and well-being – whether or not they agree with each other's concerns;
 - What is working well that promotes the safety, permanency and well-being of the child; and
 - What actions or changes need to happen to assure the safety, permanency and well-being of the child.
- As a result of this process, and the development of an Action Plan, family members should know:
 - What changes in caregiver behaviors the Department needs to see, and for what period of time, in order to close the case;
 - What services and resources the Department recommends to support changes in caregiver behaviors and to strengthen the safety, permanency and well-being of the child, and how to sustain those changes over time; and
 - What assistance and supports the Department and others will provide in order to help the family make any changes needed.

Family Assessment and Action Planning 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. When the Family Assessment and Action Planning involves a **young adult** who is sustaining connection or re-engaging with the Department after leaving care or custody at age 18, the young adult is the focus, and other family members are involved only when the young adult agrees.

Collaterals such as kin, service providers, educators and other resources are also likely to be involved. Assessment of adults who reside in the home or in the home of any non-resident parent/guardian/parent substitute is important because of the likelihood that they may assume a caregiver role, however briefly or informally, or otherwise be crucial to the child(ren)'s safety, well-being or permanency. For the purposes of the Family Assessment and development of the Action Plan, these individuals will be identified as **"kin collaterals"** and will be assessed on a limited basis.

If a Family Assessment is being completed on a previously opened case (which has a previous Family Assessment), the Social Worker reviews information from the previous Assessment(s) to inform the current Assessment. If the Family Assessment is being completed on a family whose case was open within the previous 6 months, the Social Worker updates the existing Family Assessment and Action Plan to reflect the reason for current involvement and any changes since the previous involvement that impact child safety, permanency and well-being.

When the Family Assessment identifies needs that must be addressed, the Department engages the family in the development (or update) of an **Action Plan**. In addition to identifying the assessed Area(s) of Focus, the Action Plan specifies the permanency plan for each child; identifies the needed behavioral changes; and the actions/tasks/services/resources that will be utilized to support the desired behaviors.

Permanency Plans

The Family Assessment and Action Plan must identify each child's permanency plan. In all cases, the Department makes reasonable efforts to engage in **concurrent planning** with a family so that the child may achieve permanency through adoption, guardianship or care with kin, if stabilization of, or reunification with family is determined not to be a viable option.

Action Plan Scope

Based on the information contained in the Family Assessment and the permanency goal for each child, the Action Plan specifies, at a minimum:

- the time period of the plan (usually 6 months);
- area(s) of focus based on the findings of the Department's Family Assessment of parental capacity and child safety, permanency and well-being that indicate why continued Department involvement is needed;
- for each priority area of focus, the observable changes that are needed to achieve the jointly identified goals in the Action Plan; and

- for each priority area of focus, the actions/tasks/services/supports for each open consumer and any other identified participant(s) in the Action Plan (e.g., substitute care provider, foster parent, kin collateral, etc.), including the Department.

The Action Plan may also include information and, actions/tasks for substitute care and other providers.

When the child is in placement, the Action Plan includes the visitation plan and supplemental placement-related information such as: an explanation of why the child came into placement and the circumstances of the removal; whether siblings are placed together and if not why not, and specifics of the sibling visitation schedule (when relevant); whether the placement is with kin or if not, what efforts were made to locate kin, including to whom written notification was sent; the plan for visitation with grandparent(s) and/or other kin (when relevant); whether the school-age child will remain in the school of origin and what options have been considered with the Local Education Agency (LEA) to determine and support the child's educational best interest; specific details regarding the child Indian Child Welfare Act (ICWA) status, race/culture, placement history, health and education information).

If the Action Plan is for a youth age 14 years or older, the Social Worker may review the Youth Readiness Assessment, when completed, and include tasks/services/supports to promote the youth's life skill development and readiness for transitioning to adulthood.

Multiple Family Assessments/Action Plans for a Family

In certain cases including, but not limited to, situations involving domestic violence in which the Family Assessment and/or Action Plan includes information which may compromise the safety of a child or parent, or custody situations in which parents have conflicting interests, consideration should be given to developing separate Family Assessments and/or Action Plans. The Social Worker, in consultation with the Supervisor, determines how these situations will be addressed.

Family Assessment & Action Plan for Child with a Goal of Permanency through Adoption

When the goal of adoption is established for a child, a Child Permanency Assessment is completed by the assigned Adoption Social Worker or a contracted agency. Within 5 working days after the Child Permanency Assessment is completed, the Adoption Social Worker updates child assessment information and revises the Action Plan in the electronic case record, as necessary, based on the information obtained. The revised Plan is approved by the Supervisor and signed by the Adoption Social Worker and the substitute care provider.

Services and Supports

The Department provides support and stabilization services as well as placement services either through contracts with private provider agencies or through its own resources. Contracted services and placements managed by the Department are generally initiated through service referrals. In preparation for the Foster Care Review scheduled every 6 months for a child in placement, providers of appropriate services are asked to evaluate progress made by the child or parent(s). The social work supervisor or other designated Department employee

initiates service referrals for Departmental foster homes and requests progress evaluations directly from them. The Department also refers families to non-contracted resources and supports available in their communities. It is not necessary for the Family Assessment and Action Plan to be completed to initiate the provision of services. Referrals should be made as soon as service needs are identified.

Item 21: Periodic Reviews

How well is the case review system functioning statewide to ensure that a periodic review for each child occurs no less frequently than once every 6 months, either by a court or by administrative review?

Please provide relevant quantitative/qualitative data or information that show a periodic review occurs as required for each child no less frequently than once every 6 months, either by a court or by administrative review.

State Response:

DCF Policy # 86-009, Foster Care Review (FCR) establishes the requirements and procedures for the regular review of the status of children in out-of-home placement. The Department's Foster Care Review system provides an opportunity for involved individuals to participate in a meeting focused on a review of: the necessity and appropriateness of the child's placement; individuals' participation and level of completion of tasks identified in the service plan; progress made during the preceding six (6) months toward the goal identified in the service plan; and the date by when the goal will be achieved.

This policy is currently in the process of being updated to reflect the practice principles and approaches in the Department's Case Practice Model and to prepare for migration of the functionality for the documentation of reviews to DCF's web-based SACWIS platform (i-FamilyNet). The Department's new Permanency Planning Policy embeds the Foster Care Review System within a broader system of regular and ongoing reviews of the status of children in out-of-home placement.

The Foster Care Review Unit (FCRU), an independent unit within the Department of Children and Families, is charged with selecting, scheduling and conducting reviews for all families with children in the Department's care or custody and living outside of their home. The review includes all family members, including siblings not in out of home placement (open consumers). The Department's Foster Care Review policy clearly defines both the purpose and process for periodic reviews.

During state fiscal year 2014, the Foster Care Review Unit completed 10,955 reviews involving 11,712 children. Case selection is fully automated through FamilyNet, with specific criteria that trigger initial reviews within 3 to 6 months of the child(ren) entering placement. FamilyNet sets a review cycle that identifies subsequent reviews every six (6) months following the initial review. In only very rare cases is a child not selected for review, generally due to an error or delay in data entry. Foster Care Review managers work closely with area office staff to clarify what criteria trigger reviews, identify children not selected through the automated system, and minimize and correct those situations in a timely manner.

Policy requires that reviews "are scheduled and conducted at times which ensure, to the maximum extent possible, the participation of all invited parties." Participants must receive no less than a 14 day notice of the review. This requires a high level of coordination involving Foster Care Review and Area Office staff. Effort is made to include everyone involved with the family. Policy and regulation mandate that parents, children age 14 and older, foster parents,

group care providers, and the child's attorney be invited to reviews. FamilyNet procedures are designed to automatically invite those parties. Additionally, the Foster Care Review Unit automatically invites parents' attorneys when they are open as legal court case participants in FamilyNet. The assigned social worker is responsible for identifying who else should be invited to the review and ensuring their addresses are up to date in FamilyNet. Potential invitees may, and often should, include therapists, extended family, and school personnel. Reviews are usually scheduled in the area office responsible for providing services to the family. In cases where a parent is incarcerated, arrangements are made to hold the review at the corrections facility whenever possible. To ensure that parents and other key parties are given a chance to be heard when their attendance is not possible, participation through conference calls as well as through their submission of written documentation is offered.

The Foster Care Review Unit makes every effort to complete reviews within the month they are due. Reviews not completed within the month are generally due to scheduling issues, the unavailability of the family and/or child's attorney, or cancellations (weather, emergencies, etc.). These reviews are completed as soon as possible. The Foster Care Review unit has experienced challenges managing the increased workload since renewing reviews for young adults ages 18-22 as well as the recent significant increase of children in care. To address these challenges, there has been an increase in staffing level which is continuously assessed.

Overview of Case Identification and Foster Care Review Scheduling Process

- Families with a child in out of home placement are automatically selected to be reviewed every six months with the first review taking place between 3-6 months of entering placement.
- Social workers receive a "FCR due" Tickler on the 10th of each month.
- Social worker and supervisor are responsible for completing/updating the invitee list (including current address) and review status by due date to ensure all necessary parties are invited. Mandatory Invitees include:
 - parents/guardians;
 - children 14 years-of-age and older;
 - children's attorneys;
 - substitute care providers; and
 - additional collaterals as invited by the social worker.
- 5 days before the end of each month, a Scheduling Report is system generated of all reviews coming due within two months and any prior reviews not held.
- Turn Around documents are generated for each review due identifying:
 - all children requiring review;
 - invitee list; and
 - date availability information as provided by the child(ren's) social worker.
- FCRU managers review all Turn Around documents prior to a scheduling meeting. When workload exceeds capacity, families are prioritized for review as capacity allows according to the following protocol:

- families who did not have their prior FCR held (these reviews encompass up to a 12-month review period; in these situations two reviews are “combined”);
 - initial reviews;
 - youth 17.5-18 years-of-age (for Sustained Connection decision); and
 - families with a child 5 years-of-age or under living at home.
- Scheduling process is completed and invitation letters are mailed between the 12th –15th of the month prior to the review month.
- Cancelled Reviews: When a scheduled review requires rescheduling, every effort is made to re-schedule within the review month.
 - Reasons for re-scheduling may include requests by parents, attorneys, social worker; unavailability of case reviewers, weather, etc.
 - When reviews are cancelled and do not need to be re-scheduled (e.g., reunification with dismissal of custody, adoption/guardianship finalized, older youth declines further placement services), every effort is made to schedule other pending reviews in the vacated time slot.

Foster Care Review determinations are made by a review panel. The panel is led by the Foster Care Reviewer, who is an employee of the Department’s Foster Care Review Unit. The review panel is structured to include a “Second Party” panel member, who is a manager/supervisor from the office where the review is being held, and a Community Volunteer. The Foster Care Reviewer is responsible for preparing for the review, facilitating the meeting, and recording the results. The “Second Party” on the panel is not involved in the case being reviewed, but is able to bring information and knowledge regarding the community and available resources. The Community Volunteer brings an unbiased perspective to the meeting. The panel members have an equal vote in the review determinations. Reports are sent to parents, children ages 14 and older, children’s attorneys, foster parents and parents’ attorneys. Social workers access the reports electronically.

The review panel is responsible for making specific binding determinations, with a focus on safety, permanency and well-being. For each review, the panel must decide:

- Is placement necessary and appropriate?
- What is the level of participation by each party in the tasks and services identified in the case plan?
- What progress has been made toward the child(ren)’s permanent goal(s)?
- What is the appropriate permanent goal?
- When should that goal be accomplished?

In making these determinations, the strengths and needs of the family and individuals within the family are considered. The child’s health, educational, social and behavioral needs, and how those needs are met, are key issues addressed in the process. The panel may make nonbinding recommendations in support of the goals and objectives identified at the review. While they are nonbinding, the panel at the subsequent review will explore if and how the recommendations were addressed.

Policy includes a process to address disagreement with the review panel's determinations. Parents, foster parents, children 14 and older, and children's attorneys may appeal the panel's decision to change the permanency goal. That appeal is heard through a Fair Hearing (FH) process. All other determinations may be grieved. Additionally, when the Permanency Planning Conference held at the area office disagrees with the goal identified by the review panel, the goal is reviewed at a Regional Clinical Conference. Based on the outcome of that review, the Regional Director determines the appropriate goal.

FCR Fair Hearing Statistics

CY2013 – 8 fair hearing requests

- 2 – remanded to local area office to address issue
- 6 – dismissed
 - 2 – were grievances
 - 3 – inappropriate issues
 - 1 – requested beyond the required timeframe

CY2014 – 10 fair hearings requests

- 1 – remanded to local area office to address issue
- 4 – held
 - 1 – FCR decision upheld
 - 3 – FH decision pending
- 5 – dismissed
 - 1 – was a grievance
 - 2 – inappropriate issues
 - 2 – requested beyond the required timeframe

FCR Grievance Statistics

CY2013 – 14 grievances

- 9 – upheld the FCR determination
- 3 – changed the FCR determination
- 1 – edited information in the FCR report
- 1 – deferred until the subsequent FCR review by consensus agreement

CY2014 – 11 grievances

- 5 – upheld the FCR determination
- 2 – changed the FCR determination
- 2 – were fair hearings – forwarded on for a Fair Hearing
- 2 – concern related to the local area office – forwarded on to the area office

The Foster Care Review Unit utilizes an Alert system designed to bring appropriate attention to issues, barriers or problems identified during a case review. Those issues are related to safety, permanency or well-being, and are generated in three categories: Priority, Administrative and Legal.

- **Priority alerts** generally address situations where risk to the child has been identified.
- **Administrative alerts** identify planning, progress, case management and technical issues.
- **Legal alerts** address issues requiring legal action.

Alerts are sent either to the Director of Areas or the Regional Counsel, who is expected to respond with what action(s) will take place to address the concern. Secondary alerts are sent to “specialty units” as a support to the area office. These specialty units may lend their expertise to address the identified issue. In addition to allowing the Department to identify and resolve problems or barriers that impact safety, permanency or well-being, the alert system tracks potential trends in case practice.

The Foster Care Review Unit is in the process of redesigning its data collection tool. This tool is being designed to identify trends, strengths and areas needing improvement in agency practice with the goal of strengthening family engagement, enhancing children's well-being, and achieving permanency more expeditiously. This tool is being created to track all of this information on a statewide, regional, area and individual basis to be shared with management and staff regularly. It may assist in identifying training needs for the agency. The Department anticipates that this tool will be fully incorporated within i-FamilyNet by the fall of 2016.

The Foster Care Review Unit continues to evaluate its process with a focus on improving practice and increasing participation in reviews. Reviews are strengths based with a family centered approach. To further improve and support consistent practice, Foster Care Review management participate in periodic meetings with Area and Regional Office Management and contracted providers, as well as participate in a variety of statewide workgroups and Clinical Review Teams.

Additionally, Foster Care Review staff occasionally conduct mini trainings in area offices. The Foster Care Review Unit provides an environment of continuous learning through trainings to strengthen staff and Community Volunteers' clinical skills including Trauma Informed Practice training. The Foster Care Review Unit holds monthly Practice Committee meetings, in which Community Volunteers are regular members and part of the self-assessment process.

Item 22: Permanency Hearings

How well is the case review system functioning statewide to ensure that, for each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter?

Please provide relevant quantitative/qualitative data or information that show a permanency hearing as required for each child in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter.

State Response:

The Massachusetts General Laws requires the Court which grants custody to DCF to schedule a permanency hearing within 12 months of the grant of custody and every 12 months thereafter to review the permanency plan for the child. *MGL c. 119, § 29B*. If the Court determines that reasonable efforts to preserve and reunify the family are not required, the permanency hearing is held within 30 days of that determination. The Massachusetts Trial Court has established rules to carry out this requirement. *Trial Court Rule VI: Uniform Rules for Permanency Hearings*. The Trial Court Rule requires the Custody Court to send a list of the required hearings to the Department 120 days prior to the scheduled due date. When these are sent, DCF reviews the list and notifies the court of children who have returned home for more than 6 months, or had an adoption or guardianship finalized.¹ 60 days prior to the scheduled date for the permanency hearing, the court notifies all parties of the permanency hearing date and within 30 days of the scheduled date DCF is required to file a permanency hearing report. Some of the Juvenile Courts have begun to schedule the first permanency hearing date when the Department is granted initial custody.

In addition to the lists received from the Court, DCF has its own monitoring system to determine when permanency hearings are due for each child in DCF custody. DCF runs a monthly report of all children in placement, with key information such as the child's age, permanency goal, the last permanency hearing date, the due date for the next permanency hearing and the next scheduled permanency hearing date if available. This report provides a monitoring mechanism to assist with scheduling timely permanency hearings on an annual basis, particularly where the date the child entered placement and the date the court granted custody to DCF are not always the same. The report is provided to the DCF legal managers in each region to utilize in comparing against lists and notices received from the court. DCF legal and clinical staff has established procedures to obtain and file the permanency hearing reports.

¹ Beginning in 2012 the Juvenile Court began to convert its data system to the Trial Court's Mass Courts system. As a result of the conversion, the Juvenile Court's reporting mechanisms also needed revision. As each of the courts converted to the new system they were unable to send these lists to DCF. The General Counsel has recently been in contact with the Administrative Office and they are now able, and will soon begin, to send the lists out again to the DCF Legal Offices.

The Department's Permanency Planning Policy also specifies when Permanency Hearings are to be conducted. These include (1) within and no later than 12 months after court grants Department custody, child enters placement or a Voluntary Placement Agreement (VPA) is signed—whichever occurs first (or within 60 calendar days after court extends a VPA); (2) every 12 months thereafter as long as child remains: (a) in placement, including young adults over 18; or (b) in Department custody even if at home for less than 6 months; or (c) within 30 calendar days after a judicial determination that reasonable efforts to reunify family are not required. The Court's and Department's processes provide a 60 day buffer from the date a child has entered foster care as that is defined under Title IV-E of the Social Security Act.

In FFY 2014, 67.47% of the children who had a permanency hearing due, had one held; 52.10% were held within the required 12 months.² This was a slight decrease from FFY 2013 in which 68.6% were held and 56.7% were held timely. Care and Protection (C&P) cases are the highest percentage of court cases where custody is obtained - 83.41% of the court cases - and therefore where permanency hearings are held. When you look at the permanency hearings held in C&P cases only, the Commonwealth does slightly better in the overall percentage held. In FY14 72.82% were held and of those 56.30% were timely.

In Massachusetts, permanency hearings are not the only mechanism where the court ensures that permanency for children is occurring. C&P cases are in court several times during the first year after filing for receipt of a court investigator's report (within 60 days of filing), for a status conference (within 90 days of filing), and for a pre-trial conference (within 120 days of filing). The law governing child welfare proceedings also requires the court to enter a final order of adjudication and permanent disposition, no later than 15 months after the date the case was first filed in court. The date by which a final order of adjudication and permanent disposition shall be entered may be extended once for a period not to exceed 3 months and only if the court makes a written finding that the parent has made consistent and goal-oriented progress likely to lead to the child's return to the parent's care and custody. The Trial Court monitors compliance with this requirement through its own reporting system in which it uses 4 metrics for all courts including the percentage of cases that are resolved within the time standards. For all C&Ps and CRA cases in FY11, the Juvenile Court resolved 79% of its cases within the time standard, i.e. within 15 months.³ So, although a permanency hearing may not have been held in 32.6% of the cases, the court has other requirements and mechanisms to ensure they are monitoring children's permanency.

In October 2010, the Department underwent an administrative reorganization. This reorganization included a decrease in the number of DCF regions from six to four. For the Legal Department, most of the legal managers were either assigned to new regions or assumed responsibility for additional staff and courts. The additional responsibility challenged the managers' ability to closely monitor the timeliness of the permanency hearings. In addition to the time for managers to monitor timely completion of permanency hearings, it is essential to

² DCF used 12 months from home removal (HRE) in determining the timeliness rather than using the federal definition of entry into foster care, which in Massachusetts would be 14 months from HRE rather than 12.

³ The Juvenile Court has not published its metrics for a full year since FY2011 when it began to migrate to a new data system called Mass Courts. The Metrics also did not differentiate between C&P and Child in Need of Services (CHINS) cases.

have adequate support staff to ensure permanency hearing reports are obtained, filed timely and notice is sent to foster/adoptive parents. Between FY2000 and FY2015 the legal Department decreased its support staff by 30%. Most of the decrease occurred in 2000-2001 and staff have not been replaced. Without sufficient managers or support staff to monitor this process, the Department saw a decrease in the timeliness of the permanency hearings from FFY 13 to FFY 14, both the initial hearings and the subsequent hearings – 56.68% in FFY 13 to 52.10% in FFY 14 for initial permanency hearings, and 54.47% in FFY 13 to 47.31% in FFY 14 for subsequent permanency hearings.

Beginning in early CY13 the number of C&P filings began to increase after there had been a steady decline in filings from FY08-FY12. Starting in late in FY13 there was a significant increase in C&P filings which resulted in an annual increase of 1000 filings from 2655 in SFY 13 to 3663 in SFY 14 thus causing an increase in caseload for the DCF legal staff. In SFY 14 the Department was able to hire five (5) attorneys; however, the caseloads remain very high as compared with prior years. As a result of this staffing issue, many of the legal offices were forced to utilize one of the legal managers to assist in the court process and therefore they were not available to manage and monitor the timeliness of permanency hearings or other case resolutions.

To improve the participation of youth 16 and older in their permanency hearings, the Department applied for a grant with the Massachusetts Court Improvement Project (CIP) and hired nine (9) individuals to work specifically on older youth/young adult cases. This funding allowed DCF to hire two (2) individuals per region with the exception of the Western Region where three (3) staff were hired. Additionally in SFY 2013, DCF required these staff to monitor the number of older youth/young adults who participate in the hearings. As of April 2014, the percentage of older youth/young adults who participated in a hearing during SFY2014 was 21.06%. Of note, the Northern Region exceeded this statewide percentage by over 10%. The major reasons youth did not attend was either because they refused or because of school or work. This continues to be an area that DCF is working to improve and is a topic of discussion at almost every Massachusetts CIP Steering Committee meeting. These meetings include representatives from the Courts, DCF and the Committee for Public Counsel Services (CPCS).

Conducting permanency hearings on Children Requiring Assistance (CRA, formerly CHINS) cases continues to be a challenge. CRA cases must be brought before a judge every six months. In that context, the plan for the child, and the steps to achieve that plan, are a part of what is discussed at every hearing. In SFY 14 there were 5843 petitions filed and in SFY 13 there were 5572 petitions filed. Although not labeled a “permanency hearing,” the goal of permanency hearings is met. As stated above, the new practice of having youth 16 and older at their permanency hearings has provided an opportunity to jointly – the Courts, the Department, and CPCS– remember the requirement for permanency hearings in these cases and to conduct more meaningful hearings and develop more meaningful plans for youth, especially for those who will not be returning to their parents.

Item 23: Termination of Parental Rights

How well is the case review system functioning statewide to ensure that the filing of termination of parental rights (TPR) proceedings occurs in accordance with required provisions?

Please provide relevant quantitative/qualitative data or information showing that filing of TPR proceedings occurs in accordance with the law.

State Response:

After the passage of the Adoption and Safe Families Act (ASFA), Massachusetts General Laws was amended to provide a requirement that DCF file for Termination of Parental Rights (TPR) for any child who had been in placement for 15 of the past 22 months unless the Department had documented in its case plan a compelling reason not to. To implement this requirement, DCF established three possible compelling reasons and developed a tracking system to provide clinical and legal managers in the agency with key information on children who had been in care for at least 12 months and whether a TPR had been filed or a compelling reason not to was documented in the case record. DCF continues to use this tracking system today and the report is distributed on a monthly basis to the clinical and legal managers of the agency. The discussion on filing a TPR and whether there is a compelling reason not to occurs at a Permanency Planning Conference (PPC) which involved clinical and legal staff attend. As of August 2015, there were 4450 children in placement for 15 of the past 22 months. Of those 78.6% were either freed for adoption (823), had a TPR filed (2282) or had an exception for not filing (1217).

At the time ASFA was adopted the Department issued policy guidance on the appropriate exceptions for filing a TPR. These were later codified in the most recent amendment to the DCF's Permanency Planning Policy. The TPR exceptions include the following and must be approved by the Director of Areas or designee:

1. Child in Department custody placed with kin; neither they nor any other kin is currently interested in adoption/guardianship, and it is in child's best interests to remain with current kin caregiver.
2. Critical services, identified in Service Plan and necessary for child's safe return home within specified timeframe, have not been available.
3. Department has documented compelling reason why TPR action is not in child's best interests, i.e.:
 - a. parents are utilizing services productively and eliminating/ameliorating circumstances requiring placement; will enable child to return home within 6 months or less;
 - b. for older child, permanency plan other than adoption offers highest possible level of family connection, including physical/emotional/legal permanence;
 - c. child requires placement due to emotional/ behavioral/physical needs; parents are involved/determined to be fit, responsible and committed to being child's permanent family; or
 - d. any other compelling reason established by Regional Clinical Review Team and approved by Regional Director or their designee.

In July 2014, DCF issued and implemented a revised Permanency Planning (PPC) policy in which the agency now requires that a permanency planning conference occur when a child has been in care for at least 9 months, unless one has already occurred. TPR is considered at all PPCs as are use of permanency mediation, adoption surrender and/or open adoption agreements. Participants include an area office manager who chairs the meeting, the child and family's social workers and supervisors, area adoption supervisor, family resource workers or their supervisor and Department attorney and/or legal manager. The conference and its outcome are documented in FamilyNet/i-Familynet.

In 2012, DCF began to review on a quarterly basis all children with a goal of adoption. The reviews occur at the regional and area levels and include staff from the Adoption Support Unit, the legal office, the regional office and the area office. Although the primary purpose is not to ensure that a TPR has been filed for children in placement at least 15 months, it is another mechanism by which children in placement are reviewed and if the TPR has not been filed, action can be taken to ensure that it is. These quarterly reviews have continued to date.

In addition to the Department's requirements, the trial courts have established time standards so a child welfare case will be resolved between 12 and 15 months after filing. If the case is a TPR case, the final decision granting or denying the TPR should be completed within those time frames. For FY11, the last full year the Juvenile Court published the statewide data, the Juvenile Court met the time standards in 79% of the cases. In 82.7% of the cases the Juvenile Court began the trial on the second day a trial was scheduled. Those time standards are monitored by the administrative office of the Juvenile Court or Probate and Family Court as well as the Administrative Office of the Trial Court.

Most recently, the Department provided the CIP team with information regarding the median length of time from filing a C&P petition to TPR filed and granted – this was 555 days. In FFY 2013, 48.55% of those cases that had a goal of adoption were completed within 18 months. That number increases to 70.3% within 24 months. The Commonwealth continues to be challenged in providing day to day trial time, rather than the “rolling trial” in which a case will be heard one or two days a month over several months. In 2010 the Juvenile Court issued a standing order to require a trial to be completed within 30 days once it began. Following the practice in Worcester Juvenile Court, the Hampden County Juvenile Court instituted a dedicated trial session. This allows for multiple day trials with a dedicated judge. Unfortunately, this practice cannot be replicated in a number of courts as many of the Juvenile Courts have just one judge sitting at the location. That judge is responsible for not only C&P cases, but also CRAs and delinquencies. The difficulty with a one judge court is if a trial is scheduled and an emergency temporary custody hearing needs to occur or a bail hearing, the trial will be delayed or postponed. The Department continues to work with the Juvenile Court Administrative Office to identify and resolve those courts where the delays are significant. In some courts, the Administrative office is able to bring back retired Judges to hear the trials which allows the regular sitting Judge to hearing the emergency temporary custody hearings.

Item 24: Notice of Hearings and Reviews to Caregivers

How well is the case review system functioning statewide to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of, and have a right to be heard in, any review or hearing held with respect to the child?

Please provide relevant quantitative/qualitative data or information that show foster parents, pre-adoptive parents, and relative caregivers of children in foster care (1) are receiving notification of any review or hearing held with respect to the child and (2) have a right to be heard in any review or hearing held with respect to the child.

State Response:

Massachusetts General Laws establishes the right of foster parents, pre-adoptive parents and relative caregivers to be provided with notice of and the right to be heard at both trials on the merits and permanency hearings. The Department's regulations require that notice of the 6 month Foster Care Reviews (FCRs) be sent to the substitute caregiver for the children in placement, which includes their right to attend the review. 110 CMR 6.12(4).

Every month the assigned social worker is provided with a list of cases that are due to have a FCR scheduled within two months. The notice to the social worker provides a list of invitees for the social worker to review and update. The list always includes the parents if open and the current foster parent or congregate care provider, depending on the child's placement. The list is reviewed by the Foster Care Review unit, which schedules the date of the FCR. A notice that includes the date, time and place of the review is sent to the invitees on the updated list at least two weeks in advance of the review. Following the review, a report as to what occurred in the review is written by the Foster Care Reviewer and sent to the workers, the parents and the foster parents, even if they did not attend the review.

In response to the Adoption and Safe Families Act (ASFA), the Commonwealth amended its state law to provide the right of foster parents, pre-adoptive parents and relative caregivers to be provided with notice of and the right to be heard at both trials on the merits and permanency hearings.

The Department uses several mechanisms to ensure that foster/pre-adoptive and kinship foster parents are aware of their rights under this requirement and of the dates the cases of children in their care are in court. First foster/pre-adoptive parents are informed during the training they attend before they are licensed as foster parents, i.e. Massachusetts Approach to Partners in Parenting (MAPP) training, of their right to attend and be heard at trials and permanency hearings. It is also included in a resource guide they are provided with. Second, family resource workers and the social workers for the children in the home visit the homes on a regular basis. The workers inform the foster/pre-adoptive families when a child's case has upcoming court dates. Finally the DCF legal department sends a formal notice to the current caregiver for both permanency hearing dates and trial on the merits dates. A template letter is available in FamilyNet to facilitate the requirement. The letter pre-populates with the current caregiver based on placement data in FamilyNet. This helps to ensure that as children's placements change, there is not an additional burden on either the legal or clinical staff to send

the notice to the correct caregiver. The Department worked on and developed a report that would allow the legal offices to print and send notification letters to current caregivers for permanency hearings similar to that used by foster care review notices. The program needs further review and testing before it can be implemented.

Due to the increase in caseloads and the current administrative staffing, the requirement of notice to current caregivers of permanency hearings and trials is challenging for the legal department. As previously stated, with the reduction in support staff and staff attorneys this requirement became more difficult to maintain. However, each region does have a system in place and notices are being sent for the great majority of cases when required. In addition to DCF, the children's lawyers can also be a source of information to the current foster or pre-adoptive parents about the court process and notification of upcoming hearing dates. The child's attorney is required to visit the child client in the placement at least every quarter, and more often if needed.

Although caregivers are notified, they do not typically appear to be heard except in cases where they have been called as a witness by one of the parties or where they are the possible permanent placement for the child. The process used by the court was established as a result of an appellate decision which held that the method a court should use to consider the information from a caregiver is to put them under oath to testify. If the caregiver does attend and wish to be heard, the Juvenile Court has a mechanism that permits them to testify, or if there is no objection by any party, verbally report to the court.

C. Quality Assurance System

Item 25: Quality Assurance System

How well is the quality assurance system functioning statewide to ensure that it is (1) operating in the jurisdictions where the services included in the CFSP are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identifies strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures?

Please provide relevant quantitative/qualitative data or information showing that the specified quality assurance requirements are occurring statewide.

State Response:

The Department of Children and Families (DCF or Department) has recently established a Continuous Quality Improvement Unit. The CQI Unit is managed from the central office by the Assistant Commissioner for Continuous Quality Improvement, and staffed by CQI Specialists (supervisor level positions) located in each of the DCF regions. Interviews have been completed and offers have been extended. The CQI Unit is expected to be fully staffed by October, 2015.

A newly developed function within DCF, CQI Specialists will not replace existing Quality Assurance Supervisors. The responsibilities of CQI Specialists and existing QA Supervisors will continue to be independent of one another, but their work will intersect in both a complimentary and supplementary manner.

Duties of CQI Specialists

CQI Specialists will work under the direction of the Assistant Commissioner for Continuous Quality Improvement to:

- Coordinate the Department's Continuous Quality Improvement process;
- Provide technical assistance and consultation to area office staff in implementation of quality assurance/improvement protocols, improved case practice and administrative procedures;
- Review internal cases to assure compliance with State and Federal law;
- Conduct systematic case reviews for quality improvement in child welfare practice;
- Perform special QA/QI projects initiated by the Department;
- Review management reports and participate in strategic planning to improve performance; and
- Prepare written reports in a timely, effective manner, and perform other duties as assigned.

DCF is utilizing the ACYF-CB-IM-12-07 information memorandum on *Establishing and Maintaining Continuous Quality Improvement (CQI) Systems in State Child Welfare Agencies* to inform the development of its CQI system. The Department's CQI approach will better equip DCF to measure the quality of services provided in Massachusetts by determining the impact

those services have on child and family level outcomes and functioning, and the effectiveness of processes and systems in operation statewide.

Following the outline detailed in ACYF-CB-IM-12-07, Massachusetts is incorporating the following five key functional components in the development of the DCF CQI system:

- *Functional Administrative Structure*—to ensure that the CQI system is functioning effectively and consistently, and adhering to the process established by agency leadership;
- *Quality Data Collection*—both quantitative and qualitative;
- *Case Record Review Data and Process*—with an ongoing case review component that includes reading case files of children served by the agency and interviewing parties involved in the cases;
- *Analysis and Dissemination of Quality Data*—with the ability to track, organize, process, and regularly analyze information and results; and
- *Feedback to Stakeholders and Decision-makers and Adjustment of Programs and Process*—to drive change within the Department to improve outcomes for children and families.

DCF Quality Assurance System – History and Moving Forward

In 2002, when DCF established its core values, *Committed to Continuous Quality Improvement and Continuous Learning* was established as a foundational core value for the agency. Over the past several years, DCF has incorporated CQI fundamental principles, tools and activities into its key management processes. Use of data to monitor performance on processes and outcomes and to make strategic corrections and improvements to casework practices is embedded in the Department's Senior Staff and Statewide Managers meetings, as well as other meetings with staff and key stakeholders (e.g., Regional Forums, Statewide Advisory Council). New management and outcome reports have been developed to support these efforts. There is a comprehensive array of continuous quality improvement activities that occur on a regular basis throughout the Department and multiple training opportunities have been provided to support managers in monitoring performance on indicators and outcomes related to safety, permanency and well-being.

With the development of the 2008 – 2011 DCF Strategic Plan, the Department initiated an *Integrated Participatory Continuous Quality Improvement* approach that has been sustained over subsequent years. This approach is based on the core CQI concept that continuous quality improvement requires the participation and involvement of both internal and external stakeholders, including staff from all levels of the organization as well as family, community and provider representatives. This CQI approach was adopted specifically to ensure that continuous quality improvement was not simply the responsibility of an isolated or siloed unit within the agency, but rather became the foundation upon which the agency operated and conducted its business on a daily basis. Without this integrated and participatory approach, CQI efforts become fragmented and separated rather than the *actual* focus of all activities within an organization.

This approach to CQI was reaffirmed in DCF's 2012 – 2015 Strategic Plan update in which the agency established five primary goals. Specifically, goal 4.0 *Strengthen Performance Management and Improvement* set forth two strategic initiatives and seven objectives:

4.0 Strengthen Performance Management and Improvement

4.1	Improve Outcomes
4.1.1	Strengthen Kinship Strategies
4.1.2	Strengthen Placement and Educational Stability & Educational Achievement
4.1.3	Strengthen Adoption Processes & Practices
4.2	Enhance CQI & Performance Management
4.2.1	Strengthen CQI Structures / Processes
4.2.2	Implement Regional Provider Network Management through <i>Caring Together</i> Clinical Support (CTCS) Teams
4.2.3	Strengthen Oversight Processes for Psychotropic Medications for Children in Foster Care
4.2.4	Continue to Enhance Management and Outcome Reporting

Historically, the organizational unit primarily responsible for continuous quality improvement is the Clinical and Program Services Division within Central Office. The agency's quality improvement efforts are supported by staff in the IT, Reporting, and Management, Planning and Analysis units who are responsible for producing the management and outcome reports that guide the agency's work. There is a Quality Assurance Supervisor in each of the Department's regional offices who works with the area offices within the region to coordinate QA/CQI activities. Another key component of the agency's historical CQI infrastructure includes the area, regional, statewide teams and the Steering Committee (i.e., Senior Staff). Finally, the Family Advisory Council and the Statewide Advisory Council, as well as the local Area Boards play a significant role in the Department's continuous quality improvement efforts.

There are four primary components to the Department's *Integrated Participatory Continuous Quality Improvement* approach.

1. CQI Implementation Infrastructure
2. CQI Processes
3. CQI Analytics
4. CQI Communication and Dissemination

While the Department has long continued in its fundamental commitment to CQI, the resources needed to staff a comprehensive CQI infrastructure were unavailable. Significant and protracted budget reductions over several fiscal years could not support filling key positions that would be part of the Department's CQI structure. Nonetheless, DCF worked diligently to establish foundational CQI processes, enhance management and staff commitment to CQI, and effectively incorporated CQI activities into existing structures and processes.

Foundational Administrative Structure

CQI Implementation Infrastructure

The Department of Children and Families (DCF) is legislatively mandated to ensure the quality of services provided to children and families served by the child welfare system. This requirement is reflected in agency regulations. The Department of Early Education and Care (EEC) is legislatively mandated to license all child care and residential programs operated within the state. In turn, EEC licenses the DCF to provide foster care services within the state. DCF works cooperatively with EEC in the development of licensing standards that govern these programs and in the licensing review process, and review of critical incidents that may occur within these programs. The Department contracts with private agencies for case management services for conflict of interest cases. The standards related to CQI are set forth in the contracts with these agencies and are renewed annually. Each of the conflict of interest agencies is responsible for establishing their own CQI structures and processes. Contracts for these services establish standards.

The Department has established an *Integrated Participatory Continuous Quality Improvement* framework. The CQI infrastructure reflects the commitment that continuous quality improvement engages staff across the agency. Historically, the Commissioner provides the vision and leadership for the agency relative to continuous quality improvement and continuous learning. The Clinical and Program Services Division ensures that CQI values and processes are incorporated into all casework practices, conducts regular CQI activities, and promotes the communication and dissemination of findings from continuous quality improvement efforts. The Area, Regional, Statewide teams and the Steering Committee help to integrate continuous quality improvement across the agency.

CQI Staffing

The Clinical and Program Services Division is the organizational unit responsible for ensuring that continuous quality improvement principles and practices are embedded throughout the management and casework practices of the agency. Within this Division, the Assistant Commissioners for Continuous Quality Improvement, Planning and Program Development, and Policy and Practice each have responsibility for, and the requisite knowledge to ensure that CQI values, tools and techniques are incorporated into the design, development, implementation and evaluation of all aspects of the agency's work, its contracts with provider agencies and its collaborative efforts with other state agencies and community partners. Staff reporting to these Assistant Commissioners are responsible for grounding their particular practice areas in continuous quality improvement and for promoting CQI activities and tools with the area offices and in their work with providers.

In addition to these Central Office staff, there is a Quality Assurance Supervisor within each regional office. These staff are engaged in a number of CQI activities throughout their respective regions and assist with the quality improvement efforts in each of the area offices.

Staff involved in the design, development and dissemination of management and outcome reporting are also part of the CQI infrastructure.

Massachusetts is a state administered and operated system and therefore all regional and area offices of the state are accountable to and guided by the DCF Central Office. There are a myriad of management and outcome reports produced and disseminated on a monthly, quarterly, semi-annual and annual basis that assist managers in monitoring key indicators and outcomes. At this time the Department does not have specific policies governing CQI structures and policies—these will be developed over the next several months to support the newly established CQI Unit. This notwithstanding, there are multiple mechanisms through which the Department oversees a common set of indicators and measures. The CFSR measures established by ACF, and specific indicators that are reported monthly/quarterly to the Governor's office and the state Legislature as well as a comprehensive array of indicators established by the agency are actively utilized to monitor the Department's progress toward defined outcomes.

Job Descriptions for the state positions are developed by the Commonwealth's Human Resources Division and minimum entrance requirements are established for each position. All of the existing CQI staff members exceed state requirements for their respective positions in terms of prior experience in assuring quality of services and implementing continuous quality improvement. Through the Commonwealth's hiring process all staff are determined to meet the established minimum entrance requirements (MER). Prior to posting the CQI Specialist positions, specific work duties corresponding to the new role and function and MERs were developed and approved by the appropriate hiring authorities. The five CQI Specialists positions within the CQI Unit are being filled by individuals who met and/or exceeded the established MERs.

All staff, family and community representatives engaged in CQI activities are afforded the opportunity to participate in professional development through conferences organized by federal agencies including ACF and the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as local conferences and training. The Massachusetts Child Welfare Institute (MCWI) also offers a comprehensive array of workshops and in-service training opportunities. The MCWI purchases slots for individual staff at conferences or in-service training relevant to the staff positions. A comprehensive list of professional development opportunities is readily available to staff on the Department's intranet as well as through focused or system-wide email distribution.

A Steering Committee, statewide, regional and area teams have served as continuous quality improvement teams to monitor fidelity to the structures and processes set forth in DCF's casework practice model. These teams meet monthly to monitor data reflecting performance, and regularly review the effectiveness of communication and training, as well as the challenges and progress of the area offices in casework practices. These teams actively determine needed changes to policy or practice that are identified during the reviews and assist in establishing course corrections to support improvement efforts. The Family Advisory Council and the Statewide Advisory Council have been actively engaged in continuous quality improvement activities to assist the Department in monitoring performance and identifying opportunities for improvement.

As noted previously, the Department's commitment to an *Integrated Participatory Continuous Quality Improvement* approach necessitates involvement of staff from all levels of the agency, as well as family and community representatives. Participation of a wide variety of internal and external stakeholders ensures that continuous quality improvement efforts benefit from a variety of perspectives and promotes the accountability the agency is seeking.

CQI Processes

Historically, the Department has utilized fifteen (15) key CQI processes that have been embedded in the management and casework practices of the agency. This integrated approach ensured that continuous quality improvement was not reliant upon specific resources and personnel to engage in CQI activities, but rather those activities were/are an integral part of the agency's day-to-day operation. In addition to the fifteen (15) key processes described below the Department has contracted for case record reviews which are described elsewhere in this document.

1. **CQI Steering Committee, Statewide, Regional and Area Teams.** The roles, functions and activities of these teams are described above. The Steering Committee includes all of Senior Staff – Commissioner, Deputy Commissioners, General Counsel, Assistant Commissioners, Chief Financial Officer and community/family representatives. The Statewide Team includes representation from the Steering Committee, all Regional Directors, Regional Counsels, Facilitators/Quality Assurance Managers and Coaches. The Regional and Area teams include managers, supervisors and social workers.
2. **Critical Incident Review and Risk Management Committees.** The Critical Incident Review Committee was first convened in January, 2008 and meets weekly to review critical incidents that have been submitted by the area offices in accordance with the Department's *Critical Incident Reporting Protocol*. These critical incidents may involve fatalities, serious injuries, or other incidents that receive media attention and involve families currently open with the Department, families previously known to the Department, as well as families on which the Department has a newly filed 51A. Critical Incident trend reports are prepared on an annual basis and reviewed by the Steering Committee, Statewide Managers, and the Office of the Child Advocate. When indicated, CQI Round Tables are convened in response to critical incident trends to identify and address practice challenges.
 - The Risk Management Committee meets the first Tuesday of each month. This committee reviews fatality reports prepared by the central office Case Investigation/Special Investigations Unit. The committee also identifies any casework practice trends that raise concern and identifies strategies to improve casework practice.
3. **Fatality Reviews.** All fatalities, regardless of whether the result of abuse or neglect, on any family currently opened or closed within the past six months are reviewed. The Department uses fatality reviews as a continuous quality improvement activity to review casework practice over the course of DCF involvement with the family. These reviews include analysis of all relevant documentation including the case record and interviews with DCF staff and collaterals involved with the family. The review results in a written report that contains a series of observations on effective case practice and opportunities for improvement related

to engagement, progressive understanding, capacity building, and consolidating and sustaining gains. The report is reviewed by the Risk Management Committee, the Deputy Commissioner for Clinical and Program Services and ultimately by the Commissioner. The Commissioner's review culminates in action steps for improvement in casework practice. Once the Commissioner has reviewed the report and finalized any needed directives, the report is sent to the Office of the Child Advocate for review. Action steps from all fatality reviews are logged and tracked.

4. **Statewide Managers Meeting.** Each Statewide Managers Meeting generally includes a quality improvement topic that is grounded in a review of data relevant to the topic for that month. Participants in the Statewide Managers meeting include Commissioner, Senior Staff, Regional Directors, Regional Counsels, Regional Clinical Directors and Directors of Areas. These meetings occur on the 4th Thursday of each month. The Commissioner determines the topic for the month and the Assistant Commissioner for Quality Improvement (supported by reporting staff) prepares the analysis of the data for that topic. The participants engage in a dialogue about the performance level indicated by the data and explore strategies for improvement. These discussions may include a panel presentation from area/regional offices that are performing well and achieving positive outcomes for this measure.
5. **Area Clinical Review Teams.** Each area office regularly convenes Clinical Review Teams that include the Area Clinical Manager, Area Program Manager, Supervisor and Social Worker involved with a particularly complex case. The Clinical Review Teams are either requested by a manager in response to a critical incident or may be requested by a social worker or supervisor seeking assistance in working with a particularly challenging family. Clinical Review Teams review the clinical formulation, the family's strengths and needs, and the course of casework practice. The outcome of these reviews is a shared consensus on modifications to interventions or services to support more positive outcomes for the family.
6. **Area Office Topic Driven Dialogues.** Historically, on a monthly/quarterly basis DCF Senior Staff determine a topic relevant to improving casework practice that will be discussed in area office staff meetings across the state during that month/quarter. A PowerPoint presentation may be prepared that includes management and outcome data relevant to the topic and a series of queries to guide staff discussion. The PowerPoint presentation is reviewed at a Statewide Managers meeting, adapted to incorporate their feedback, and then disseminated to all area offices for presentation at the following month's area office staff meeting. The purpose of these discussions is to identify current practices that support positive outcomes as well as opportunities for improvement and specific strategies to improve practice. After the area office staff meeting, historically, each area office submits the results of their discussion to the Deputy Commissioner for Clinical and Program Services who consolidates the feedback. This statewide feedback is then presented back at a Statewide Managers meeting. This process promotes continuous quality improvement activities by engaging all staff in a discussion about improving practice.
7. **CQI Round Tables.** CQI Round Tables are conducted when the Critical Incident Review or Risk Management Committee identifies an emerging concern relative to casework practices. Staff from across the agency are invited to participate in a series of regionally-based Round Tables during which current practices are explored, relevant data are shared and practice

improvement recommendations are generated. Resulting recommendations for practice improvement are consolidated, reviewed with Senior Staff and Statewide Managers, and posted on the DCF Intranet. Recent examples of CQI Round Tables include Fatalities (specifically screening and response practices), Sudden Unexpected Infant Deaths (including Safe Sleeping), and Substance Exposed Newborns.

8. **Regional Forums.** In recent years, the Department has conducted six (6) annual Regional Forums. Regional Forums are conducted in each region and structured to include a two hour session with staff, a two hour session with managers, a two hour session with key stakeholders (including local community representatives, legislators, judges, police, school personnel, and providers) and a two hour session with family and youth (including birth families, as well as foster and adoptive parents). The Regional Forums have been utilized to present updates on current Departmental initiatives, as well as to elicit feedback on what is working well, what are opportunities for improvement and strategies for effecting change. Through this process the Department is able to engage a wide range of internal and external stakeholders in a quality improvement process designed to elicit feedback on topics relevant to casework and management practices.
9. **Review of 3 or More 51As.** Area Offices conduct a review of cases where more than three (3) 51As have been filed within three (3) months. These clinical and administrative reviews provide an important quality assurance activity as well as an opportunity to make modifications to the services or course of casework to improve outcomes for the family.
10. **Local Focused CQI Reviews.** Area and regional offices routinely convene a CQI effort that is topic specific. For example, if a region identifies a variance in practice on screening decisions, they will convene a team of staff from the Area Offices to review a random selection of 51A reports and the screening decisions. The team will then engage in a process of determining what led to the variability in the decisions and determine needed strategies to support greater consistency or fidelity to the practice guidance. Area offices may also convene a CQI team that is topic specific when there is an emerging practice concern or when review of data in management or outcome reports indicates a drop in performance on a particular measure.
11. **Foster Care Reviews.** The Department's Foster Care Review Unit (FCRU) also performs a critical quality improvement function. The FCRU's semi-annual reviews of each child in placement focus on whether there is a need for continued placement, whether the child is in the appropriate placement, and whether sufficient progress is being made toward the child and family's goal. Among others, results of the Foster Care Review are shared with the social worker, supervisor, and managers to ensure that they are apprised of the outcome and can make any needed changes in the interventions or service plan for the child and family.
12. **IV-E Audits.** These audits provide essential information on the Department's compliance with IV-E requirements and on the quality of casework practices and services.
13. **Area Boards.** All twenty-nine (29) area offices have an Area Board comprised of local community and family representatives. The composition and roles/functions of the Area

Boards were set forth in the *Massachusetts Acts of 2008 Chapter 176* legislation. Area Boards are routinely provided with data on current performance on a wide variety of indicators and outcome measures, including CFSR outcomes, and engage in a dialogue about how the area office might improve performance.

14. **Statewide Advisory Council.** The Statewide Advisory Council was also legislatively mandated in 2008 and membership, roles/functions were set forth in that legislation. The Statewide Advisory Council meets quarterly with the Commissioner and members of Senior Staff and routinely reviews performance and outcome data, discusses key DCF initiatives, and makes recommendations for improving casework/management practices and addressing gaps in service.
15. **Family Advisory Council.** The Family Advisory Council (FAC) has been active for the past decade and provides an important quality assurance function. The FAC regularly reviews casework practice guidance, performance data, and policies to ensure that practices and services meet the needs of families served by DCF. The FAC undertook a CQI effort in 2013 and 2014 to conduct surveys of families served by the Department to better understand their experience and level of satisfaction. The results of these surveys were shared with management staff across the agency. Similar surveys will be repeated annually.

CQI activities conducted by contracted providers are governed by contracts with each agency. Standards and service specifications are included in each contract. As stated earlier within this response section, the Department does not currently have agency regulations or policies that specifically govern internal CQI activities—policy will be developed over the next several months to support the newly established CQI Unit. Nonetheless, the commitment to embedding CQI in all agency activities is reflected in the fact that continuous quality improvement is one of the well-publicized core values of the agency and incorporated into its strategic plan, as well as compliance with a variety of federal and state regulations and requirements. All DCF regulations, policies and practice guidance are available on the DCF Intranet.

The Assistant Commissioner for Continuous Quality Improvement has reviewed a somewhat dated draft of the Department's CQI manual. The CQI Unit staff, along with key internal stakeholders will revise the document during state fiscal year 2016. Once finalized, the DCF CQI manual will be available on the DCF intranet and distributed throughout the Department.

Quality Data Collection

Data collection at DCF is an on-going process, not a set of discrete activities. Case workers are continuously *collecting* data as they document their case events. As this ongoing process of case documentation feeds a plethora of reports, data entry of information that is of high criticality to DCF is monitored by the management staff who utilize the reports. All data/reports are rigorously validated prior to dissemination. Validation includes comparing the data/report to similar data sets, ensuring not only that the records/data elements selected meet the report criteria, but also that all relevant records/data elements are selected. Validation is conducted both at the "coding/data extraction" level and at the "report/synthesis/analysis" level. These are discrete functions conducted by multiple individuals. In addition to data integrity and comparison checks, reports are scrutinized for outliers. Reports often include both summary statistical

information and the underlying detail data elements. This allows for a degree of field-validation of reports.

Report validity/reliability concerns are presented by end-users to the report-owner. The report-owner utilizes this feedback to evaluate the report/dataset and determines if there are issues with either the report/synthesis/analysis, with the underlying data, the data extraction process, or the policy the report is intended to promote/measure. Problems with the data extraction are documented in a central repository (i.e., *Remedy*) and acted upon according to urgency. Informal and formal trainings are provided for data entry issues. Because data entry is a routine part of case work, no distinction is made between *placement* and *non-placement* cases except to the extent that fewer activities pertain to non-placement cases.

Massachusetts has had an AFCARS Review and has an AFCARS Improvement Plan (AIP). Most recoding has been done as requested. There remain several areas requiring further work. Changes are needed to FamilyNet/i-FamilyNet to identify abandoned, Safe Haven children and children adopted by only one parent to ensure accurate data entry of demographic information for these, albeit small populations. There are also a couple of areas where data entry is problematic. These include documentation of disabling conditions and foster parent demographics.

Considerable effort has been expended to create useful data sets for children in placement, reports of abuse/neglect, case openings and closings, open consumers, authorized, projected and paid service referrals, child fatalities and near fatalities, staffing, etc. These are used to provide regular and ad hoc reports to stakeholders as needed.

Through the processes described in the previous section the Department integrates both qualitative and quantitative data on practice issues. By conscientiously engaging both internal and external stakeholders in multiple forums throughout the year, the Department is able to incorporate a variety of perspectives and objective information to provide a comprehensive picture of performance.

Qualitative data are routinely collected and stored in FamilyNet/i-FamilyNet to document Foster Care Reviews, Incident Reports, and Treatment Plan Progress reviews. Qualitative data are also collected as part of fatality, near fatality and critical incident reviews.

Through the automated Performance and Career Enhancement (PACE) system, established for all state agencies, DCF is able to collect information for all staff for every training opportunity they attend. In addition to PACE, the agency also collects information at many of the individual workshops / in-service trainings. The data in PACE can be run for any time period desired back to 2007.

Through the FamilyNet/i-FamilyNet system DCF is able to track all referrals made for services purchased by DCF. In addition, providers are required to enter a treatment plan in i-FamilyNet outlining services provided to clients. The Department is not able to aggregate data from FamilyNet on services received by DCF clients purchased through Medicaid or by other state agencies from which clients may be receiving services. However, this information is noted in individual case records within the body of dictation included in FamilyNet/i-FamilyNet. Individual

case records in FamilyNet/i-FamilyNet are updated regularly through dictation entered by social workers.

Case Record Review Data and Process

DCF has contracted with the Center for Support of Families (CSF) to conduct case record reviews. This agency was selected because of their wealth of public child welfare experience and prior involvement in conducting CFSR reviews. The use of an external, independent agency with expertise in conducting case record reviews, ensures that reviews are objective, and that criteria are applied consistently across the state and not subject to local interpretation. While the Department may elect to utilize non-Departmental reviewers for specific projects, systematic ongoing case review will be the responsibility of the newly established CQI Unit at DCF.

2007 CFSR PIP Case Reviews

During the Department's 2007 CFSR PIP period, the CSF utilized case record review instruments, instructions, and consistent rating criteria approved by PMAG in case record reviews conducted for Massachusetts between 2010 and 2013. The case record review process utilized the CFSR selection criteria and included second-level quality assurance completed on at least 50 percent of cases. The second-level QA was conducted by a senior member of the CSF team. DCF also established a process with CSF to ensure consistency in how ratings were determined across multiple sites and multiple reviewers. This included regular meetings with staff from CSF to ensure that there was a shared understanding of expectations. In addition, DCF staff randomly reviewed specific cases evaluated by CSF to determine whether there was a consistent approach to the reviews. Interviews were not incorporated into these PIP related reviews.

Safety and Risk-Related Case Reviews

Detailed earlier in the Safety Outcomes section of this document, as a correlate to its foster care review system which assesses the safety and quality of care provided to children and youth in out-of-home care, CSF conducted two-hundred (200) safety and risk-related case reviews on children and families in the DCF in-home population. These case reviews provided insight into safety and risk-related practice issues which may be present in DCF's work with children and families. Because the Department is able to supplement its review of outcomes and certain performance indicators through aggregate data reports, this review was designed to explore the "practice behind the numbers" in order to provide insight into which practices are working well and which warrant attention for improvement.

The Department worked with CSF to develop a case review instrument that systematically guided these in-home safety and risk-related case reviews. Review instrument development was informed by findings relating to child safety and risk from prior case reviews conducted by CSF on behalf of the Department. These findings sort into the following thematic categories:

- A need for improved use of the Safety and Risk Assessment Tool, including identification of parental protective capacities;

- A need for attention to caseworker visits with children and parents;
- A need for improved engagement of family members;
- A need for timely initiation of CPS responses and face-to-face contacts with children involved in screened-in reports of alleged maltreatment; and
- A need to identify and consider underlying issues within families contributing to maltreatment of children.

The Department's Safety and Risk-Related Review Instrument probes the quality of safety and risk-related activities in each case reviewed for each of the thematic categories identified above. Safety and risk-related reviews were conducted in ten (10) area offices on two-hundred (200) randomly selected in-home cases. While interviews with social workers and case members were not included in this focused review, managers in the ten (10) area offices were given an opportunity to complete an online survey assessing area office strengths and areas needing improvement relative to safety and risk. The Department's leadership team reviewed the report in September of 2014 and incorporated findings into its performance management and accountability system.

In its CQI strategic planning, the Department assessed the benefits of building internal capacity for conducting case reviews; in lieu of, or in combination with contracted case reviewers. The recently established DCF CQI Unit was the end product of that planning. The Department anticipates the development of a comprehensive case review instrument in state fiscal year 2016. Interviews will be incorporated into the agency's case record review system.

Analysis and Dissemination of Quality Data

Significant effort is directed to the analysis of data by the Assistant Commissioner for Quality Improvement, the Office of Management, Planning and Analysis, the Reporting Unit and IT staff. DCF data are regularly reviewed with DCF managers at Statewide Managers meetings, Regional Directors meetings, and at area office staff meetings. DCF data are provided regularly to the state legislature and are posted on the Executive Office of Health and Human Services (EHS) web site. Management and outcome reports are also posted on the DCF intranet. Historically, these data have been shared regularly with the DCF Area Boards and Statewide Advisory Council and have been incorporated into the annual Regional Forums that have included a wide array of external stakeholders.

Trend reports are a routine part of the Department's standardized and ad hoc reporting. All reports are routinely reviewed by the Steering Committee, the Statewide Implementation Team and at Statewide Managers Meetings. The availability of data on the EHS website, the DCF intranet, as well as the multitude of forums at which the Department's data are presented allow multiple opportunities to ensure that internal and external stakeholders are being reached.

Feedback to Stakeholders and Decision Makers and Adjustment of Programs and Processes

Key structures and processes established for the purpose of obtaining feedback from both internal and external stakeholders include:

- Statewide Managers Meetings
- Steering Committee
- Statewide Implementation Team
- Area Office Staff Meetings
- Area Boards
- Regional Forums
- Family Advisory Council
- Youth Advisory Council
- Additional structures and processes for obtaining feedback were outlined in the fifteen CQI processes outlined in the previous section.

Obtaining internal and external feedback is a foundational principle in the Department's CQI processes. The Department has utilized feedback obtained from these structures and processes in making adjustments to its Strategic Plan, as well as specific initiatives (e.g., development of the Integrated Casework Practice Model, Placement Stability, Kin First, Timeliness to Adoption, Promoting Well-being, etc.).

The Department's commitment to utilizing CQI data is reflected clearly in the DCF strategic plans from 2008 and 2012. CQI data and input from both internal and external stakeholders guided the development of the agency strategic plan including establishing agency goals and the priority strategic activities. The Integrated Case Practice Model established in 2008 and implemented in 2009 was founded on results of the CFSR review and the agency's internal CQI processes. The Department's 2012 - 2015 strategic plan incorporates findings of CQI reviews / input.

D. Staff and Provider Training

Item 26: Initial Staff Training

How well is the staff and provider training system functioning statewide to ensure that initial training is provided to all staff who deliver services pursuant to the CFSP that includes the basic skills and knowledge required for their positions?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- staff receive training pursuant to the established curriculum and time frames for the provision of initial training; and
- how well the initial training addresses basic skills and knowledge needed by staff to carry out their duties.

State Response:



The Massachusetts Child Welfare Institute

Purpose

The Massachusetts Child Welfare Institute (MCWI) is the professional development and training division of the Department of Children and Families. The purpose of the MCWI is to improve child welfare practice in the Commonwealth. Through a focus on three interdependent responsibilities, the MCWI promotes a shared understanding of and agreement about the Department's core practice values, commitments and priorities; teaches the knowledge, skills, and tools of facilitative child welfare practice, which makes it more feasible for social workers to help families keep their children safe; and, supports the continuous learning of social workers, supervisors, and managers as they lead agency initiatives and practice innovations.

Context

The MCWI is focused on a vision of providing high quality, evidence-informed, and relevant training programs that are helpful to the approximately 3,400 DCF social workers, supervisors, and managers across the Commonwealth in their efforts to insure the safety, permanence, and well-being of children and families. The MCWI has a budget of 2.5 million dollars for fiscal year 2016. This represents a significant increase in funding dedicated to professional development and learning programs for DCF staff over prior fiscal years. The MCWI consists of 8 full-time staff members focused on training and professional development programs (Associate Director, 4 Professional Development Managers, 1 Program Coordinators, 1 Administrative Assistant, and a Coordinator of Fellowship Programs) and a number of part-time contracted training specialists. The MCWI also employs a part-time librarian to manage the DCF child welfare library. MCWI training managers oversee the design, development and implementation of agency training programs, coordinate the work of external trainers, conduct a considerable amount of classroom training, and act as Practice Coaches in the field.

Framed by the major themes of the DCF Strategic Plan which are most connected to innovations in training and professional development; the MCWI has advanced and implemented a series of highly regarded programs. With a considered strategy to promote continuous learning and professional identity for child welfare social workers, supervisors and managers at DCF, the MCWI promotes organizational effectiveness by building on our many strengths of training, including:

Profile of DCF MCWI Training Staff:

- MCWI staff are all dedicated, highly experienced and credentialed child welfare practitioners and innovative facilitators of learning opportunities for staff
- During FY 2015, the MCWI hired two additional full-time staff: a Professional Development Manager and a Program Coordinator
- The MCWI has created an approach to curriculum design and training development that is founded on facilitative learning
- The MCWI offers practice coaching to support the transfer of learning from the classroom to the field
- The MCWI contributes to the planning and implementation of policy change initiatives
- Staff training and professional development are essential agency priorities which strengthen effective succession planning and cultivate organizational leadership.
- The MCWI has a clear budget allocation from a dedicated line-item within the DCF appropriation

Desired Outcomes

Broadly framed and organized by the DCF key strategic themes, the MCWI training and professional development programs are focused on the following important outcomes:

- Social workers, supervisors, and managers will leave any learning experience with an increased sense of their capacity, competency, and confidence in child welfare practice.
- Participants will demonstrate child welfare practices that increasingly improve the level of safety, permanency, and well-being for children and families.
- Participants will embrace continuous learning as a key to professional growth, professional identity, and advancement in the agency

Framework for Professional Development

The Department of Children and Families (DCF), through its Child Welfare Institute (MCWI), developed an innovative methodology for engaging staff in training and learning forums. The MCWI created this approach to help staff demonstrate practice skills that are reflective of the agency's core values, priorities and key concepts of safety organized child welfare practices. This approach to training is founded upon the concepts and tools of interactive facilitation. An essential principle of this training approach is that child welfare social work is a defined, unique and distinct profession within the field of social work. As a profession, child welfare social workers embrace a clear set of values which describe why their work is important and necessary. They also share common principles about how the work gets done in an effective manner. Further, the profession of child welfare social work requires that staff have a grasp of core competencies and specific knowledge and skills needed to help families keep their children safe. Finally, the profession of child welfare social work utilizes unique tools to facilitate the engagement, assessment and planning processes with vulnerable children and families.

Understanding that the purpose of training for DCF staff is to prepare social workers, supervisors and managers with the practices and skills needed to engage with families, the MCWI uses a learner-centered program design. A learner-centered approach appreciates the experience and knowledge that participants bring into the classroom and utilizes facilitated dialogues to create a deeper understanding of the principles, better relationships, and greater relevancy of the material. Ultimately, this approach helps participants leave feeling more confident using new skills and tools in practice. Learner-centered principles are directly aligned with a basic tenet of adult learning - that learning is an individual's process of incorporating new ideas and actions into their existing knowledge base or skill set.

A learner-centered approach significantly changes the nature of the relationship between the trainer and the participant. The role of the trainer transforms from "the expert with the answers" to "the facilitator asking questions" which represents a shift in thinking and new skills to capitalize on the power of questions to promote relationships in a shared learning experience. This is the fundamental principle of the Facilitated Learning Model. In order for the MCWI to successfully prepare staff for the demands of child welfare work, the facilitator must master a range of facilitation skills and have knowledge of the content needed to effectively lead a series of learning dialogues. Facilitators are challenged to demonstrate these advanced skills in order to help social workers, supervisors, and managers:

- understand the purpose of practice tools and have confidence in using practice tools effectively
- know how to access supervisory, management, and area office support in decision making
- have a commitment to the shared values and purpose of DCF interventions
- be able to reflect on their own practice skills and the impact that they have on families
- build collaboration among all of the key stakeholders needed to help families keep their children safe

This framework is a shift from the Department's traditional delivery of content based, expert driven training and appreciates that effective child welfare practice is less reliant on "what content a social worker knows" and more on "how well a social worker can facilitate change". This distinction informs the emergent curriculum design of the MCWI professional development programs, in particular the New Social Worker Professional Development Program and the Supervisor Professional Development Program.

Scope of DCF Training and Professional Development Activities

The MCWI has responsibility for providing training and professional growth opportunities for all of the approximately 3,500 staff. The learning programs available to staff through the MCWI are varied and include:

- New Social Worker Professional Development Program
- Supervisor Professional Development Program
- Investigations/Hotline Training
- New Area Program Manager Training'
- In-Service Training
- Field Based Practice Coaching
- MSW Fellowship Program
- Post-Masters Clinical Certificate Programs
- Professional Certificate Programs
- Licensing Test Preparation
- Professional Conferences
- Policy Implementation and Training

The Executive Office of Health and Human Services implemented the statewide web-based Learning Management System called PACE. This system is utilized by state agencies to create agency level training catalogues, online registration, employee training transcripts, and to generate reports to help agencies evaluate their training programs. The PACE system allows the MCWI to track employee participation, geographic accessibility, training facilities, class

sizes, trainer information, and scheduling of events. The PACE system includes a user interface to encourage employees to build their own training transcripts and professional portfolios. Furthermore, the PACE system allows the MCWI to track the attendance of individual employees in required training programs, such as new worker training, investigations training and supervisor training.

Although the PACE system is a considerable resource for the MCWI, the reporting functions do not allow for user defined queries or customizable reports. This is a considerable challenge for the MCWI as we utilize this learning management system. Although the content and approach used for all Initial Staff training is informed by contemporary evidence of successful social work practice, the DCF practice model, and adult learning theory, to frame the classroom experiences, the MCWI relies on “participant reaction”, the most rudimentary level of training evaluation, to assess the success of our current training programs.

Training evaluation efforts are often approached using the 4-level Kirkpatrick Model. The first level on this scale is “reaction”. This level simply measures how participants felt about the training. It is a survey or questionnaire that asks participants about their perceptions of the training experience. Level 1-evaluation methods are an important step in quality improvement as it helps describe how well received the training or trainer was by the participants. It also helps you improve the training for future trainees, including identifying important areas or topics that are missing from the training. The MCWI utilizes Level 1 evaluation methods almost exclusively in our ongoing evaluation of our training programs. MCWI trainers and managers utilize the feedback from participants gathered through a simple form to plan for edits and updates to the training outline for future workshops. The MCWI does not routinely gather hard data or utilize a formal evaluation tool to assess the experience of participants in the classroom and the impact that the learning has on their practice. Nor do we have the capacity to assess the transfer of knowledge from classroom learning to assess the overall impact on consumer outcomes.

The PACE system does not serve a specific function in assessing the perception or reactions of participants to the actual training program. The primary mechanism for assessing the training program run by the MCWI is paper evaluation forms completed by trainees at the completion of the training event. These written evaluations are compiled to understand the themes of feedback speaking to what was effective and helpful in the learning process and what could be upgraded in the future. The MCWI managers and trainers reflect upon the information contained in these evaluations when revising or creating new training programs.

To enhance and expand the utility of the PACE program, MCWI managers have conducted a series of capacity building workshops at the area office level to encourage staff to more effectively utilize the PACE system. These learning demonstrations were specifically designed to help local administrators to routinely create training events and courses in PACE when they hold area level trainings and workshops. The desired outcomes of this initiative was to better capture and track the full scope of training happening throughout the agency and give participants the chance to record the number of hours that they actually spend in training. The impact of this initiative has been a very significant increase in the training activities documented in PACE. In

FY 2014, there were 854 distinct training events entered into PACE. In FY 2015, this number rose to 1900 training events with a total of just over 22,000 enrolled participants.

The PACE system poses certain challenges and limitations, indeed. There is no imminent plan to upgrade the PACE system which will continue to challenge the MCWI's access to real-time and meaningful training data. The accessible data reports through PACE show the following summary of training participation for the following programs in Fiscal Year 2016:

- New Supervisor Professional Development Program included 104 individuals in two separate training groups
- New Area Program Manager training had 18 participants
- Investigations Training series had 180 participants in three separate training groups
- Professional Conference slots: 235 individuals were registered to attend conferences in fiscal year 2015.
- In-Service Training: Although cumbersome to calculate in the PACE system, the MCWI estimates that 2150 slots were filled by DCF staff for professional development and advanced practice workshops.

New Worker Professional Development Program: Initial Staff Training

- New Social Worker Professional Development Program trained 410 individuals divided by monthly training groups for 12 months in FY2015. All 410 new staff completed this program in order to be qualified for case management responsibilities.
- Over the past ten years, the department has continued to expand, diversify, and revise training and professional development programs for staff. This has included a complete revision of the New Worker Professional Development Program, the evolution of the Supervisor Professional Development Program, and the creation of a Facilitative Child Welfare Supervisor Practice Model. These examples are but a small sample of the many progressive and meaningful learning programs lead by the MCWI. All of the programs designed and implemented by the MCWI are informed through a close connection to the field and direct participation from staff at all levels of the agency. The MCWI relies consistently upon practice committees, field advisory groups, focus groups, and the feedback received from each training event to upgrade the learning experience for all participants.

Summary of MCWI Training and Professional Development Activities

The MCWI offers a range of training opportunities for DCF staff. (Please refer to the ACF Title IV-E State Training Plan for a detailed list and explanation of the training and professional development programs offered to DCF staff.) The following table summarizes the primary MCWI initial staff training program and identifies the steps necessary to connect the curriculum and content of these topics to the major strategic areas and priorities for organizational effectiveness and practice improvement:

Training Program	Current Program Objectives and Highlights	Program Goals and Objectives	Resources and Supports Needed for FY2016
Initial staff training			
New Social Worker Professional Development	<p>The NWPDP consists of 15 days of in-class training for the first month and 4 On-the-Job training days. New workers also attended 4 In-service workshops during first 6 months.</p> <p>The NWPDP curriculum engages participants to help them:</p> <ul style="list-style-type: none"> • understand the purpose of practice tools and can use tools to strengthen their initial involvement with families, • commit to the shared values of effective child welfare practice and case processes to improve interventions with families, • demonstrate that they are willing and able to reflect on their own practice skills and the impact that they have on families, • Have an increased level of collaboration among all of the key stakeholders who are committed to continuous learning and professional development in the Department of Children and Families. 	<ul style="list-style-type: none"> • The NWPDP will serve as a national model for training new social workers • MCWI will work to integrate the content of NWPDP with trauma informed practices defined by the DCF trauma grant • The MCWI will continue to refine the training schedule to include necessary content • The NW PDP curriculum and approach to training will be documented • In-Service training for NW PDP will be developed further to align with the content and methods of the first month • MCWI will develop case scenarios to represent the key practices of the ICPM • The MCWI will facilitate stronger and consistent connections to the field to support OJT • The MCWI will include field staff directly in the training as co-facilitators • The MCWI will include family representatives intentionally in key training segments 	<p>The MCWI plans to develop an effective Worker Assessment Tool to better understand the learning needs and existing knowledge base of newly hired staff.</p> <p>The MCWI will clarify the purpose and mission of the Field Advisory Committee to specifically focus on On The Job Training</p> <p>It is the MCWI's intention to include more field staff and family partners directly as co-trainers in learning programs. MCWI will need support in the implementation of a Training of Trainers for field staff and Family Partners, and leadership to encourage field staff to play an active role in training as facilitators and content experts.</p>

Item 27: Ongoing Staff Training

How well is the staff and provider training system functioning statewide to ensure that ongoing training is provided for staff that addresses the skills and knowledge needed to carry out their duties with regard to the services included in the CFSP?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Staff, for purposes of assessing this item, also include direct supervisors of all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- that staff receive training pursuant to the established annual/bi-annual hour/continuing education requirement and time frames for the provision of ongoing training; and
- how well the ongoing training addresses skills and knowledge needed by staff to carry out their duties with regard to the services included in the CFSP.

State Response:



The Massachusetts Child Welfare Institute

On-going Staff Training:

- In-Service Training: Although cumbersome to calculate in the PACE system, the MCWI estimates that 2150 slots were filled by DCF staff for professional development and advanced practice workshops.
- For the past 14 years, the MCWI has supported DCF staff efforts to become licensed social workers. As of August 17, 2015, 81% of DCF social workers held a license. This is a significant increase from the prior year when 60% of social workers were licensed. Staff are supported in their effort to obtain a license through attending a Test Preparation workshop created by the NASW Mass Chapter.

- Training programs offered by the MCWI have continually evolved to include a variety of professional development opportunities for staff, including: MSW fellowships, professional certificate programs, clinical practice in-service training, child welfare conferences, and orientation training for newly hired staff

The MCWI offers extensive professional education opportunities for staff including MSW Fellowships and professional certificates as an essential component of On-going staff training. Although tracking of participation in these programs occurs outside of the PACE system, the data presented below is considered to be accurate:

- MSW Fellowship Program, in its tenth year, has included over 150 DCF staff from the schools of social work at Salem State University, Bridgewater State University, Westfield State University, Springfield College, and Simmons College.
- Each year, up to 24 DCF staff are awarded Fellowships. The Fellowships support continues through the completion of the MSW program.
- Simmons College School of Social Work Post Master's Clinical Certificate in Trauma has produced over 220 DCF staff as graduates. This is a graduate level program with course assignments required for granting of a certificate.
- Suffolk University Certificate in Public Human Services Leadership and Management graduated 16 DCF staff in November 2014. Many of these staff have since been promoted into higher level leadership positions within DCF. This is a graduate level program with course assignments required for granting of a certificate.
- Wheelock College Certificate in Child Development produced three DCF graduates in FY 2015 with three new candidates scheduled to begin the year-long program in September 2015. This is a graduate level program with course assignments required for granting of a certificate.
- Springfield College Post-Masters Certificate Program in Advanced Practice with Children and Adolescents graduated 60 DCF staff. This is a graduate level program with course assignments required for granting of a certificate.
- Bridgewater Post-Master's Addictions Certificate has produced 3 DCF graduates last year and there are 16 scheduled to begin the program in October 2015. This is a graduate level program with course assignments required for granting of a certificate.
- The Commonwealth offers tuition remission benefits to all employees who are attending degree programs at state colleges and universities.
- Through the DCF tuition support program, eligible staff members can receive a tuition reimbursement of up to \$1,000 per year to assist with the costs of their graduate level education when they attend a private college or university

The department has continued to expand, diversify, and revise training and professional development programs for staff. This has included the expansion of on-going staff training

options, the evolution of the Supervisor Professional Development Program, and the creation of a Facilitative Child Welfare Supervisor Practice Model. These examples are but a small sample of the many progressive and meaningful learning programs lead by the MCWI. All of the programs designed and implemented by the MCWI are informed through a close connection to the field and direct participation from staff at all levels of the agency. The MCWI relies consistently upon practice committees, field advisory groups, focus groups, and the feedback received from each training event to upgrade the learning experience for all participants.

The many successful programs initiated by the MCWI to support on-going staff learning have been accomplished with significant challenges. The key barriers faced by the MCWI in the provision of high quality and varied training programs involve the interconnected reality of limited funding and a small number of full-time training staff. Further challenges impacting the quality and effectiveness of agency training include:

- The MCWI operates one dedicated training facility at the DCF Central Office in Boston. Having a training center in Boston does not promote ease of access statewide or cost effectiveness in the training program.
- The MCWI training space in Central Office will only accommodate small class sizes due to the physical space and configuration of the room.
- Without a dedicated and large enough training space in a geographically central location of the state, the MCWI must pay for hotel and conference space for the majority of training events. This poses budgetary challenges for the MCWI.
- Training and professional development programs could be better institutionalized into the agency's operations with a dedicated and identifiable statewide training facility.
- New legislative requirements for staff licensing and minimum yearly training hours will substantially increase the expectations on the MCWI to provide training opportunities, track participation of staff, and create reporting functions for agency accountability and quality improvement. The legislative mandates regarding staff credentials and training standards are a real motivation to advance the agency's culture of learning.
- The DCF practice coaching model has considerable promise in facilitating lasting practice change across the agency and subsequent improved outcomes for children and families. This coaching program is challenged by the key factors of the small number of coaches available to support all of the area and regional offices and the reliance on external providers to fill the existing part-time positions. The agency is challenged to implement a fiscally sustainable, internal coaching program that builds the capacity of staff in safety organized practices.
- The Practice Coaching model allows field staff access to support and guidance as they try out innovative practices and tools. It is a challenge to appreciate the full extent of the impact of coaching without data to describe the frequency, breadth, and type of coaching that is taking place in a given area office.

- The MCWI runs competency based training programs for newly hired social workers, investigators and supervisors. The expectation at the completion of these training programs is that participants have the increased knowledge and skills to use specialized child welfare tools in their practice. It has been a challenge for the department's training system to test the competency level of staff upon their completion of a given training program.
- The MCWI makes considerable efforts to inform all staff of upcoming training opportunities. It is a challenge for staff to participate in training programs when they feel overwhelmed by the demands of their daily work and feel that they do not have supervisory and management encouragement to focus on their professional growth.
- The department is challenged by the use of the current PACE Learning Management System. The PACE system is intended as an on-line resource for all staff to both maintain their own personal training portfolio and to register for MCWI training events. Users find it difficult and not intuitive to navigate the system which can dissuade them from signing up for training and attending. The PACE application is challenging for MCWI staff and trainers trying to set-up training events and to generate aggregate information about routine training activities. Although there were efforts over the past fiscal year to implement a more modern and user-friendly learning management system by the Commonwealth, this initiative has been stopped due to a lack of funding by the legislature.
- At the end of FY 2015, the MCWI lost three key staff members to the Early Retirement Incentive Program. The MCWI Director, Fiscal Coordinator and PACE Administrator all took advantage of this benefit. These positions are not going to be immediately filled. The significant gaps in work responsibilities are being filled by remaining MCWI staff.

Summary of MCWI Training and Professional Development Activities

The MCWI offers a range of training opportunities for DCF staff. (Please refer to the ACF Title IV-E State Training Plan for a detailed list and explanation of the training and professional development programs offered to DCF staff.) The following table summarizes the primary MCWI ongoing staff training programs and identifies the steps necessary to connect the curriculum and content of these topics to the major strategic areas and priorities for organizational effectiveness and practice improvement:

Section IV: Assessment of Systemic Factors

Training Program	Current Program Objectives and Highlights	Program Goals and Objectives	Resources and Supports Needed for FY2016
On-Going Staff Training			
Supervisor Professional Development	<p>Currently, the Sup PDP is a series of facilitated regional based Learning Circles. There are 9 active learning circles involving approximately 95 Supervisors. The Learning Circles encourage supervisors to:</p> <ul style="list-style-type: none"> • Share in a reflective process of improving social work practice • Learn and develop the skills of facilitative supervision • Discuss what actions they can take to promote agency innovations such as STS. • Improve their clinical skills through appreciation of trauma informed, safety organized practice. • Consider supervisory practices that influence the larger agency goals regarding placement stability and repeat maltreatment 	<p>The MCWI strives to further develop the Sup PDP through:</p> <ul style="list-style-type: none"> • Promoting the DCF Facilitative Supervisor Practice Model • Expanding the level of participation by supervisors in the program • Building the capacity of supervisors to facilitate learning circles • Developing in-service training to advance supervisor's skills in trauma informed practice • Using the Sup PDP to engage supervisors as practice leaders in innovative approaches to engaging families and children. 	<ul style="list-style-type: none"> • Continued support and increased clear commitment from managers for supervisors to attend learning circles
ICPM Coaching	<p>There are currently 6 ICPM coaches facilitating practice innovations at DCF. Each coach works closely with a set of area offices through a variety of methods, including:</p> <ul style="list-style-type: none"> • Facilitation to build collaboration in direct practice decision making, • ICPM implementation teams • Formal training on IA and STS • Management consultation 	<p>In the coming years, the MCWI strives to institutionalize coaching in DCF practice.</p> <p>The strategy for coaching is currently being considered.</p> <p>The primary focus for coaching in the upcoming fiscal years is to build the capacity of staff to facilitate the practices of the ICPM</p>	<p>The MCWI will continue to define the role and scope of the coaches' work in the supporting practice advancements in the field.</p> <p>The institutionalization of coaching at DCF represents a continued commitment of resources and leadership.</p>
MSW	Through partnerships with the	In the future, the MCWI will	

Section IV: Assessment of Systemic Factors

Training Program	Current Program Objectives and Highlights	Program Goals and Objectives	Resources and Supports Needed for FY2016
Fellowship Program	schools of social work at Salem State University, Bridgewater State University, Springfield College, Westfield State University, and Simmons College, participating DCF social workers are advancing their education and practice skills and leadership opportunities.	involve Fellows more as practice leaders to support the agency initiatives and learning culture. Fellows will play a more defined role in the NWPDP, as mentors and will promote the professionalization of social work at DCF.	
Investigations and Hotline Training Series	The current 7-day training series represents an evolution of content and curriculum to better reflect the ICPM. In addition, the MCWI supports a regular conference to bring together Hotline workers to share best practices and challenges.	Future development of the program will be guided by the emerging practices of the ICPM and include a more clear emphasis on trauma and the specific practice skills of safety organized child welfare work.	Work will continue to align each day of training for investigators with the key practices of the ICPM and the vision of the Permanency Planning Policy.
Topic based Training	The MCWI offers topic-based training programs and workshops for all staff. The MCWI has a partnership with CPI and the Bridge Training Series to offer a range of highly regarded trainings that are relevant to DCF staff.	In the next three years, the MCWI will develop child welfare specific in-service training that capitalized on the clinical expertise of DCF staff as contributors to the content and delivery.	<p>As the MCWI develops the In-service catalogue for FY 2016, we need staff at all levels to contribute their ideas and expertise to the content and material.</p> <p>Increased emphasis by leaders at all levels of DCF on training as a key aspect of quality improvement.</p> <p>The MCWI will need to continue to build networks and connections to the field to include front line staff in the development and facilitation of in-service training</p>
Simmons College School of Social Work Post Master's Clinical Certificate in Trauma	This intensive training program engages DCF staff in a deeper understanding and appreciation of trauma as a factor in parent/child relationships.		

Section IV: Assessment of Systemic Factors

Training Program	Current Program Objectives and Highlights	Program Goals and Objectives	Resources and Supports Needed for FY2016
BU Certificate in Non-Profit Management and Leadership	Program support effective management, leadership, and organizational improvement. Program supports succession planning.		
Wheelock College Post Master's Certificate in Early Childhood Mental Health	Early Childhood Grad Certificate for Social Workers and Other Mental Health Professionals Wheelock College's innovative Graduate Certificate in Early Childhood Mental Health—structured so it can be completed in as little as one year—enables master's level social workers and other mental health professionals to develop expertise in early childhood development, psycho-social risk and resilience, and in providing mental health services to young children (age 0-6 years) and their families and consultation to early care and education providers.		
Springfield College Post Master's Certificate in Advanced Practice with Children and Adolescents	This program imparts the latest knowledge of clinical practice and increases skill sets. The program is designed for social workers, nurses, mental health professionals, school counselors, and others who have earned a master's degree. The 90 CEU curriculum includes contemporary practice, theories, and intervention techniques.		
Bridgewater Post Master's Certificate in Addictions	DCF offers staff the opportunity to attend the Bridgewater State University School of Social Work post-Master's certificate program. This series of classes focuses on addictions with special emphasis on substances and additional segments on gambling, internet and food. The certificate program will offer 30 Continuing Education Credits for Social Work.		

Item 28: Foster and Adoptive Parent Training

How well is the staff and provider training system functioning to ensure that training is occurring statewide for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities (that care for children receiving foster care or adoption assistance under title IV-E) that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children?

Please provide relevant quantitative/qualitative data or information with respect to the above-referenced current and prospective caregivers and staff of state licensed or approved facilities, that care for children receiving foster care or adoption assistance under title IV-E, that show:

- that they receive training pursuant to the established annual/bi-annual hourly/continuing education requirement and time frames for the provision of initial and ongoing training.
- how well the initial and ongoing training addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children.

State Response:

Foster and Adoptive Parent Training

The Massachusetts Approach to Partnership in Parenting (MAPP) is the mandatory pre-service education program for people interested in fostering or adopting children in the custody of the state of Massachusetts. All prospective foster or adoptive parents are given the opportunity through MAPP to learn about the Department of Children and Families (DCF) and the children in need of foster or adoptive families. The MAPP education program provides parents with information and skills-building to effectively prepare them to parent children who need care. In line with this, MAPP is designed so that upon completion of the pre-service training, parents have realistic expectations of the rewards and challenges of parenting a child through foster care or adoption. Continuous learning opportunities support parents' ongoing needs as they tackle the challenges and reap the rewards of watching children and families grow and develop.

In addition to requiring that all Unrestricted, Licensed Foster Homes for the Department complete MAPP, the Department as of July 1, 2006, began requiring all contracted intensive foster care agencies (IFC) to use the MAPP curriculum, as well as requiring the agencies to follow the DCF Family Resource Policy and regulations to support licensure of their foster homes. All homes are required to be trained (unrestricted, child-specific, and kinship). In the summer of 2003, in response to an increase in kinship/child-specific foster and pre-adoptive families, the Department developed the Kinship and Child Specific Training and Resource Guide in English and Spanish. This guide provides the pre-service training component for the Department's Kinship and Child Specific foster and pre-adoptive homes.

To assure consistent, on-going in-service training of all foster/pre-adoptive families, the Department has engaged with MSPCC/Kidsnet in developing our post-approval curriculum and

provide an array of support services to Departmental Foster/pre-adoptive homes including a Helpline, information, support from an experienced foster parent, and respite. MPSCC is contracted to provide post-approval foster/adoptive/kinship training at a minimum four hours per month per DCF Area Office, track attendance at trainings, develop curriculum, and identify and document training needs for foster/pre-adoptive families.

Staff of State Licensed or Approved Facilities Training

Congregate care facilities contracting with the Department of Children and Families to serve children under its care and custody are contractually obligated to ensure that the following performance specifications are maintained:

4.01(A) Staff Supervision and Training:

4.21(A)(1) Staff Proficiencies: A Contractor ensures that all service staff are trained and demonstrate proficiency regarding applicable contract requirements particular to their duties and responsibilities, as well as organizational policies and procedures.

4.21(A)(2) Oversight of Clinical Service: A Contractor ensures all clinical services delivered by the Contractor are overseen by an independently licensed clinician.

4.21(A)(3) On-Going Training: A Contractor will ensure staff have sufficient training to effectively work with youth and families. Ongoing staff training includes, but is not limited to:

- Family-driven youth-guided treatment;
- The Building Bridges initiative and principles;
- Role of Family Partner
- Strength-based assessment and care;
- Requirements of Rehab. Option (applicable to Continuum, Group Home, Follow Along, and Residential Schools);
- Medication Administration Program (MAP)
- Mandated Reporting of suspected abuse and neglect (DPPC, DCF, and Elder Affairs);
- Roles, responsibilities and establishing and maintaining professional boundaries;
- Positive youth growth and development;
- Working with families of adopted youth;
- Health, wellness and sexual decision making;
- Behavior support skills and interventions;
- Restraint prevention;
- Serious emotional disturbance in youth;
- Crisis prevention and intervention;

- Trauma-informed care;
- Learning disabilities and other neurological impairments and implications for clinical and milieu interventions;
- Medical conditions of youth served;
- Cultural responsiveness;
- The effects of out-of-home placement on youth and families;
- Substance use/abuse (signs, techniques to support recovery, resources);
- Domestic violence;
- Working with Gay, Lesbian, Bisexual, Transgender, & Questioning youth;
- PAYA (working with youth 14 and older); and
- Staff safety training.

4.21(A)(4) Staff Training in Restraint Prevention. If a Contractor uses restraint or seclusion, it has must have a restraint prevention program based on a well-recognized and validated model of staff training and include annual training, evaluation and validation of staff competency. The Contractor must monitor restraint competencies of staff and provide regular refresher training and immediate remedial training for staff who fail to perform de-escalation and restraint techniques proficiently. The Contractor will adhere to a staff retraining plan that ensures that there are no lapses in annual de-escalation and restraint re-certification.

4.21(A)(5) Training Records. A record of all staff training is maintained. The record, at a minimum, captures topic, date and staff participation.

E. Service Array and Resource Development

Item 29: Array of Services

How well is the service array and resource development system functioning to ensure that the following array of services is accessible in all political jurisdictions covered by the CFSP?

- Services that assess the strengths and needs of children and families and determine other service needs;
- Services that address the needs of families in addition to individual children in order to create a safe home environment;
- Services that enable children to remain safely with their parents when reasonable; and
- Services that help children in foster and adoptive placements achieve permanency.

Please provide relevant quantitative/qualitative data or information that show:

- The state has all the above-referenced services in each political jurisdiction covered by the CFSP;
- Any gaps in the above-referenced array of services in terms of accessibility of such services across all political jurisdictions covered by the CFSP.

State Response:

Massachusetts was rated as being in substantial conformity with the Service Array systemic factor in the 2007 CFSR. A number of the Department of Children and Families' (DCF or Department) Policies guide its service array, accessibility and individualization including: Assessment, Service Planning and Referral; Permanency Planning; Placement Prevention and Placement; and Service Delivery for Intact Families Policies.

DCF is a state administered agency and as such its services are accessible to all children and families who become involved with the Department. The DCF Treatment Planning Process is web-based and completely transparent. Information on service resources is available to DCF Area Office staff and Lead Agencies from all service providers facilitating fuller and more efficient use of services and lessening delays in accessing services.

Starting in 2005 and continuing to 2014, the Department has continued to develop and implement services that support children and families; assess needs and strengths; and address service needs in a way that maximizes the capacity of children to remain at home or when this is not possible, addresses permanency issues. These services include:

- Family Networks
 - Lead Agency Services
 - Support and Stabilization Services
 - Congregate Care (replaced by Caring Together Residential Services in 2013)
- Comprehensive Foster Care (this service replaced the Family Networks Intensive Foster Care services)
- Caring Together
- Family Partners

- Family Resource Centers

Family Networks:

In 2005-2006 the Department established its Family Networks system. Family Networks is an integrated system of both DCF (then called DSS) -purchased services (support and stabilization services, intensive foster care, and congregate care) and non-purchased supports. Family Networks was designed to fully engage providers in enhancing the capacity of parents to safely care for their children and in fostering and protecting children's permanent connections to family, kin, and other significant adults. By establishing Area Lead Agencies, Family Networks includes an enhanced management system.

On July 1, 2005, the Department established contracts for 29 Area Based Lead Agencies. Area Lead Agencies work in partnership with each of the 29 Area Offices and their communities to support and enhance the performance of the area office in achieving positive permanent outcomes for children and their families. The Area Lead Agency serves as the hub for coordinating purchased services and non-paid community supports and provides service coordination.

In 2006, the Department established contracts for Network Services (support and stabilization services, intensive foster care, and congregate care), developing Provider agencies of network services charged with identifying and breaking down the structural barriers that had historically made the flow into, through, and out of the service system towards permanency ineffective, choppy and inefficient. By integrating these services, we were better able to support families in caring for and safely nurturing their children at home; reduce cycles of repeat involvement with DCF; maximize community connections and reduce isolation; minimize the need for and the time spent in out-of-home placement; reduce the number of unproductive moves that occur during placement; reduce the length of time a child spends in a non-permanent placement; and support youth transitioning to young adulthood in a manner that maximizes their potential.

Integral to the functioning of Family Networks are Family Team Meetings, which are charged with developing a service plan that meets the unique and individualized needs and strengths of the family. Area Lead Agencies convene these family teams, which are attended by family members, their natural supports, the DCF social worker, and others who play a key role in the family's life. The team develops a plan that integrates the specific Network services needed to help the family achieve the goals established in the DCF service plan. The Child and Adolescent Needs and Strengths (CANS) assessment tool is used to identify child and family needs and strengths and to support team communication and decision-making for cases in which residential services are being considered.

One of the initial key goals for Family Networks was to shift the Department's reliance on residential campus-based programs to community-based placements and in-home services. In the first nineteen months of Family Networks implementation, (7/1/06 through 1/31/09) the Department decreased its use of residential schools by 24% and its use of group homes by 8%, while increasing its use of community based services by 17%.

Caring Together:

While the Department was pleased with the successes of Family Networks, as the time approached for the required renewal of these services, DCF wanted to take the opportunity of the re-procurement process to continue to drive the system even further toward an integrated service delivery system that is youth guided, family driven, responsive to needs, provides successful transitions and outcomes, and is community focused. The first step in this process was the development and implementation of a re-designed residential (congregate care) service system, called Caring Together. The Caring Together Request for Response (RFR), released in August of 2012, represents a partnership between DCF, the Executive Office of Health and Human Services (EHS) and the Department of Mental Health (DMH). The involvement of youth and families in all phases of the design and implementation of Caring Together, including focus groups, design teams, program evaluation teams, the Provider Advisory Committee, and the Evaluation workgroup, has been tremendously helpful in ensuring that services were designed to be, and remain, responsive to the needs of youth and families.

The vision statement of the Caring Together RFR states that families are the center of the design, development and delivery of services and supports they need. The system is designed so that Massachusetts children and families will have timely access to an integrated network of out of home and in home treatment services and supports that reflects their voice, is responsive to their needs, and strengthens their ability to live successfully in their local communities. As the Commonwealth transforms residential levels of service for children, there is recognition that our efforts are establishing an important framework and foundation for ensuring an integrated Child Welfare and Behavioral Health System of Care for strengthening families.

The following principles guided the development of Caring Together:

- Services are youth guided and family driven, responsive to needs, and utilize evidence informed practices.
- Services are trauma informed and employ positive behavioral supports and interventions to assist children with problematic behaviors.
- Families will experience “No Wrong Doorway” into residential services regardless of agency affiliation.
- Children and families will have access to the right level of service at the right time for the right duration.
- Services will be integrated in a manner that provides continuity of treatment and therapeutic relationships.
- Treatment success is measured by the extent to which improvements are sustained following discharge from this level of service.
- Reimbursement methodologies will support innovation and improved outcomes.
- Performance measures are developed through a consensus building process with providers and families.
- Agency processes and structures will maximize administrative efficiencies.

The primary goal in this service procurement is to achieve better and more sustainable positive outcomes for children and families who come to the attention of either DCF or DMH. This requires full family engagement during the course of the residential service in all aspects of a

child's care and treatment unless there are safety concerns that require alternative planning. The objective is to prepare families, including foster, kinship or adoptive families, to manage their children successfully at home and promote their capacity to sustain their child's and the family's well-being. The secondary goals of Caring Together are:

1. Maximize the Commonwealths' fiscal resources by eliminating redundancy in administration and management;
2. Promote innovation and creativity among service providers;
3. Transform the residential treatment system from a primarily placement oriented service to one that is primarily community treatment oriented;
4. Increase family and youth satisfaction with these services; and
5. Improve family well-being as measured by increased caregiver/parental capacity and increased child functioning.

Caring Together integrates congregate care treatment and home or community based treatment under a single service model. This method of purchasing provides several important benefits. First, it allows providers to serve children and families on a continuous basis regardless of where the child is living. If a child meets the criteria for a residential level of service, it does not preclude providing that intensity of service in the child's home. It also allows for eligible programs to be primarily a community based model with placement as an adjunct service, or to primarily be an out of home treatment model with services that follow the child back into the community. For some families it will be possible for children to remain at home or have a very brief episode of out of home placement. When youth do need to receive services out of the home, Caring Together requires that providers work collaboratively with DCF toward permanency goals. In addition, Caring Together includes an increased emphasis on providing successful transitions. In response to requests from parents (during focus groups) to increase family supports while children are receiving residential services and after children are returned home, services were developed that allow the clinicians who work with the families at the residential service to begin working with the family in the family's home preparatory to discharge and to continue this work after the child has left the residential program. The Department believes that these transitional services will positively impact long term outcomes for families.

A related but separately purchased service that the Department is currently developing in partnership with EHS and DMH, and in collaboration with the MassHealth (Medicaid), is Family Partners. This service pairs individuals with lived experience within the state's mental health or child welfare systems, who will help families to better understand and navigate these systems. Family Partners will also assist professionals within Caring Together in better understanding the experience of parents, and in improving parental involvement. Within Massachusetts, Parent Partners have been used successfully within the Child Behavioral Health Initiative (CBHI). The Caring Together Parent Partner service has been designed in collaboration with the CBHI model.

Within Caring Together, four regionally based Caring Together Clinical Support (CTCS) teams have been established in order to ensure that the services within Caring Together are of high quality, meet the needs of DCF's children and families, and can be accessed uniformly across the state as needed.

Title IV-E Demonstration Waiver:

Massachusetts was approved for a Title IV-E Demonstration Waiver in Federal Fiscal Year 2012, with which DCF has started to invest federal reimbursements into the new Caring Together residential services system developed in collaboration with the DMH and EHS. The waiver demonstration project was implemented statewide on January 1, 2014, and broadly targets children of all ages in state custody who are in residential placement and can return to a family setting, are preparing for independence, or who are at risk of residential placement with four new services: Follow Along, Stepping Out, Continuum, and Family Partners.

Follow Along services will provide intensive home-based family intervention and support to children, youth, young adults, and families, both while they are being prepared to return to home/community from congregate care settings and after this return has taken place. Stepping Out services will support youth who have transitioned to living independently after receiving Pre-Independent Living and Independent Living Group Home services. Continuum services will be provided to children and youth at risk for residential placement where the family is identified as able to care for the child at home, or work toward return home, with intensive supports. Family Partners will be offered on a voluntary basis to families. Family partners will have lived experience with the child welfare and/or child behavioral systems themselves and will support families during the residential experience and stay with the families during a youth's transition back to the home or community, when requested.

Caring Together (CT) uses flexible Title IV-E funding through the waiver to support the new programs offered in conjunction with DMH. Follow Along and Stepping Out services were implemented beginning July 1, 2013, and have been offered to DCF clients since that date, while Continuum services began later in 2014. Family Partners are being rolled out utilizing a focused pilot process in 2015, along with a consolidated management and governance approach in collaboration with DMH, to make improvements in permanency, well-being, safety, and child abuse and neglect recurrence rates within those families who participate. The new programs are a comprehensive transformation of the current DCF congregate care system using the principles and values laid out by Building Bridges, a national initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) to create "systems of care" between families, youth, communities, and residential treatment providers.

While still in the data collection stage, both the broader Caring Together population and the subset enrolled in the IV-E Demonstration Waiver will be tracked and evaluated using a comprehensive set of process and outcome measures. These include but are not limited to the following:

- *Satisfaction* – consumer children/youth/parents, provider/foster parent/DCF staff, etc.
- *Follow Along utilization* – children served counts; days of service
- *Stepping Out utilization* – children served counts; days of service
- *Continuum utilization* – children served counts; days of service
- *Congregate Care utilization* – children served; days of service; length of stay
- *Family Partners utilization* – # and % of children served; # and % of families served
- *Restraints* - % of children in congregate care restrained; restraints/1k enrollment days
- *CANS* – pre/post comparisons
- *Placement Stability*

- *Child Risk Behaviors* – # and % of children with ≥ 1 critical incidents; average # of critical incidents per child; # and % of children with one or more incidents of self-injurious behavior (self-harm); # and % of children with one or more unauthorized leave incidents
- *Safety* – repeat maltreatment and maltreatment in foster care
- *Permanency* – # and % of children returned home or to a permanent placement
- *Reentry* – # and % of children re-entering Caring Together

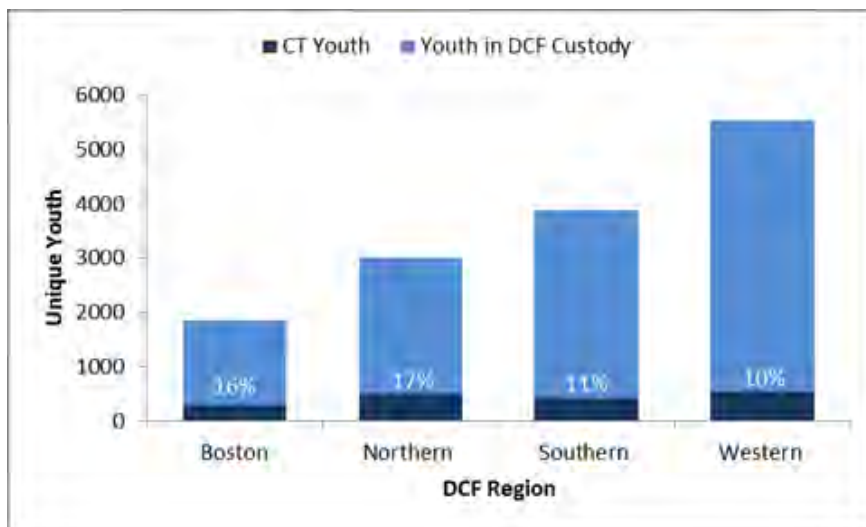
Significant IV-E Demonstration Waiver Evaluation Findings:

The evaluation team has held focus groups with DCF staff, providers, and parents/caregivers. Overall, the focus groups have identified many strengths in the progress of Caring Together services. DCF staff and providers have demonstrated a commitment to the principles of this procurement and report better collaboration between DCF and DMH. Providers also report that they appreciate the opportunity to join forums to provide feedback.

These focus groups have also identified areas for improvement such as the need for further clarification of the role of the CTCS teams and improved alignment and coordination across levels of care. Providers are also feeling the need for more flexible options for the placement of latency youth and addressing issues such as the new Medication Administration Protocol. There also needs to be a continued focus on parental involvement in youth's treatment plans and incorporating cultural and linguistic needs of families in service delivery.

During the period January 2015 through June 2015, 1,818 youth in the waiver received CT services, out of 14,623 youth in DCF custody. Consistent with CY 2014, waiver youth receiving CT services comprised 12% of all youth in DCF custody, and this varied by regional office (Figure I.1). The Boston Regional office served 1,852 youth in the period January 2015 through June 2015; of those, 297 youth (16%) received CT services. The Northern Regional office served 3,017 youth, of which 508 (17%) received CT services. The Southern Regional office served 3,877 youth, 430 (11%) in CT services. The Western Regional office served 5,536 youth, of which 541 (10%) received CT services.

Figure I.1. Number and percentage of youth in Caring Together compared with all youth in DCF custody, by region from January-June, 2015.



Level of Service (LOS) Tool:

The LOS tool is currently being piloted in four DCF area offices. Caring Together leadership has developed the Caring Together LOS tool with help from DCF and DMH staff. The tool will promote a standard referral review process for assisting area offices in determining which Caring Together service is the most appropriate clinical fit for a given youth. CTCS staff will support DCF and DMH areas in a phased process for rolling out the LOS tool and review process.

CTCS Provider Record Reviews/Network Management:

DCF and DMH implemented a joint quality assurance process related to Caring Together services in 2014. Annual CTCS Provider Record Reviews were completed for all Caring Together providers between January and June 2015. During the 2014 round of reviews, CTCS teams found a compliance rate of 40-50 percent related to clinical formulations, services following treatment plans, and daily documentation of plan goals. As a result of technical assistance from the CTCS teams, the compliance rate increased and now exceeds 70 percent. During the 2015 round of reviews, the CTCS teams provided further technical assistance and encouragement to providers related to model fidelity. DCF is encouraged that providers appear to be adapting to the standards.

Additional baselines established during the most recent reporting period include frequency of family and youth engagement and strengths-based treatment planning. As an indicator of engagement, DCF has found that 64 percent of provider treatment plans are signed by family members and 69 percent are signed by the youth. DCF also found that 81 percent of provider treatment plans indicated strengths as a part of planning. As with the overall compliance rate above, these figures indicate a baseline from which DCF hopes to improve in the months ahead.

A Network Management Survey, addressing the key goals of Caring Together which cannot be addressed through Provider Record Reviews, was distributed to the providers in May, with a reporting deadline of July 15, 2015. The survey is intended to (a) monitor quality assurance relative to Caring Together contractual requirements outlined in the Caring Together Joint Standards, and (b) gather data as required by IV-E reporting regulations. This evaluation data will be analyzed in aggregate and by provider and will be conducted annually. The Department will use the aggregate data to assess strengths and areas for improvement in the Caring Together system as a whole. In addition, CTCS teams will examine each provider's data to inform ongoing quality improvement efforts and the promotion of promising practices.

Family Resource Centers:

Building upon a successful pilot, the Department is currently soliciting bids for a larger compliment of Family Resource Centers across each of the counties in Massachusetts. Family Resource Centers are community-based, culturally-competent programs that provide evidence-based parent education programs, youth and parent support groups, early childhood services,

information and referral, educational support, cultural events, and other opportunities for families whose children range in age from birth to age 18. Families access Family Resource Centers on a voluntary basis, and therefore need not be involved with DCF in order to avail themselves of this community-based service.

Comprehensive Foster Care:

The foster care services included in this procurement incorporate a clinical treatment model that utilizes specially trained foster parents who partner with contractor agency clinical staff and Department staff to develop and implement individualized treatment plans. These foster care services are trauma sensitive and rely on a structured system of care that utilizes evidence and strength-based treatment interventions to promote the child's/youth's safety, healing, well-being and development of healthy and sustained lifelong relationships. These programs have the capacity, skills, and commitment to work with children, youth and families on the full range of permanency plans: reunification, adoption, guardianship, permanent care with kin, or an alternative permanent planned living arrangement. Success is linked to the achievement of each child's permanency plan, while maintaining safety and well-being.

Item 30: Individualizing Services

How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be individualized to meet the unique needs of children and families served by the agency?

Please provide relevant quantitative/qualitative data or information that show whether the services in item 29 are individualized to meet the unique needs of children and families served by the agency.

- Services that are developmentally and/or culturally appropriate (including linguistically competent), responsive to disability and special needs, or accessed through flexible funding are examples of how the unique needs of children and families are met by the agency.

State Response:

The Department of Children and Families' (DCF or Department) entire purchased services array can be individualized to the needs of a specific child and family. The use of Family Team meetings allows for a family driven process in which individualized needs and strengths are identified, and the resulting treatment plan focuses on these identified needs while enhancing strengths. The DCF Treatment Planning Process focuses on treatment Domains, Goals and Activities, all of which can be tailored or customized. A primary responsibility of the Departments' Lead Agencies is to ensure that services are individually tailored to a child and family's needs. To be able to accomplish this task, Lead Agencies are contracted to work with their respective area offices to develop an overall array of services that will effectively service the collective and individual needs of that office's children and families.

Caring Together residential services include a wide range of programming, allowing the service to be matched to the child and family's needs. In addition, Caring Together services can be supplemented with Add-On services when it is determined that the needs of a child and/or family require additional staffing or services. Family Networks Support and Stabilization services are flexible, rooted in the community, and have the capacity to be shaped in a manner that will address the specific needs of each family. The service array includes a number of services with varying staffing, intensity levels, and interventions, allowing this service to be customized to individual needs. Comprehensive Foster Care (CFC) services also include a wide range of models which can be accessed depending on need.

F. Agency Responsiveness to the Community

Item 31: State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR

How well is the agency responsiveness to the community system functioning statewide to ensure that in implementing the provisions of the CFSP and developing related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

Please provide relevant quantitative/qualitative data or information that show that in implementing the provisions of the CFSP and related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP.

State Response:

The Massachusetts Department of Children and Families (DCF) was found in substantial conformity on the Agency Responsiveness to the Community systemic factor during CFSR rounds 1 and 2. DCF continues to take affirmative steps to engage both the public and private sectors as well as to ensure representation of DCF consumers (both parents and youth), providers, staff and partners in the planning, development and implementation of systemic reforms. The Department employs a broad array of strategies to ensure that stakeholders are engaged in consultation with the state to implement the provisions of the CFSP. Stakeholders include representatives from the State's federally-recognized tribes, former consumers, foster and adoptive parents, service providers and state agency partners.

Consumer Engagement in Consultation

In 2004, the Department launched the Family Involvement Initiative by hiring a full-time Family Representative as part of the Family Support Team. The purpose of the Family Representative is to promote partnership between DCF and community members on behalf of families and to facilitate the inclusion of parents in the planning, delivery and monitoring of DCF practice and contracted services. The Family Representative has recruited over 200 community representatives to work with the Department on policy, practice and to provide feedback on the quality of services. Of these community representatives, between 18 and 24 sit on the Commissioner's Family Advisory Committee (FAC). One significant indicator of how successful this program has been is that a family representative and several community representatives sit on DCF Senior Staff, Statewide Managers, and a number of intra-agency and interagency planning groups at area, regional, and statewide levels.

The Director of Family Engagement is also available for on-going technical assistance to the area offices as well as the community representatives. A yearly retreat is organized for the Family Advisory Committee to look at the work that was done in the last two years and prioritize the work that needs to be accomplished. The Family Advisory Committee is committed to working in their communities and at the area office level, concentrating on the following:

- Reviewing how DCF area offices work with fathers
- Participating in and assisting in the development of Fatherhood Engagement Leadership Teams (FELT)
- Reviewing how DCF area offices work with kin, especially grandparents
- Providing advocacy to fathers, families with mental illness and grandparents raising grandchildren.
- Participating on area boards and mentoring new consumer applicants.

As part of the Department of Children and Families' continued commitment to assessing the impact of its work and including family perspective, beginning in 2013, the Department developed a multi-year process for gathering and incorporating DCF parent and family feedback into DCF policy and practice. This effort includes an annual survey of parents and guardians with recent experience with DCF.

In 2014, the Legislature tasked the Office of the Child Advocate (OCA) with conducting a DCF client survey. Given the methodological implications of conducting two separate surveys close in time to one another, the OCA elected to partner with DCF with its parent and guardian survey. Building upon the 2013 Parent and Guardian Satisfaction Survey, the 2014 survey consisted of -- 14 Likert scaled questions (i.e., strongly agree, agree, disagree, strongly disagree), 5 yes-no, and 5 open-ended questions (4 of the survey questions were developed by the OCA).

The confidential survey included questions in the following areas:

- initial engagement with the family
- DCF's communication and work style with the family
- efforts to build family capacity and focus on family strengths
- opportunities to engage children
- promotion of family partnerships in service planning
- respect for family's individuality and culture
- access and availability of community services
- case closure

From November 5, 2014, to March 17, 2015, twelve Community Representatives from the DCF Family Advisory Committee—parents with prior DCF experience—began conducting the survey by telephone, in English, Portuguese and Spanish. Prior to survey administration, DCF provided a survey 'script' to the community representatives as well as training on survey techniques in efforts to standardize administration protocols and reduce bias and measurement error. Cases with an identified primary language of Portuguese or Spanish were assigned to community representatives proficient in these languages; the remaining families were divided among the community representatives in a randomized fashion.

The survey population consisted of 6,168 parents and guardians whose DCF cases were closed within the eight month period ending August 31, 2014. The community representatives

attempted to reach everyone in the survey population at least once and at most three times: in all, they were able to reach 1,722 parents and guardians and receive verbal consent from 1,157; reaching an effective response rate of 67%.

DCF anticipates conducting the Parent and Guardian Survey on an annual basis in order to ensure regular and consistent attention to including the family voice, experience and perspective in efforts to change the way DCF works with families. Future phases may also include surveys of foster parents, DCF alumni and DCF providers. Findings are/will be utilized to influence policy development and practice guidance.

2014 Parent and Guardian Survey

Excerpt of Key Findings

- 80% reported satisfaction with the communication they had with DCF.
- 87% reported being treated with dignity and respect by DCF.
- 84% reported that their DCF worker understood their families' strengths.
- 83% reported that their DCF worker understood their families' needs.
- 80% reported that their DCF worker helped them to find ways to address their families' needs.
- 90% reported that their DCF worker respected their cultural traditions.
- 84% reported that their DCF worker encouraged them to participate in making decisions about their families.
- 84% reported that their DCF worker explained what to expect during their involvement with the Department.
- 85% reported that their DCF worker paid attention to their children's needs and wants.
- 85% reported that their DCF worker met with them and their family as often as they felt was needed.
- 88% indicated that DCF worked with them to develop their DCF Service Plan.
 - 84% indicated that the tasks on their DCF Service Plan helped their families.
- 81% reported that their families had the supports they needed at the time their DCF case was closed.
- 75% reported that, overall, DCF helped their families.

Opportunities for consumer engagement include:

Family Advisory Committee (FAC) to the Commissioner – As noted above, 23 parents meet quarterly with the Commissioner to advise on policy, practice and program development. The FAC produced a new guide for parents involved with DSS, a family involvement brochure, and consumer feedback cards for use in area office waiting areas. The FAC reviews service delivery models at various stages of design, and is taking up the issue of foster care placements and how to make transitions smoother for children entering care or moving from one foster home to another.

Youth Advisory Committee - The Department's Youth Advisory Board has been active for more than 14 years. Presently, there are 32 members of the Regional Youth Advisory Boards who are committed to promoting change for future foster youth through their voice, advocacy, and action. They provide recommendations to the Department on services, policy and practice. Additionally they want to ensure that foster youth are known for their strengths, achievements, and goals and not labeled as likely failures. The Regional Youth Advisory Boards generally meet monthly, providing a forum for youth in out-of-home placement to voice their concerns and offer suggestions to the agency on issues facing youth in care. Delegates from each Regional Board sit on the Central Office Advisory Board; they are statewide representatives for their peers' interests, concerns, and questions. The agenda topics for each meeting are jointly developed by the Board members based upon their own ideas/concerns or those of the youth they represent and by DCF administration – often seeking youth input on policy, programming, etc. See the 2016 APSR Report/Chafee section for greater details regarding the activities of the Youth Advisory Committee.

Ombudsman's Office – Family Liaison Program - The DCF Office of the Ombudsman is charged with responding to consumer inquiries about case practice and working toward resolution of problems and complex situations. Working with the Family Advisory Committee, this office created the **Family Liaison Program** to increase problem-solving resources for DCF staff and families.

Family Liaisons are parents who were formerly involved with DCF. Their cases are closed, and they have become parent representatives on the Family Advisory Committee, and on Regional and Area Boards throughout Massachusetts. They are carefully selected and trained.

The Family Liaisons:

- are impartial—committed to listening to all sides and helping all parties;
- have attended DCF Core Training and have an understanding of DCF policy and practice;
- can spend up to 5 hours listening and meeting with all parties;
- some Family Liaisons have specialized knowledge about mental health, substance abuse, local community resources, the criminal justice system, probate court and fatherhood engagement.

Liaisons have been instrumental in helping families effectively engage with the Department to produce successful outcomes. The program has been enormously helpful to families ensuring that they have a voice, are empowered and have the tools, to successfully navigate a complex system.

The following chart outlines categories in which liaisons were involved:

Fatherhood	Special Needs	Substance Abuse	Grandparents	Family	TOTALS
17	17	7	1	6	48
35.4%	35.4%	14.6%	2.1%	12.5%	

Community Representatives on Service Proposal Review Teams – A cadre of parents and other interested community members have been recruited, largely from the Community Connections

coalitions, and trained to sit on proposal review teams to assist DCF to select the most qualified service providers.

General Meetings – Outreach to other advocacy groups, agencies devoted to children and parent councils, such as Parents Helping Parents, the Federation for Parents of Children with Special Needs, the Children’s Trust Fund, etc., is conducted on a regular basis, with the goal of leveraging additional support for families served by DCF.

Fatherhood Engagement - DCF has become a nationally recognized leader in its work to engage fathers. The research is absolutely clear: when fathers are engaged in a safe and consistent way, children and families benefit in the short- and long-term. Internally, the Department is working with more and more fathers every day and providing them with the support and resources they need to build stronger relationships with their children.

The work of integrating Fatherhood Engagement into statewide Area Office practice has often seemed daunting. In addition to the reluctance to begin new programs during a time of decreasing resources, an additional factor is sometimes at work. Many believe that there can be some conflict between the fields of Fatherhood Engagement and Domestic Violence. The Director of Fatherhood Engagement has worked with both fields to promote an understanding that, while there may always be an inherent tension between the two practices, that tension can be effectively addressed. There has been collaborative work between the Director of Fatherhood Engagement and the DCF Director of Domestic Violence and a specially convened committee to develop policies and practice tip sheets for situations in which fatherhood practice is complicated by the existence of domestic violence. The goal is to work with fathers who have a history of domestic violence in a way that prioritizes safety, encourages men to take responsibility for changing abusive behaviors, and acknowledging the harm that witnessing domestic violence can inflict upon children.

The Director of Fatherhood Engagement worked with 16 Area Offices in creating Fatherhood Engagement Leadership Teams (FELTs) in order to promote the institutionalization of routinely engaging with all fathers, to provide training for social workers on positive fatherhood engagement and to create/support appropriate services for fathers. Creating services frequently involves collaboration with community partners, such as Community Connections Coalitions. This is the case in Lynn, Lawrence (in Spanish), Lowell, Worcester (2 offices), Springfield (2 offices), Boston (3 offices), Holyoke, Brockton, Cape Cod, New Bedford, and Fall River - all of which have established Nurturing Fathers Programs.

Coalitions have played a crucial role in creating and expanding services for DCF-involved fathers. In addition to the services hosted or co-hosted by Community Connections, fatherhood groups have been established and maintained in Arlington, Worcester, Lowell, Plymouth, Cape Ann (Salem), and Weymouth. Groups are planned in Pittsfield and Chelsea (also Spanish). Altogether, between fatherhood groups and support groups for fathers facilitated by DCF staff and/or community partners, there are currently fatherhood groups at 21 locations and two more groups are planned.

The Family Nurturing Center (FNC) in Boston and Enlace De Familias in Holyoke (Enlace) have been longstanding leaders in local fatherhood programming. The Family Nurturing Center, in

partnership with organizations like Enlace, is also providing training on facilitation of fatherhood groups statewide. Since 2013, 90-100 group facilitators are estimated to have received training sponsored by DCF and supported with PSSF grant funds.

Statewide Events: In partnership with multiple state agencies and communities, the Department has hosted annual Fatherhood Summits; a gathering of leadership from state agencies. The Fatherhood Summit promotes commitment and action in order to expand services for fathers and to coordinate cross agency work to help low income fathers with multiple challenges. The 2014 Fatherhood Summit brought together 150 participants, mostly from upper level managerial ranks. It has brought about increased collaboration across agencies to provide services for fathers, to make sure fathers have access to services they are entitled to as parents, and to share training resources.

The Statewide FELT retreat brought together 140 DCF staff from 20 Area Offices and 15 community partner agencies to share best practices, information about services, and to broaden the community engagement in services for fathers. Community Connections Coalitions have been core participants in each of these events.

The Director of Family Engagement assists the Fatherhood Initiative at DCF in all levels of its work. She has met with Responsible Fatherhood providers across the state to identify and recruit fathers to work with the child welfare system in determining needs, and to support fathers' participation at area and statewide advisory councils. The Director of Family Engagement is a member of the Steering Committee for DCF's Strategic Plan for Fatherhood Engagement. The Director of Family Engagement supervises and mentors an advocate to work with fathers who are involved with the court and with DCF in extremely complicated cases. This advocate guides the fathers through the legal paths and provides direction on how to self-advocate in arenas that are foreign to their experience and are often punitive if one doesn't understand the culture of these systems.

State Engagement and Consultation with Stakeholders:

The Department's interagency efforts involving housing and homeless prevention, children's behavioral health, substance abuse, early education and care and domestic violence has provided greater coordination of services and case management, ensuring that our case practice is community-connected and better integrated with the work of our sister agencies and community providers.

One example is the work done by DMH and for the joint residential procurement "Caring Together". This procurement has generated creative engagement on the part of providers across the Commonwealth to ensure that services are delivered in a child's home and community whenever possible. Caring Together is built upon the nationally recognized Building Bridges to Evidence Based Practice and eliminates silos between residential care and community services.

In addition, DCF's Family Resource Centers are an effective model to increase the capacity of communities to more effectively respond to the needs of families at risk. DCF is moving towards the implementation of a Family Resource Center model that fully integrates a number of family support innovations and state and federal funding stream.

DCF has been an active partner in addressing the prescribing practices related to psychotropic medication for children in foster care. In 2009, the Office of the Child Advocate in collaboration with other state agencies began to explore the efficacy and effectiveness of the process in place in Massachusetts for authorizing consent of antipsychotic medications for children in DCF custody. In January, 2012, the Commissioner of DCF and the Child Advocate convened an interagency group to develop a plan for monitoring psychotropic medication for children in foster care. This interagency group includes representatives from DCF, OCA, DMH and several divisions within MassHealth. The group identified four potentially problematic prescribing practices to be addressed.

Consultation with Tribes

As of April 2, 2015, DCF served 106,856 open consumers. Those with Native American/Alaskan Native heritage numbered 828 which is less than 1% of the total open consumer population.

Families usually self-identify their race and ethnicity during the initial or comprehensive assessment phase of a family's work with the Department. This is usually the stage in the case when the DCF social worker becomes aware of a family's ancestry. The social worker is required to notify the MA ICWA Coordinator when custody of a child with Native American/Alaskan Native heritage is awarded to DCF. Over the past several years, DCF has encouraged staff to ask families about their Native American/Alaskan Native heritage as soon as DCF becomes involved, rather than at the time of seeking custody. Various trainings provided to DCF encourage staff to ask the question about family ancestry throughout the life of the case as extended family members may embark on a history of the family tree after the initial question is asked or, the family may feel more comfortable talking about their heritage as their relationship with their social worker deepens.

Notices are sent to federally recognized tribes across the United States by the ICWA Coordinator. The notices are sent prior to or whenever DCF gains legal custody of a child whose family informs DCF of their Native American/Alaskan Native status. Copies of all responses from the tribes are forwarded to the DCF social worker, DCF attorney and to the Regional ICWA Liaison. These notices and subsequent responses are filed in the legal section of the family case record. The tribal affiliation for each consumer is documented in the demographic screen in FamilyNet/i-FamilyNet.

Coordination and collaboration with MA Tribes

Wampanoag Tribe of Gay Head (Aquinnah) – WTGH(A)

The Tribal contact is Bonnie Chalifoux, Human Services Director. Collaboration during this past year focused on trainings for court personnel (through the Court Improvement Plan – CIP). These trainings included the courts of Worcester and Boston. In addition to the planning meetings and trainings through the CIP, meetings with the DCF Liaisons and WTGH(A) took place in May and October 2014. These meetings reviewed our goals for the year and

recommendations for next steps that will lead to greater compliance with the ICW Act and each 5-year plan.

The WTGH(A) terminated its Intergovernmental Agreement (IA) with Massachusetts effective 2/5/13. DCF has communicated to the Tribe its continued desire to begin the IA process.

DCF and Ms. Chalifoux discussed future collaboration around the Tribe's 5-year plan. There is a great opportunity for the Tribe and the Department to educate each other, share lessons learned and collaborate around many issues. ICWA cases are managed in collaboration with the applicable Tribe ICWA staff to ensure that Tribe input into case planning is an integral part of any plan for service provision and goal setting. The prioritized issues to note are compliance with ICWA, appropriate services related to permanency and independent living. While these goals are set forth with WTGH(A), there are currently 2 pending ICWA family cases. Close work with the Mashpee Wampanoag Tribe (MWT) and their 26 open cases serves as a solid foundation for future work with WTGH(A).

Mashpee Wampanoag Tribe (MWT)

The Tribal contact is Catherine Hendricks, the ICWA Director. Collaboration during this past year also focused on trainings for court personnel through the CIP.

The Tribe's 5-year plan has stressed the importance of addressing many social service needs of their membership. The MWT is looking to increase their foster parent recruitment efforts, wraparound services for children/youth, prevention of domestic violence, provide designated slots for parents who foster ICWA children in their parenting classes and offer increased support and training to Grandparents Raising Grandchildren. Given the common needs of the families DCF and the Tribe work with, DCF has offered assistance with their 5 year plan projects related to child welfare.

MA DCF was notified on October 23, 2014 that the MWT Intergovernmental Agreement (IA) has been approved by the Tribal Council. Attorneys from DCF and the Tribe have entered into initial discussions while DCF hopes to receive permission from the Tribe to provide copies of the proposed IA to key DCF and EHS staff for feedback. Additional discussions relative to the clinical considerations in the proposed IA will occur in this next year.

Wampanoag Tribe of Gay Head (Aquinnah) – WTGH(A) & Mashpee Wampanoag Tribe (MWT)

DCF, in partnership with Justice Resource Institute's My Life My Choice Program and the Suffolk County Child Advocacy Center's Support to End Exploitation Now Program, were awarded a Grant in September 2014 from the Administration for Children and Families to address the Commercial Sexual Exploitation of Children (CSEC) within DCF. This 5 year Grant is addressing the identification of and response to CSEC at DCF. The grant work will also provide guidance and support to DCF policies and practices along with a robust data collection system. The MWT and WTGH(A) committed through letters of support to participate in future county CSEC training and the implementation of the safe harbor provisions in the Massachusetts human trafficking law. Both Tribes have been invited to participate in the quarterly meetings of the grant Leadership Advisory Board. DCF and its grant partners will continue to stress the value of the Tribes' participation in this important effort to address CSEC.

The Tribes will be invited to all CSEC trainings offered to DCF/community staff. It is anticipated that the training will be offered in their geographic area in October 2015.

DCF collaborates with the Tribes in terms of Massachusetts Approach to Partnerships in Parenting (MAPP) trainings. The need for Tribal foster homes has been a focal point for DCF and the Tribes for years.

The ICWA trainings over the past five years have resulted in greater awareness by DCF staff who are now asking families about Native American/Alaskan Native heritage. The direct result of this work is that the ICWA volume is at an all-time high. DCF has recently coordinated monthly conference calls to be held with the ICWA Directors of each tribe. More frequent communication among ICWA leaders in Massachusetts is a natural outgrowth of the increased demands on all parties.

Sharing the APSR with each Massachusetts Tribe

DCF and the two Wampanoag Tribes met in 2014 to discuss their 5-year plans. Collaboration among all parties continues to deepen while addressing challenges. The APSR reports from each party spoke to common goals related to the strengthening of families through community services and informal supports. Upon finalization of the DCF APSR, a copy will be shared with both Tribes.

Notification of Indian Parents and Tribes

DCF received 125 ICWA inquiries during state fiscal year 2015. 181 inquiries are active as genealogy information is pending. 11 families representing 17 children were found eligible for membership with the Mashpee Wampanoag Tribe. The Tribe intervened in every family case.

Tribe reports 26 open ICWA cases.

DCF is diligent about its process to uncover genealogy necessary for an ICWA notice. When social workers are having difficulty documenting a child's ancestry information, the DCF attorney enlists the assistance of the attorney representing the appropriate parent. DCF also utilizes an Accurant search for missing family tree information. This is a data base that can search public records for information such as names, dates of birth, addresses, and phone numbers when demographic information is loaded into it.

Special Placement Preferences

The Mashpee Wampanoag Tribe continues to recruit tribal members to become foster parents specifically to take tribal children if the need arises. DCF works hard to notify the Tribe upon placement of children who 'may' be eligible for membership so that ICWA placement preferences are met.

Active Efforts to prevent breakup of the Indian Family (past, present and future)

Over the past five years, DCF has made notable strides in its commitment towards Active Efforts. With the new ICWA Guidelines, DCF is in the process of updating its ICWA FAQ. This document will be distributed to all DCF staff and will underscore the importance (with specific examples) of active efforts.

Use of Tribal Courts in child welfare matters, Tribal rights to intervene in State proceedings, or transfer proceedings to the jurisdiction of the Tribe

To date Massachusetts continues to have jurisdiction of tribal children in DCF custody.

Regional Forums

Since 2007, the Department has annually conducted Regional Forums for the purpose of providing updates on key activities, as well as eliciting feedback on implementation efforts that may be currently underway and planned initiatives for the coming year. A forum is held in each region at a convenient community location and the structure has remained generally the same each year. There are four two-hour sessions throughout the day for 1) DCF staff, 2) DCF managers, 3) key stakeholders (including community representatives, providers, courts, schools, etc.) and 4) a session specifically for families and youth. Each year, the Department has been able to engage over 300 participants in each of the Regional Forums and they have served as an important strategy for eliciting feedback from staff, community representatives and other key stakeholders. These forums have served as an important source of information to monitor the implementation of the Integrated Casework Practice Module. Through the forums, the Department received valuable suggestions that have guided implementation efforts and highlighted areas where adjustments were needed in structure, process or clinical approaches. The Department also utilizes the forums as a time to present updates on strategic plan progress and make adjustments based on input from these key stakeholder groups.

Item 32: Coordination of CFSP Services With Other Federal Programs

How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population?

Please provide relevant quantitative/qualitative data or information that show the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population.

State Response:

DCF is a key contributor in the state's Court Improvement Plan (CIP). The DCF General Counsel represents the Department by participating in the CIP steering committee. Additionally, the Deputy General Counsel and Regional Counsel attend and collaborate with the courts in the CIP's Training Committee and Permanency Committee. CIP continues to support initiatives in Massachusetts including National Adoption Day celebrations in Massachusetts, the hiring of Permanency Youth Coordinators as well as training programs for lawyers who represent children or parents; this included 4 ICWA trainings between the Southern Region, Worcester and Boston. Both Court representatives, CIP colleagues and the Department recently attended the CFSR training session held in Boston in preparation for the upcoming Round 3 Child and Family Services Reviews.

Under a large scale reorganization of the state's Executive Office of Health and Human Services, DCF works in a much more collaborative manner with a number of the state's federally assisted programs serving the same population, including the Department of Mental Health (DMH), Department of Public Health (DPH), MassHealth (Medicaid) and the Department of Early Education and Care (EEC).

DCF staff work closely with the Board and staff of the Massachusetts Children Trust Fund (CTF) to address issues related to child abuse prevention in Massachusetts. The CTF leads statewide efforts to prevent child abuse and neglect by supporting parents and strengthening families. As an umbrella organization, CTF funds, evaluates, and promotes the work of over 100 agencies that serve parents.

The Department has initiated a creative placement program designed to meet the unique needs of medically-needy children in foster care. The Special Kids-Special Care Program was developed in Partnership with the Division of Medical Assistance (utilizing Medicaid funding) to meet the needs of children with special health care needs.

DCF has been collaborating with the state Department of Housing and Community Development for the last few years to manage the Family Unification Program (FUP) vouchers for housing for transition age youth and the newer program, the Youth Transitioning to Success (YTTSP). (Fuller descriptions can be found under the housing section.) To date we have served or are presently serving 75 young adults with FUP housing vouchers and 20 young adults in the YTTSP.

Massachusetts was approved for a Title IV-E Demonstration Waiver in Federal Fiscal Year 2012, with which DCF has started to invest federal reimbursements into the new Caring Together residential services system developed in collaboration with the DMH and the Executive Office of Health and Human Services (EHS). The waiver demonstration project was implemented statewide on January 1, 2014, and broadly targets children of all ages in state custody who are in residential placement and can return to a family setting, are preparing for independence, or who are at risk of residential placement with four new services: Follow Along, Stepping Out, Continuum, and Family Partners.

The Department of Children and Families was selected to receive a grant from the Administration for Children and Families, Children's Bureau, to build capacity to provide trauma informed casework practices and trauma specific evidence based treatments (EBT). DCF has partnered with LUK, Inc., Justice Resource Institute Trauma Center, Boston Medical Center's Child Witness to Violence Program and UMass Medical Center to provide basic and advanced training for DCF staff and to provide training to selected mental health providers. This five year grant also provides an opportunity to provide training for DCF resource parents (kin, foster and adoptive) on the impact of trauma on child development and behavior. Through our collaborative partnership and the training and resource development made possible by this grant the Department is able to substantially build capacity across child serving systems to provide more trauma informed care.

State Agencies Group - DCF meets regularly with other state agencies that fund and/or are closely involved with the delivery of domestic violence and/or sexual assault services in Massachusetts. These include the DPH, the Massachusetts Office of Victim Assistance, the Executive Office of Public Safety, and the Department of Transitional Assistance. We meet to coordinate funding, data collection, identify strengths and needs of agencies and to problem solve and enhance program development.

The state Department of Elementary and Secondary Education(DESE) has continued its data sharing with DCF providing a range of demographic and educational information (SIMs data) which is visible for workers on i-FamilyNet, including the SASID (State Assigned Student Identification Numbers), language, country of origin, enrollment information, truancy days, grade, school attending, and special education status. The agencies continue to work to improve the timeliness of the data. DCF also receives the MCAS scores on students who were in agency custody when they took the exam. All this educational data is essential to social workers as they support youth in reaching their educational potential.

Collaboration on children 0-5 years of age – DCF has been collaborating with the EEC on the implementation of the Early Learning Challenge grant – Race to the Top. Activities include implementation of the DCF/EEC Memorandum of Understanding, strengthening referral processes for supportive child care and providing additional training for DCF staff on early childhood development. Additionally, DCF has collaborated with DPH on the development of a public education campaign on safe sleeping, summer safety and Shaken Baby Syndrome.

DCF Adolescent Services staff have continued to work collaboratively with staff at the Board of Higher Education, the state universities, the 2- year public colleges as well as the staff of the campuses of the University of Massachusetts.

A related but separately purchased service that the Department is currently developing in partnership with EHS and DMH, and in collaboration with the MassHealth, is Family Partners. This service pairs individuals with lived experience within the state's mental health or child welfare systems, who will help families to better understand and navigate these systems.

G. Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 33: Standards Applied Equally

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that state standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

Please provide relevant quantitative/qualitative data or information that show the state's standards are applied equally to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds.

State Response:

MA DCF Background Record Check Policy, Policy # 86-014, Effective: 5/1/1986, Revision Date: 2/3/2015

MA DCF Permanency Planning Policy, Policy # 2013-01, Effective: 07/01/2013

The MA DCF Family Resource Policy, Policy #2006-01, effective: 02/06/2006, was implemented by the Department of Children and Families (DCF or Department) in February of 2006. The policy requires a multi-step process that the Department uses to assure the quality of its foster/pre-adoptive family resources and incorporates standards to ensure that children placed with foster/pre-adoptive families and in foster/pre-adoptive homes are provided quality services that protect their safety and health. The standards establish basic requirements regarding eligibility to apply as a foster/pre-adoptive parent; the physical characteristics of the home itself; and standards for the licensing of the family resource for placement of children by the Department.

The policy includes clearly defined practice guidelines to be followed by staff to identify, address and monitor safety and health issues and concerns on an ongoing basis in order to protect children in foster/pre-adoptive care. The "Enhanced Safety Assessment Guidelines" and "Waivers for Placements of Children in Homes with Presumptively Disqualifying Dog Breeds and Other Potentially Dangerous Pets/Animals" support the Department's efforts in this regard.

Massachusetts requires that all children in the custody of the Department be placed in licensed homes. Relative (Kinship) and Child-Specific homes are licensed through the same process as are Unrestricted (Unrelated) Foster and Pre-Adoptive homes.

DCF monitors the status of all inquirers, applicants, and approved homes using the Active Family Resources Report (DSSRP225) which is distributed monthly to central, regional, and area office staff. This report is extracted from the i-FamilyNet system and includes the following data elements: Regional Office, Area Office, Unit, Assigned Family Resource Social Worker, , Primary Caregiver Name, Resource Name, Race of Primary Caregiver, Ethnicity of Primary Caregiver, Address, Resource Type, Type Start Date, Resource Status, Status Start Date, Event Type, Event Date, Event Status, Background Record Check (BRC) date, Household Outcome, Final Disposition, # of children in the home through placement, # of children living in

the home, # of children in the home total, # of children in the home in the last 30, 60, and 90 days. The number of data fields displayed and reported in the DSSRP 225 report supports multiple uses of the information to inform tracking and decision making through the episode of a foster/pre-adoptive family's interaction with DCF and care of a foster child/ren.

The steps in process for licensure of foster/pre-adoptive homes are: inquiry on the part of the prospective foster/pre-adoptive parent/s, initial eligibility screening through evaluation of eligibility standards (including eligibility to apply, physical standards for the home, and enhanced safety assessment), completion of Application A and B, pre-service training, comprehensive license study including assurance that all licensing standards are met, and approval. Homes are licensed following successful completion of this process.

In certain circumstances a child can be placed with a relative in an emergency situation prior to full approval. These placements are covered by a variance granted by the Department of Early Education and Childcare (EEC), the agency responsible licensing DCF as a placement agency. Requirements to allow placement with a relative prior to completion of the licensing process include compliance with all initial eligibility standards including BRC requirements, physical standards, and enhanced safety assessment requirements for the home. The relative home must meet preliminary standards for the child to be placed. A full license study must be completed within 40 days. If a relative is not approved during the full licensed study, the child is removed. This activity is monitored for statewide consistency with the practice expectations in the Family Resource Policy by edits in the i-FamilyNet system which assure successful completion prior to placement activation; supervision and management requirements; and monthly reporting, specifically, Unapproved Homes with Active Placements report (DSSRP 171). This report is generated monthly and distributed to central, regional, and area office managers and family resource managers and supervisors.

The Massachusetts Approach to Partnership in Parenting (MAPP) is the mandatory pre-service education program for people interested in fostering or adopting children in the custody of the Department. All prospective foster or adoptive parents are expected through MAPP to learn about DCF and the needs of children living in foster or adoptive families. The MAPP education program provides prospective foster parents with information and skill-building to effectively prepare them to parent children who need care. MAPP is designed to ensure foster parents have realistic expectations of the rewards and challenges of parenting a child through foster care or adoption. Continuous learning opportunities support foster parents' ongoing needs as they tackle the challenges and reap the rewards of watching children and families grow and develop.

In addition to requiring that all foster families licensed by the Department complete MAPP, since July 1, 2006 all contracted intensive foster care agencies must use the MAPP curriculum and follow the DCF Family Resource Policy and regulations to support licensure of their foster homes. All homes are required to be trained (unrestricted, child-specific, and kinship). In the summer of 2003, in response to an increase in kinship/child-specific foster and pre-adoptive families, the Department developed the Kinship and Child Specific Training and Resource Guide in English and Spanish. This guide provides the pre-service training component for the Department's kinship and child specific foster and pre-adoptive homes.

Foster/Pre-adoptive homes are provided placement support and monitoring through monthly home visits by the assigned Family Resource Social Worker during the first six months of placement and bi-monthly thereafter (this home visit requirement will be changed to monthly in the next revision of the Family Resource Policy). Children placed in foster care have a social worker who is also required to visit the child monthly.

To assure consistent, on-going in-service training of all foster/pre-adoptive families, the Department has partnered with the Massachusetts Society for the Prevention of Cruelty to Children MSPCC/KidsNet in developing a post-approval curriculum and to provide an array of support services to Departmental foster/pre-adoptive homes including a Helpline, information, support from an experienced foster parent, and respite. MSPCC is contracted to provide post-approval foster/adoptive/kinship training, track attendance at trainings, develop curriculum, and identify and document training needs for foster/pre-adoptive families.

The Department's strengths have been demonstrated in our ability to establish strong working relationships and mutually supportive partnerships with contracted providers, families, national resource centers and neighboring states.

Unfortunately, the Department still faces the barriers of distance to training locations and daycare needs of our foster/pre-adoptive families. We continue to address these issues by utilizing a portion of our contract with MSPCC/KidsNet for support services to Departmental foster families and are currently able to provide some coverage of those daycare needs. The Department also continues to explore and develop technology based training alternatives such as teleconferencing and on-line curriculum modules.

Homes are required to undergo a formal review on an annual basis and to be relicensed every 2 years from the initial approval date. i-FamilyNet assists family resource staff with completing these requirements in a timely manner by issuing work reminders 90 days prior to the event due date and are visible to the social worker assigned to the foster home and to their supervisor and manager. The Department issues a monthly report, Overdue License Renewals and Annual Reassessments (DSSRP242), to further aid in timely relicensing and reassessment.

The DCF structure in place to support consistent practice statewide in compliance with family resource policy and regulation includes the Central Office Foster Care Support Services Unit staffed with a full-time Director, a full-time Director of Recruitment, two Foster Care Managers, each assuming responsibility for routine monitoring of family resource policy compliance for two regions respectively and three Recruitment Supervisors. There are Contracted Foster Care Coordinators and a Family Resource Specialist who assure compliance and provide quality assurance for the contracted agencies. The foster care managers also provide technical assistance and support to field staff on improvements to family resource practice. There are routine meetings between central office, regional, and area family resource staff where the compliance reports are reviewed and discussed and family resource experts can share effective practices. Foster care and adoption staff from central office meet regularly with regional and area staff to review reports and the family resource reports are sorted and distributed to the family resource field staff and managers on a monthly basis. Central office family resource staff have trained regional and area staff to effectively utilize the reports and continue to meet regularly to review recommendations regarding enhancements to i-FamilyNet and compliance

reports. Central, regional and area staff utilize the family resource reports to assure compliance with safety and health standards.

Key internal stakeholders including central office foster care support staff and two on-going foster care advisory committees, the Family Resource Information Committee comprised of representatives from each regional office and the Family Resource Advisory Committee comprised of family resource supervisors representing their area and region, are attentive to identifying and prioritizing recommended improvements to the family resource functionality in FamilyNet/i-FamilyNet. FamilyNet/i-FamilyNet data and reports are used for documenting compliance. The Regional Clinical Directors assist the field with quality improvement and oversight of clinical practice. Each region also has a Quality Assurance Supervisor whose role includes specific supports and oversight to assure quality and consistent practice throughout the region regarding foster family homes. The Central Office Foster Care and Adoption Support Services unit works with regional and area office staff to assure the completion of family resource tasks in a timely and consistent manner.

In terms of statewide data regarding the recruitment, licensing, and retention of foster/pre-adoptive families, DCF provides central office foster care staff, regional office staff, supervisors, clinical managers, legal managers and family resource licensing staff with many aids and opportunities to verify the accuracy of data contained in FamilyNet. Although DCF has not had a dedicated case review unit for some years, it has worked hard to promote a culture of data accuracy by making pertinent detailed data available in all reports and on windows throughout the FamilyNet/i-FamilyNet application. Routine family resource events and administrative reports provide opportunities throughout the year for the staff most familiar with a foster/pre-adoptive home to review the data recorded in i-FamilyNet, and to identify and correct inaccurate data. These events and reports for family resource/foster care/pre-adoptive care include, but are not limited to the following checkpoints: DSSRP 225, Active Foster Homes monthly report; DSSRP 171, Unapproved Homes with Active Placements monthly report; DSSRP 242, Overdue Annual Re-assessments and License Renewals monthly report; desktop work reminders through the i-FamilyNet application, and quarterly and annual data reports.

Item 34: Requirements for Criminal Background Checks

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

Please provide relevant quantitative/qualitative data or information that show the state is complying with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children.

State Response:

In accordance with MA DCF Background Record Check Policy, Policy # 86-014, Effective: 5/1/1986, Revision Date: 2/3/2015, the Department of Children and Families (DCF) conducts Background Record Checks (BRCs), which include the child welfare history found in “FamilyNet” or “i-FamilyNet” and comparable systems of other states, Criminal Offender Record Information (CORI) found in records maintained by the Office of the Commissioner of Probation (OCP) and comparable systems of other states as well as the Federal Bureau of Investigation (FBI), and Sex Offender Registry Information (SORI) found in records maintained by the Sex Offender Registry Board on all applicants seeking licensure as foster and pre-adoptive parents, and their respective household members age 15 and older. Beginning July 1, 2014, DCF began conducting fingerprint-based checks for all applicants for kinship/child specific, foster and pre-adoptive parent licensure and all licensed foster/pre-adoptive parents at the next license renewal. BRC requests are submitted through the FamilyNet application and the results of a completed BRCs are entered into FamilyNet for each household member 15 and older.

The FamilyNet system has built-in safeguards to prevent the approval of a foster or adoptive home until a BRC is completed and results entered into FamilyNet. Placements can only be activated once a home is approved. DCF conducts BRCs annually during either re-evaluation or relicensing for all approved foster and adoptive resources and their household members age 15 and up. The BRC Policy effective 2/3/2015 further clarified the roles of individuals connected with foster/pre-adoptive homes who must have a BRC check completed. These roles are defined as:

HOUSEHOLD MEMBER

Any individual, regardless of age, who resides in the home, who moves into the home with the intent to make it their residence, or who is temporarily visiting for more than 30 calendar days. Children/young adults in DCF care or custody are not considered household members of the foster/pre-adoptive home for the purpose of the fingerprinting requirements.

FREQUENT VISITOR

Any individual, regardless of age, who spends substantial time in the home. This may include, but is not limited to, a non-custodial parent who visits the home; relatives, significant others,

and/or other individuals who spend overnights in the home; and an individual who routinely baby-sits in the home and/or otherwise assumes some degree of caretaking responsibility, in the home, for **any** child in that home.

In accordance with DCF policy, regulation, and practice the utmost attention is given to the safety of foster homes. This is demonstrated throughout the application, training and license study process, disposition (approval/denial), on-going support and supervision including the annual reassessment or relicensing process. All applicants and their household members age of 15 years and older are required to have a BRC. This check includes criminal charges and identifies any household member previously included as a consumer in a case open with the Department.

All criminal and DCF histories are coded in categories by the DCF BRC unit. Family resource social work staff assigned to the applicants' homes are notified of these results. If a finding exists, the worker and their supervisor determine whether to make a BRC Approval request (e.g. apply for a waiver of the requirement). DCF policy is very prescriptive regarding what level of review is needed to make a decision about the BRC Approval Request. In certain cases foster families may submit their own BRC Approval requests.

The BRC Approval request/review forms are currently an off-line process. This process of review includes consideration of specific factors for approval to determine whether the BRC finding has a substantial effect on the prospective or current foster/pre-adoptive parent's ability to assume and carry out the responsibilities of a foster/pre-adoptive parent in a manner that maintains the rights of the child/ren who may be placed with them to safety, well-being and permanence and is in each child's best interests. The final decision, or disposition, of this review/approval process is recorded in i-FamilyNet/i-FamilyNet requires that a disposition be entered before a foster/pre-adoptive home can be approved or reapproved. Edits regarding approval of foster/pre-adoptive homes were built into the i-FamilyNet system to assure compliance with DCF policy and regulations. These edits enforce the approval hierarchy required by policy.

The Department tracks BRC information using reports and reviews. The monthly Active Foster Homes report (DSSR225) includes information sufficient to see the status and outcome of the most recent BRC.

Item 35: Diligent Recruitment of Foster and Adoptive Homes

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide?

Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide.

State Response:

The Massachusetts Department of Children and Families (DCF) is committed to recruiting foster and adoptive parents that reflect the ethnic and racial diversity of children in its care and custody. The ultimate goal is for every child leaving placement to live in a permanent family which is safe and nurturing. Massachusetts has created a strong foundation on which to build an effective recruitment program which reaches into the communities it serves. Local DCF offices are especially active in recruitment efforts at the grass roots level in order to identify resources which allow children to maintain vital connections to their communities, including kin, schools, and other significant relationships.

Massachusetts regards proactive recruitment as a fundamental tool for achieving permanency—a process which begins before a child enters care. Effective recruitment efforts must provide key information to potential foster families about what fostering entails. This includes understanding the needs and dynamics of children entering foster care and the responsibilities that come with this commitment.

The overall Massachusetts strategy is to build capacity for early and continued exploration of kin and others with existing or prior relationships and to find families willing to commit to some form of permanency, including adoption, if reunification cannot be achieved. By beginning this process before placement is needed, the goal is to identify a nurturing family who will become the child's new home if needed and which includes an extended community of support.

Types of Foster/Pre-Adoptive Family Resources: (Policy#2006-01)

- **Kinship Family:** Kinship Care is the full time nurturing and protection of children in a licensed family setting by relatives or those adults to whom a child and the child's parents and family members ascribe a "family relationship." Kinship families are persons either by blood, marriage or adoption (i.e., adult sibling, grandparent, aunt, uncle, first cousin) or a significant other adult to whom the child and parent(s) ascribe the role of family based on cultural and affectional ties or individual family values. It is believed that placement with a kinship family reinforces the child's racial, ethnic, linguistic, cultural and religious heritage and strengthens and promotes continuity of familial relationships.
- **Child Specific Family:** A non-kinship individual(s) is identified and licensed as a placement for a particular child. (e.g., school teacher comes forward; child recommends a friend's parents).

- **Unrestricted Family:** An individual(s) who has been licensed by the Department as a partnership resource to provide foster/pre-adoptive care for a child usually not previously known to the individual(s).

DCF gives first consideration to placement with a relative or member of a child's extended family. As reported in the 3rd Quarter of FY 2014 report, 44% of children in departmental foster care were placed in kinship foster homes. On 12/31/2014 DCF had 1870 approved kinship foster homes. The total number of approved foster homes under the direct supervision of DCF as of 12/31/2014 was 5524.

Recruitment campaigns are developed and implemented to recruit foster and adoptive families for the children DCF has in its care and custody. Campaigns are varied and can be targeted to a specific group of children or for general recruitment. Recruitment activities include, but are not limited to, participation in community and neighborhood events, development of recruitment materials, statewide media campaigns, adoption parties, radio and television ads, displays, and special events. Media campaigns utilize radio, television, community newspapers, and banner advertising on social media outlets. During state fiscal year 2015 DCF ran three separate campaigns. The most recent campaign extended over a 6-month period, January to June 2015.

Partnering with community resources and those with expertise in public communication has helped DCF create new informational brochures. Current brochures have been updated and posted on the DCF web page. Brochures which provide information on foster care, adoption and kinship care are designed to be welcoming to all who wish to consider providing a home for a child from the community or for a member of their extended family.

Posters, flyers and brochures are developed, updated and distributed to area offices for use in recruitment events. They are also provided to school systems, doctor's offices, libraries, and other locations where a family might go for services. Foster care posters use the slogan "Foster Parents Matter," and adoption posters, "At any given time in Massachusetts 600 children in foster care are waiting for an Adoptive Family."

An example of targeted group recruitment efforts involved adolescents, 12-17 years old, who represent DCF's largest age group in placement. DCF conducted two statewide media campaigns in June and September, 2014. These campaigns focused on youth in need of foster placements and on older youth in need of part-time placement as they complete higher education. Posters specific to fostering a teen were created and distributed for statewide use..

The public is made aware of the Department's need for adoptive families through local community events and activities, and partnerships with the Massachusetts Adoption Resource Exchange (MARE) and Jordan's Furniture. The following public/private partnerships and activities form the core of DCF adoption recruitment efforts:

- MARE, the contracted provider for registering legally free Massachusetts' children for adoption as well as for recruiting foster homes for the children statewide, lists information about each of these children in its Adoption Manual and on its website.
- MARE is also the Rapid Response vendor for Adopt USKids in Massachusetts and for posting information on all legally freed children onto the Adopt USKids web site.

- DCF and MARE and their corporate partner (Jordan's Furniture) host the Heart Gallery at Jordan's Massachusetts stores in rotation. The Heart Gallery is a heartwarming pictorial and narrative display of children awaiting adoption.
- DCF hosts Adoption Coalition meetings with private adoption agencies in regions across the state to discuss issues related to recruitment for children awaiting adoption.
- The Department sponsors small and large adoption matching parties across the state. Prospective adoptive parents and children awaiting adoption along with their social workers are invited to these parties, which are themed events, during which fun activities are scheduled to allow for low stress social interactions between the children and families.

Adoption recruitment events, held annually include:

- Walk/Run for Adoption, MARE, (May 2015)
- Adoption/Foster Care Information Weekend, (June 2015)
- Summer Adoption Mixer, Assumption College, bi-annual event (August 2014)
- Adoption Option, (September 2015)
- National Adoption Day, (November 2015)
- Adoption Parties, across the state

In April and May, 2015, DCF provided Massachusetts Approach to Partnership in Parenting, Trainers of Trainers (MAPP TOT) training to staff to ensure area offices have an adequate number of staff trained and ready to provide training to foster and adoptive parent applicants. Referred to as a Rolling MAPP, MAPP groups can be organized to run on a continuous basis. This allows applicants to start training as soon as they have passed initial eligibility standards. Several offices are conducting MAPP groups in this format; other offices have opted to stay with a ten-week session held several times a year.

The Department maintains a full time Foster Care and Adoption Recruitment Unit that is part of the Foster Care, Adoption and Adolescent Services Division. DCF has two recruitment supervisor positions who assist the area offices with their recruitment plans and activities. These supervisors are responsible for coordinating statewide recruitment events, receiving calls through the 1-800 recruitment line; supervising the Foster Care Recruitment Ambassadors who are located at each of the 29 area offices. A third recruitment supervisor position is being added and will greatly enhance work with the local area offices.

Data used to support recruitment:

- DCF uses the Active Family Resources report (DSSRP225) to identify the race and ethnicity of foster/pre-adoptive parents. On a quarterly basis this information is compared to the Children in Placement report (DSSRP210) which includes the age, race, and ethnicity of children in placement. We continue to work with staff to increase the accuracy and completeness of this information. Central office staff use this data to hold discussions with area office staff to prioritize area-specific needs for placement-matching purposes and tie these to local and statewide recruitment efforts.
- DCF creates maps using the addresses of foster homes and the home addresses of children in placement to graphically display the geographical areas of most significant need. Maps are created at statewide, region and area levels.

An intensive, targeted and sustained recruitment campaign is crucial to building awareness of the need for foster and adoptive parents while creating public value for the role foster and adoptive parents have in the life of a child. The Department's efforts are aimed at encouraging more families to step forward and help children remain in their own communities until a safe return home, placement with kin or a transition to another permanent situation occurs.

By increasing the use of current and emergent technology we enhance our local reach and respond in a customer friendly and professional manner. When fiscally able we conduct statewide media recruitment campaigns. Each time a campaign is released conventional as well as newer advertising methods are utilized to spread our messaging. Our plan is to continue the utilization of professionally developed advertising campaigns to ensure a consistent message is provided to the public.

Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide?

Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide.

Please include quantitative data that specify what percentage of all home studies received from another state to facilitate a permanent foster or adoptive care placement is completed within 60 days.

State Response:

Although rated an area of strength in the prior CFSRs, the Department of Children and Families (DCF) has taken numerous steps to further strengthen its work in recruiting and licensing pre-adoptive resources. DCF continues to foster a strong relationship with the Massachusetts Adoption Resource Exchange (MARE) and, through MARE, to access nationwide pre-adoptive resources through Adopt USKids.

Interstate Compact for the Placement of Children (ICPC)

In accordance with *Regulation 110 CMR 7.502*, the Compact Administrator for Massachusetts is the Deputy Commissioner for Field Operations; her/his designee (referred to as "Compact Administrator/designee"), the Interstate Compact Unit Director, is responsible for all day-to-day administrative responsibilities and duties of the ICPC Unit.

To aid in the in- and out-of-state placement of foster and adoptive children, the Massachusetts Interstate Compact staff are available to DCF and provider agency staff. They assist with issues related to the Interstate Compact policy and procedures, articles and regulations and with child specific situations. The Compact Staff are available to assist with all out-of-state ICPC requests. These requests are processed centrally and sent to the appropriate DCF area Office for home study and/or placement supervision.

As of January 2007, DCF began to assign all incoming ICPC requests for foster care and adoption home studies to contracted placement agencies. These agencies are expected to complete their studies and make a placement recommendation within the new federal time frame. These contracts are monitored by DCF contract managers. The Massachusetts ICPC Unit still monitors these requests and makes final placement decisions.

All ICPC referrals, whether Massachusetts is the Sending or Receiving state are entered into i-FamilyNet. Area office staff record ICPC requests for children in DCF care or custody and ICPC Unit staff record all private agency ICPC requests and all requests where Massachusetts

is the receiving state. ICPC data is periodically queried by a DCF analyst and presented to the Director of the ICPC Unit for careful review and comparison with written documentation.

Tracking Timeliness of ICPC Referrals

For Calendar Year 2013: MA DCF ICPC unit had a total of 812 referrals.

Initial Report	Receiving	Sending	Grand Total
1 - Parent Home Study	73	116	189
2 - Relative Home Study	94	49	143
3 - Public Adoption Home Study	39	100	139
4 - Private Adoption Home Study		1	1
5 - Foster Home Study	110	229	339
5 - Foster Home Study - Private Agency	1		1
Grand Total	317	495	812

MA ICPC Calendar Year 2013: Days to Complete

Days to Complete	MA Receiving State	Completion Rate	MA Sending State	Completion Rate
0-30	23	19.3%	39	26.5%
31-60	24		92	
more than 60	139	57.0%	200	40.4%
(blank)	58	23.8%	164	33.1%
Grand Total	244		495	

NOTE: MA as receiving state excludes Parent Home Studies initial reports

For Calendar Year 2014: MA DCF ICPC unit had a total of 913 referrals.

Initial Report	Receiving	Sending	Grand Total
1 - Parent Home Study	65	179	244
2 - Relative Home Study	77	66	143
3 - Public Adoption Home Study	33	130	163
4 - Private Adoption Home Study	2	2	4
5 - Foster Home Study	99	259	358
5 - Foster Home Study - Private Agency		1	1
Grand Total	276	637	913

MA ICPC Calendar Year 2014: Days to Complete

Days to Complete	MA Receiving State	Completion Rate	MA Sending State	Completion Rate
0-30	31	23.2%	79	26.4%
31-60	18		89	
more than 60	127	60.2%	297	46.6%
(blank)	35	16.6%	172	27.0%
Grand Total	211		637	

NOTE: MA as receiving state excludes Parent Home Studies initial reports

Comparing CY2014 (23.2%) to CY2013 (19.3%), Massachusetts demonstrated a 20.2% improvement in timeliness of home studies completed in its role as a receiving state. Nonetheless, the data reveal that the majority of these home studies are being completed in greater than 60 days. In an effort to facilitate the completion of home studies, DCF contracts with private adoption agencies to complete home studies. Digging into potential root causes for delay has revealed the following:

- Resources not completing necessary paperwork in a timely manner.
- BRC delays related to the resource's inability to obtain timely FBI finger prints.
- MA ICPC Unit delays in forwarding home study requests to the appropriate Adoption Contract unit or to the local area office for processing.

These pinch points are being analyzed to identify actionable steps for maximizing efficiencies. Barriers which specifically affect the state's ability to ensure the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children include:

- IV-E ineligibility makes it difficult to provide medical coverage in another state.
- Children must be legally freed before an adoption home study can be requested.
- Most states do not license pre-adoptive homes. As such, the resource has to be licensed as a foster home prior to the request for an adoption home study.

Commonwealth of Massachusetts

Department of Children & Families

***Update to the Plan for Improvement and Progress Made to Improve
Outcomes***

DCF APSR Progress Report

In 2014, the Massachusetts Executive Office of Human Services engaged Child Welfare League of America (CWLA) to conduct a review of the Massachusetts Department of Children and Families (MA DCF). CWLA presented the Commonwealth with a series of recommendations to help enhance the work of this agency. The CWLA report provided a blueprint for the Department to follow on its path to reform, and laid out initiatives for DCF to enact through FY18. In 2015, one of the authors of that report, Ms. Linda Spears assumed the role of Commissioner. As Commissioner, she has continued to assess the strength of the Department's policy, practice, and operations and the CWLA report remains one of the foundations of DCF's reform efforts, including many addressed in our Program Improvement Plan (PIP). Some of the key areas of progress made to date on various aspects of our work:

- The CWLA report recommended updating Department policies such as case transfers, children missing from care, and background record checks, among others, and ensuring staff are appropriately trained on the policies:
 - To that end the Department has worked collaboratively with the social worker union, Service Employees International Union (SEIU) Local 509, to draft and negotiate significant policies governing our case practice. In FY16, the Department in collaboration with the Union worked to revise the Protective Intake policy and to create a new staff Supervision policy.
 - The new Protective Intake policy substantially updates and clarifies protocols for DCF's screening and investigation of reports of abuse or neglect.
 - The first-ever Supervision Policy is designed to support DCF front-line workers in decision-making and to identify circumstances where cases need to be elevated for higher-level review and/or consultation with specialists.
 - The work on these two policies builds upon the Case Transfer policy, Education policy and Background Record Check changes finalized last year. Together, these policies provide clarity to staff and promote standard and consistent practice across the state—with the ultimate goal of keeping children safe.
 - Ensuring social worker staff are adequately trained and licensed was another key recommendation in the CWLA report and something advanced by our partners in the Legislature as well:
 - With regard to social worker licensing, the Department has hired a social worker licensing coordinator to help track the licensure of our staff and ensure that staff are properly licensed. As of September 16, 2016, 94.5% of the Department's social worker staff who are required to be licensed have achieved licensure. This is a 15.4% increase from a year ago;
 - Strengthening the management capacity of the Department was also a theme of the CWLA report. This included decoupling the area office "pairings" so that each area office has its own Area Director.
 - During FY16, the Department restored its "Central Region" headquartered in Worcester to allow for greater oversight and managerial capacity. DCF is also in the process of hiring 20

clinical manager positions to restore a manager to supervisor ratio of 4:1, which will strengthen clinical management oversight of supervisors and their social worker units.

- The Department also identified the need to add specialty staff to area offices with expertise on the issues of substance abuse, domestic violence, mental health and medical issues. Toward this end, the Department has hired its first Medical Director, and a child psychiatrist consultant. Additionally, the Department is hiring 29 new medical social workers; ten of which are onboard, or in the hiring process. DCF is also in the process of hiring five substance-abuse specialists, doubling the number tasked with assisting social workers and connecting families with resources.
- The Department continued its efforts to reduce caseloads for workers with the goal of achieving a weighted caseload standard of 18 to 1.
 - We continue to make progress in this area. In FY16, the Department added 252 social workers. The FY17 budget also includes funding for a significant increase in social worker staff.

However, even with this progress, more remains to be done. To address reform with the urgency the children of the Commonwealth deserve, the Department has embarked upon a major improvement initiative we call simply the Agency Improvement Initiative (AII).

The initiative utilizes a project management methodology called “Agile Scrum” which allows for implementation of significant change in rapid succession. The Agency Improvement Initiative was launched on Friday, September 11, 2015. These efforts are undertaken by DCF with leadership and support from the Secretary of the Executive Office of Health and Human Services and the Governor’s office. Through a series of “releases,” of which the fifth is currently underway, the Agency Improvement Initiative’s areas of focus are to:

- provide an management infrastructure to support case oversight and strengthen overall agency operations;
- enhance the agency’s policy, practice, and accountability; and
- strengthen workforce capacity.

At the helm of the Agile Scrum Agency Improvement Initiative process is the Agency Improvement Leadership Team (AILT), representing DCF Central Office, Regional, and Area Office Managers. AILT is charged with working with the Commissioner, the Secretary, and the Governor to realize goals and implement change. Specific topics and goals are assigned to Scrum Teams. Each Team has a specific area of focus, and has both regular team members and “Subject Matter Experts” (SMEs) who work with the team as needed. Teams may include front line and supervisory field representatives, and family members. Each Team meets at least weekly, has daily telephone check-in “scrum calls,” and tracks its progress through the AILT ASANA system.

The Area Improvement Initiative’s **Release 1** ran from 9/21/2015 – 11/25/2015. During those 10 weeks, the Department:

- drafted and negotiated the Protective Intake and Supervision policies noted previously (Historically, the Department has typically spent more than two years developing and negotiating new policies.);
- posted approximately 200 positions including backfills for all staff who departed through the early retirement incentive program as well as additional managers to allow for appropriate clinical oversight of cases;
- restored the Department's Central Region to reduce size and improve oversight of the agency's largest region; and
- planned IT modifications to incorporate new policies into the i-FamilyNet system.

The Agency Improvement Initiative's **Release 2** began on 11/30/15 and ran to 3/18/16. During these 15 weeks, the Department advanced the following critical reforms:

- drafting and negotiating additional policy updates including new Family Assessment and Action Planning, Case Closure, and In-Home Case Work policies;
- training staff and implementing the Department's new Protective Intake and Supervision policies;
 - Trainings on these policies kicked off at the beginning of February (2016). For the Protective Intake policy, 32 sessions were scheduled to train 1,400 staff throughout February. The first phase of training on our new Supervision Policy featured an online component that trained 575 people by March 1st. In person Supervision training began in May, 2016. Approximately 70% of Managers and Supervisors have completed training, and additional trainings have been scheduled.
- on-boarding the 200 positions posted during Release 1;
- posting additional positions to complete the decoupling of remaining area offices with a paired management team¹;
- enhancing existing and developing new metrics to inform case practice and management decision making;
- developing social worker retention strategies in partnership with SEIU 509; and
- producing a detailed work plan to enhance the recruitment, retention and training of foster parents that incorporates best practices and accounts for area office needs.

Release 5 comes to completion at the end of October, 2016. Current AILT Scrum teams, whose names are indicative of the focus of their work, are:

- Caseload Management
- Continuous Quality Improvement

¹ Remaining Area Office Pairings to decouple: Greenfield/Holyoke, Lawrence/Haverhill, Salem/Lynn, Plymouth/Barnstable, Taunton/Brockton, Arlington/Braintree, Hyde Park/Roxbury, Chelsea/Dorchester

- Family Resource Development
- System Support
- Training & Implementation

Other areas of our work, where we have shown meaningful progress include:

- **Fair Hearings.** Over the past several months the Fair Hearing unit has increased its staff in order to issue decisions in a more timely fashion. Currently the Fair Hearing Office has increased the number of Hearing Officers from 12 to 14 and has hired seven paralegals. In CY 2015, the Office closed a total of 1,670 cases. In the first nine months of CY 2016, the Fair Hearing Office has closed 2,255 cases; already a 35% increase over CY2015.
- **Family Resource.** Focusing in on an 18-month period of backlogged foster homes stuck in the process for approval, the Department employed a strategy that has resulted in the resolution of 98% of the targeted 1,242 applications by September, 2016.

The end goal of all these efforts is to achieve significant, lasting, and positive change in the Department. Our children and families deserve no less. Of course, change does not happen overnight. It is going to take time, a lot of hard work, and the support of communities, partners, and stakeholders. We are pleased with the progress made towards achieving this change, and are empowered to build upon these successes and advance our reform efforts in the coming year.

While much of this reform effort will be directed inward, the Department will also continue to engage the community at large. Child welfare is not the work of one person or one agency – the work cannot be done alone without stakeholder support. Staff will continue working with our community partners, our children and youth, our parents and partners in the legislature. Real engagement without partners and our families, together with a strong foundation of casework from DCF staff will be the catalyst for change in the days, months, and years ahead.

The Massachusetts Department of Children and Families views the current PIP as an integral part of this work, and looks forward to making excellent progress during the Improvement period.

PARTNERSHIPS AND COLLABORATION

The Department's interagency/stakeholder efforts involving housing and homeless prevention, children's behavioral health, substance abuse, early education and care and domestic violence has provided greater coordination of services and case management, ensuring that our case practice is community-connected and better integrated with the work of our sister agencies and community providers and that stakeholder input and feedback is received and incorporated into future APSR, PIP and policy development.

STATEWIDE ADVISORY COUNCIL AND AREA BOARDS

DCF Continues to convene consumers, youth in care, providers and other community leaders who participate with and advise the DCF Area Offices. Representatives from those local boards also participate in the Statewide Advisory Committee which typically meets three times a year. Among the participants are a variety of agencies and organizations that are engaged with DCF on initiatives designed to protect children and strengthen families:

- The Children's League of Massachusetts
- The Parents Helping Parents
- Massachusetts Law Reform Institute
- Massachusetts Society for the Prevention of Cruelty to Children
- Massachusetts Alliance for Families
- Berkshire Children and Families
- Children's Trust Fund of Massachusetts
- Massachusetts Citizens for Children
- Massachusetts Adoption Resource Exchange
- DCF Family Advisory Committee
- Children and Family Law Project
- Rosie's Place
- Department of Youth Services
- Department of Mental Health
- United Way
- Wayside
- MA Chapter of the American Academy of Pediatrics
- Committee for Public Counsel Services
- New England Child Welfare
- Massachusetts Network for Foster Alumni
- Parent Professional Advisory League
- The Black Mental Health Alliance
- Family Nurturing Center
- Massachusetts Association of Private Schools
- Justice Resource Institute
- Jane Doe, Inc.
- More Than Words
- MA Chapter- NASW
- Department of Transitional Assistance
- MA Council of Human Service Providers

THE COURTS

DCF continues to work collaboratively with the Juvenile Court Department of the Massachusetts Trial Court to address areas of mutual concern and to improve coordination and court practice. The DCF Commissioner Linda Spears and General Counsel, Andrew Rome provide leadership for this work through regular communication with Chief Justice of the Trial Court, Paula Carey of The Trial Court and Chief Justice Amy Nechtem of the Juvenile Department. Key activities have included:

- Court Improvement Project (CIP) – DCF maintains an active working relationship with the CIP in addressing strategies to improve court practice and strengthen collaboration between DCF and the Courts in Indian Child Welfare, Permanency Planning, and educational success especially among older youth.
- Training – DCF regularly participates in the Courts Judicial Training activities including the most recent training held in the Spring of this year.
- National Adoption Day – DCF continues to partner with the courts, the Massachusetts Adoption Resource Exchange on this annual that results in the adoption of approximately 120 children.

- Permanency calendar –DCF and the Court continue to work together to address a variety of operation challenges before courts where there have been increases in the number of Care and Protection petitions filed or in the number of Termination of Parental Rights cases before the courts.
- The Leadership Forum – The DCF Commissioner along with Commissioners from the Departments of Youth Services, Probation, The Committee for Public Counsel Services, The Center for Juvenile Justice for a core group of leaders who have agreed to work together to improve outcomes for children served across child welfare and juvenile justice. This group is supported by a broader work team including the Office of the Child Advocate, The Executive Office of Education, the Massachusetts Chiefs of Police Association, the Children’s League of Massachusetts, and others.

This year the Commissioner, General Counsel and other members of the agency executive leadership team have been work proactively with members of the Probate and Family Court, lead by Chief Justice Angela Ordoñez. A series of brief planning meetings have been conducted to identify topics of mutual concern including improving communication and collaboration so that the court has the information needed to make decisions in cases involving Sua Sponte petitions for child guardianship. Out of these sessions have come protocols for teleconferences between Judges and social workers to facilitate testimony when needed, along with plans for joint forums for Probate and Family Court Judges slated for the fall.

STATE/TRIBE RELATIONSHIPS

The Department of Children and Families works collaboratively with two federally recognized tribes:

- The Wampanoag Tribe of Gay Head (Aquinnah) - (WTCH (A) which is located in Aquinnah, MA. The Tribal contact for DCF is Bonnie Chalifoux, Human Services Director.
- The Mashpee Wampanoag Tribe (MWT) is located in Mashpee, MA. Catherine Hendricks directs the tribe's Indian Child Welfare programs and serves as primary contact with DCF.

Collaboration this year continued its focus on strengthening state-tribe relations and collaboration including the following:

- 1) The ICWA Coordinator attended the National Indian Child Welfare Association Annual Conference (4/16) to expand upon strategies for improved compliance with ICWA.
- 2) DCF launched its ICWA intranet page in August 2016:
<https://hhsvgapps01.hhs.state.ma.us/ehsintranet/community/departement-of-children-and-families/icwa>
 This serves as a great reference to staff to increase the understanding of ICWA as well as providing Supervisors with agenda topics for Unit meetings that result in improved compliance
- 3) The Part-time ICWA Coordinator (12/15-6/16) worked on the administrative requirements of ICWA and brought MA DCF into full compliance with all ICWA inquiries received at the DCF Central Office.
- 4) Anticipate the approval of a drafted ICWA FAQ that brings the new ICWA Rules and Regulations to staff in a Question/Answer format (to be posted on the Intranet with a special announcement). The regulations are effective for any court filings that happen on or after 12/12/16
- 5) DCF met with both MA federally recognized Tribes: Mashpee Wampanoag and the Wampanoag Tribe of Gay Head (Aquinnah) in August 2016 to review our formal and informal collaborations
- 6) Mashpee Wampanoag Tribe has been approved for the Tribal Title IV-E Development Grant. The ICWA Coordinator will work closely with the Tribe during this period
- 7) Mashpee Wampanoag is represented on the Steering Committee and the Advisory Group at the Children’s Cove Multi-Disciplinary team to address Human Trafficking

- 8) Both federally recognized Tribes are invited to any Training DCF provides. Specific outreach and invitations are given regarding Human Trafficking trainings. There are many trainings coming up (1/17-6/17) that will increase their understanding and capacity to address this particular population
- 9) As DCF policies are updated, the Tribes are made aware of each.
- 10) ICWA PowerPoint presentation for trainings is underway and is targeted to be finalized by Spring 2017
- 11) A drafted MOU from the Mashpee Wampanoag Tribe is in the process of review with the State

DCF Psychopharmacology Task Force

DCF Psychopharmacology Task Force is currently chaired by the DCF Commissioner with day-to-day activities conducted by Dr. Linda Sagor, DCF's new full-time Medical Director and Dr. Wynne Morgan, DCF's part-time child psychiatry consultant. Together with the Massachusetts Child Advocate, the MassHealth Pharmacology Program, the Office of Medicaid/MassHealth, and several private practice Child Psychiatrists who work directly with DCF children, DCF has continued its efforts to strengthen prescribing practices for children in care and reduce disproportionate use of psychotropic medications. Through this initiative, the MassHealth Pharmacy Program, completed implementation of the state's new Pediatric Behavioral Health Medication Initiative (PBHMI). PBHMI requires prior authorization to ensure the highest quality and safest care to pediatric members less than 18 years of age in the Primary Care Clinician (PCC) Plan who are prescribed behavioral health medications. An expert workgroup convened by the DMH served as an advisory board to the MassHealth Pharmacy Program to create the approval criteria that will be used to evaluate prior authorization requests submitted to the Drug Utilization Review Program. As part of this initiative the following situations now require a prior authorization:

1. Behavioral health medication polypharmacy: pharmacy claims for any combination of four (4) or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotic agents, and mood stabilizers) within a 60 day period for members less than 18 years of age;
2. Antipsychotic polypharmacy: overlapping pharmacy claims for two (2) or more antipsychotics for at least 60 days within a 90 day period for members less than 18 years of age;
3. Antidepressant polypharmacy: overlapping pharmacy claims for two (2) or more antidepressants for at least 60 days within a 90 day period for members less than 18 years of age;
4. Cerebral stimulant polypharmacy: overlapping pharmacy claims for two (2) or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for at least 60 days within a 90 day period for members less than 18 years of age;
5. Benzodiazepine polypharmacy: overlapping pharmacy claims for two (2) or more benzodiazepines for at least 60 days within a 90 day period for members less than 18 years of age;
6. Mood stabilizer polypharmacy: overlapping pharmacy claims for three (3) or more mood stabilizers for at least 60 days within a 90 day period for members less than 18 years of age;
7. Any pharmacy claim for an antidepressant, antipsychotic, atomoxetine, benzodiazepine, buspirone, hypnotic or hypnotic benzodiazepine, or mood stabilizer for members less than six years of age; and
8. Any pharmacy claim for an alpha2 agonist or cerebral stimulant for members less than 3 years of age.

As a method for continuous quality assurance, improvement, and transparency, a multidisciplinary Therapeutic Class Management (TCM) workgroup has been created to retrospectively review prior authorization requests that do not meet the required criteria and to provide an increased level of clinical expertise to evaluate outlier cases. The workgroup may also conduct outreach to individual prescribers to discuss clinically appropriate treatment options in certain cases.

PBHMI reviewed 16,275 Prior Authorization (PA) requests for 3,395 unique users who were children under 18 years of age. It approved 10,648 and provided Provisional Approvals for 5,398 requests. A total of 229 denials were issued. Over a six month period, 649 PAs were forwarded for review to the PBHMI

workgroup process designed to problem-solve instances where prescribing practices were considered high risk.

In this initial round, it became evident that MassHealth Data on children in DCF care and custody did not provide accurate and current information about those children who were served by state agencies.

Together the task force made recommendations regarding changes in the PA form to better capture a child's custody status; agency involvement with DCF, the Department of Mental Health, and the Department of Developmental Disabilities; current placement setting including whether the child is being treated in an acute care setting.

Medical

DCF continues to expand its partnership and capacity with the medical community. In January 2016, DCF brought on its first full-time Medical Director, Dr. Linda Sagor. DCF also hired a part-time child psychiatry consultant, Dr. Wynne Morgan who is an active leader on the Psychopharmacology Task Force. Dr. Sagor has been charged with forming maintaining and developing relations with key medical entities engaged in assessment and treatment related to child abuse and neglect and foster care including Bay State Medical, UMASS Medical, Boston Children's Hospital, Boston Medical Center, Tufts New England and, Massachusetts General Hospital. She also maintains relationships with community and regional clinics and hospitals as needed.

During this first year, Drs. Sagor and Morgan have worked actively with the medical community. In the spring of 2016, Commissioner Spears and Dr. Sagor were invited to speak before the Massachusetts Chapter of the American Academy of Pediatrics on issues facing the medical community regarding child abuse and neglect, and children in foster care.

Dr. Sagor and Morgan have also provided consultation on select child abuse and neglect cases where there may be unusual challenges including cases where conflictual findings among medical professional about the etiology of a child's injuries or medical condition. Dr. Sagor also is a key participant in the agencies Critical Incident Review process through which DCF which examines and analyzes serious, near-fatal and fatal child maltreatment.

Dr. Sagor also leads a team of 6 nurses, and a Central Office Medical Social Workers. This year that team has been expanded with a goal of placing a full-time Medical Social Worker. To date 18 of those social workers have been hired. For the first nine area office medical social workers hired in the spring of 2016, the Department has seen an overall increase of 123% in the number of seven and 30-day health care exams completed on children entering DCF care.

During this year, the Department has worked to strengthen its capacity to address Substance Exposed Newborns/Neonatal Abstinence Syndrome. DCF Commissioner, Linda Spears and Central Office, Kim Bishop Stevens, now sit on the state's new Interagency Task Force on Newborns with Neonatal Abstinence Syndrome. The task force is jointly led by the Secretary of Health and Human Services, Mary Lou Sudders and Attorney General, Maura Healey. Also serving on the Task Force is the Massachusetts Health Policy Commission, The Department of Public Health, and the Department of Mental Health. An Advisory Committee to the Task Force will be formed and include advocates, consumers, and providers of services to mothers and their children in health care, substance use disorders, parenting and nurturing. The overall objective of the Task Force is to develop a unified statewide plan where all executive agencies are working in coordination to address the needs of newborns, infants and young children impacted by their exposure to substances by collecting data, developing outcome goals and ensuring quality services and programs.

Human Trafficking

The Department continued its partnership with the Justice Resource Institute (JRI), to implement the Child Welfare Trafficking Grant. The goal of the grant here in MA is to develop within the state's child welfare

system sustainable methods for preventing minor trafficking, identify trafficking victims and connect them with support and services. The process will include data gathering, infrastructure development awareness-raising and cross-systems collaboration and outreach. The collaboration with DCF includes the My Life My Choice Program which works with at-risk youth and youth who have experienced trafficking and the Support to End Exploitation Now (SEEN) Program, a multi-disciplinary response addressing human trafficking in the Boston area. The Massachusetts Juvenile Court and a variety of other stakeholders are actively engaged in this initiative.

In implementing a new Protective Intake Policy in February 2016, DCF expanded its reporting criteria and investigations determinations to include Sexual Exploitation and Human Trafficking. In conjunction with this change, the Department initiated training for DCF staff in partnership with My Life, My Choice and Roxbury Youth Works beginning in the spring of 2016. This training will be expanded to include a focus on trafficking prevention, and on trafficking involving boys.

Massachusetts Child Trauma Project

Ruth Bodian continues to represent DCF on the Massachusetts Child Trauma Project Steering Committee providing both a family voice perspective and serving as the DCF point person on trauma training, and in the integration of trauma informed and trauma-focused practice. Ruth leads a team of DCF Clinical Managers across the state who work collaboratively to support Trauma-Informed Leadership (TILT) Teams that operate in DCF area offices. This team also participated in the annual New England Trauma Convening sponsored each year by the New England Child Welfare Commissioner's Association and supported by Casey Family Programs.

DCF is also a partners on several new federal grant initiatives related to child trauma including work with UMASS Medical and the Cambridge Health Alliance. A focus of this work will be strengthening community-based capacity to recognize trauma, and other serious emotional disturbances, in children early on; and to create a collaborative treatment approach.

Partnerships for Adolescents and Youth Aging Out of Care

As noted in the Chafee/ETV report contained in the APSR document, the Department uses stakeholders' input to assist with Chafee programming that helps youth and young adults build strong foundations for success. Among the groups that partnered with DCF are:

- The DCF Youth Advisory Board
- Department of Mental Health through a SAMHSA grant
- Board of Higher Education, along with 4-year and 2-year colleges
- Department of Housing and Community Development
- Department of Public Health
- Department of Transitional Assistance
- Department of Elementary and Secondary Education
- MassHealth
- Jordan's Furniture

Input on DCF progress on its PIP and APSR goals is solicited from the above partners. Our partnership with providers to ensure the availability of quality services will continue to be a priority. Through our shared collaboration and diligence, we will also continue to strengthen the safety net for children and families for all in the Commonwealth. Input on DCF progress on its PIP and APSR goals is solicited from the above partners.

COMMUNICATION AND COMMUNITY ENGAGEMENT

Recommendations	Status/ Timeline	Comments
Revise policies, practice guidelines, website, and written materials to consistently communicate agency's primary responsibility to protect children. (CWLA)	FY15 Complete	New mission and vision statement created and posted. All policy revisions reiterate primary focus on safety first (Case Transfer, Background Record Check, Protective Intake, Supervision, Family Assessment and Action Planning).
Revamp and Reorganize DCF Website to provide current and comprehensive information to external stakeholder. (New)	FY16-17	Working with MassIT to revise website utilizing new Massachusetts-wide format. One particular area of focus will be around recruiting potential foster or adoptive families.
Revamp and Reorganize DCF Intranet to provide current and comprehensive information to DCF staff on current events, policies and procedures and promote internal communication. (New)	FY16 Complete	New DCF Social Intranet launched statewide. Allows for greater communication across the organization. One particular feature of new intranet is that it allows staff for the first time to access DCF policies via their iPads.
Reinstate DCF Newsletter to provide current and up-to-date information on progress on Department reforms and current initiatives. (New)	FY16-17	
Initiate Foster Care Campaign to increase the availability and retention of foster families. (New)	FY16-17	Foster Care recruitment has been embedded into the Department's Agency Leadership Improvement initiatives. Department has developed a revised business process to be implemented by June 2017 and is currently seeking a vendor to assist with a media campaign. The Department has also hired 15 dedicated foster care recruitment staff.
MA media outlets undertake public education campaign to raise awareness of each individual's responsibility to protect children from abuse and neglect and to uphold the rights of children. (CWLA)	TBD	
Increase community engagement in educating the public on unsafe sleep for infants. (CWLA)	FY15 & Ongoing	<i>Safe Sleep</i> and <i>Welcome Baby Campaigns</i> launched in 2014. Work ongoing with Medical Director and others.
Increase active engagement of children, youth, families, leadership, and workforce in determining and responding to needs within communities. (CWLA)	FY15 & Ongoing	DCF has active Family, Youth and Provider advisory boards; and local Area Boards.

LEADERSHIP AND ORGANIZATIONAL CULTURE

Recommendations	Status/ Timeline	Comments
Maximize Staff and Work Place Safety (New)	FY16-17	Department holds bi-annual safety conferences. Department has created safe workplace signage and placed it in all area offices. The Department has also invested in an emergency alert system that contacts staff via text, telephone, and/or e-mail to alert of an emergency. In addition, the Massachusetts State Police have been conducting "lock-down" trainings and drills with DCF area offices to educate staff on proper procedure to maintain safety in the event of an attack on an office.
Strengthen clarity of Practice Model, address related dissent among managers and staff, and reduce inconsistencies in implementation. (CWLA)	FY16-17	Building new Practice Principles to guide all future policy and practice development. This was included as a strategy in the recently submitted CFSR PIP.
Establish consistent expectations and protocols for management and clinical case reviews including when they are initiated, who attends, how they are conducted, and how information is synthesized, documented and shared to inform case direction/decision-making and system improvement. (New)	FY16-17	Included in Protective Intake and Supervision policies (implemented); included in Family Assessment and Action Planning and In-home Casework Policies to be implemented in February 2017.
Develop a plan to ensure that staff at each level of leadership has the necessary competencies. (CWLA)	FY17	Skills and competencies for DCF staff being developed with a focus on clinical trainings and supervision.
Cultivate a positive culture and climate in which accountability, communication, responsiveness, and commitment to improvement are valued and rewarded. (CWLA)	FY16-17	Culture and climate, accountability, communication, responsiveness, and commitment to improvement are emphasized in DCF's new CQI plan approved by the Commissioner and beginning implementation this fiscal year.

POLICY AND PRACTICE

Recommendations	Status/ Timeline	Comments
Visits and Contacts with Children and Families		
Develop visit protocols to assist SWs with quality contacts and engagement in home visits. (CWLA)	FY15 Complete	Developed and issued to all staff: <i>A Field Guide for Social Workers: Quality Visits and Contacts with Families.</i>

Implement statewide mandatory mechanism for real-time data entry for visits to children, families, and foster/adoptive/kinship homes; Enforce expectation on documentation of visits/contacts w/in 30 days after contact. (CWLA)	FY15-17	iPads now issued as standard equipment to all field staff to enable real-time data entry. New dashboard available to staff on status of visits/children needing to be seen. Timeline on data entry included in revisions to <i>In-Home Casework Policy</i> .
Transfer of Cases		
Revise Case Transfer Policy to require face-to-face meetings among staff for case transfers. (CWLA)	FY15 Complete	New Policy in effect as of March 2015.
Background Checks		
Develop, revise and promulgate regulations to ensure foster/adoptive parent applicants and kinship resources are appropriately assessed. (CWLA)	FY15 Complete	Implemented through revised policy and procedures.
Revise regulations to create approval processes, rather than waiver or variance, for kinship and foster/adoptive caregivers (CWLA)	FY15 Complete	Implemented through revised policy and procedures.
Review all child placements in homes approved through background check waiver, to identify those for heightened case monitoring, home visitation, supervision, or case oversight. (CWLA)	FY15 Complete	Intense one time review of all waivers conducted in FY2015.
Revise regulations & standards to require results of background check with conviction of certain felonies to exclude eligibility as a foster/adoptive parent, or kinship provider; Require outside screening for certain offenses. (CWLA)	FY15 Complete	Implemented through revised policy and procedures.
Ensure compliance with current policy relative to retaining all records of any criminal background checks for applicants for foster care, adoption, or kinship care. (CWLA)	FY15 Complete	Adherence to policy affirmed.
Executive branch and legislature consider ramifications of changes to background checks on foster and kinship resources. (CWLA)	FY15 Complete	Discussed as part of implementation of policy and procedural changes.
Regulations and standards updated to identify qualities and characteristics needed and the minimum requirements that must be evident in the home—align with standards developed by ABA, NARA, GU and Annie E. Casey Foundation; limit waivers to non-safety standard. (CWLA)	FY17 Complete	New approval process completed incorporating recommended standards. IT system updates to support new process implemented in September 2016.
Missing Children and Runaways		
Require digital photo of each child who enters the care and custody; updated every 6 months. (CWLA)	FY15 & Ongoing	Required for children at case transfer and for all children placed in a contracted placement; planned requirement for all children in DCF care or custody.

Revise runaway and missing child procedures to include age appropriate variables, procedures for search, procedures for notification of law enforcement, and for initiating Amber Alert protocols. Develop assessment on vulnerabilities that place a child at heightened risk for running away. (CWLA)	FY16-17 Complete	<i>Policy on Responding to Children Missing from DCF Care and Custody</i> , finalized and negotiated and implemented in September 2016.
Initiate Business Process Redesign to merge “siloe” programs and resources dedicated to preventing, locating and returning runaway and children missing from DCF Care and Custody. (New)	FY16-17	Bringing together Runaway Assistance Program from EOHHS with DCF resources and programs.
Case Practice Model		
Practice Model refined to clearly reflect rights of children and priority on child safety; Define the practice model by clarifying the desired elements: Practice Principles and skills and competencies that reflect the agency’s mission/vision , and alignment with DCF policy requirements. (CWLA)	FY15-17	Building new Practice Principles to guide all future policy and practice development. This was included as a strategy in the recently submitted CFSR PIP.
Involve DCF staff from every level of the organization, including representatives from SEIU Local 509 and parents, in redefining and rebuilding the case practice model. (FY15)	FY15 Complete	SEIU and parent representatives on Steering Committee.
Consolidate and clarify multiple/conflicting directives and guidance documents related to provide clear direction and expectation for screening and responding to reports of abuse and neglect (e.g., Protective Intake policy). (New)	FY16 Complete	Addressed in new Protective Intake Policy implemented in February 2016.
Ensure practice model guides and supports all child protective and preventive work in by all parties: DCF, lead agencies, community-based providers; Revise training modules for the ICPM. (CWLA)	FY16-17	Once Practice Principles are finalized, training curriculum will be revised and implemented.
Revise DCF Policies to align with Practice Model values, principles and skills (e.g., Family Assessment and Action Planning, Case Closing, etc.). (New)	FY16-18	All newly revised policies will align with Practice Principles.
In-Home Safety		
Develop protocols for evaluating risks to children living at home, including risks from household members who are not the child’s parents. SDM tool to be used consistently. (CWLA)	FY16 - 17	Included in <i>In-Home Casework Policy</i> implemented in March 2016. DCF working with a vendor to validate and update SDM risk assessment tool.
Child Care/Early Education		
With EEC, revise standard on discontinuing child care due to excessive absences. (CWLA)	FY15 Complete	Implemented through procedural change to ensure continuity of care.

QUALITY IMPROVEMENT

Recommendations	Status/ Timeline	Comments
Develop a plan for establishing a robust quality improvement system using Council on Accreditation's (COA) public agency standards for Performance and Quality Improvement (PQI) . (CWLA)	FY16-17	CQI system developed to comply with the federal CQI standards and modeled after PQI. 5 CQI Specialist positions hired. CQI instruments currently being tested.
Initiate discussions with MA institution(s) of higher learning to partner with them to evaluate the Practice Model. (CWLA)	FY17	Engage higher education partners in review of draft Practice Principles.
Explore data management and display tools to make management data visible, transparent and easy to use by DCF managers and other stakeholders. (New)	FY16-17 Complete	New management data reports have been created and implemented focusing on specific metrics relevant to area office managers. Reports are designed with easy-to-understand charts and graphs to facilitate review and understanding by managers.
Implement mechanisms for soliciting and considering feedback from children, youth, families, partners, collaborators, etc. on a regular basis. (CWLA)	FY15-18	Parent/Guardian Satisfaction survey completed 2x – plan to continue on a rolling basis. Process in place within Caring Together.
Establish outcome measures that are clearly articulated, measurable and regularly published. (CWLA)	FY16-18	Dashboard of key measures for internal publication implemented in January 2016; Program Improvement Plan (PIP) completed and submitted in Fall of 2016 as result of CFSR review in fall of 2015.
Make QI process transparent to youth, families, providers and the public. (CWLA)	FY16-17	Dashboard of key measures for internal publication implemented as of January 2016.

HEALTH AND MEDICAL SERVICES

Recommendations	Status/ Timeline	Comments
Hire Pediatric Nurse Practitioner (PNP) in each Area Office and a Medical Director. Area Office PNP responsible for reviewing, within 24-hours, significant medical information for the child. PNPs should rotate responsibility for coverage on weekends and holidays. (CWLA)	FY16-17	Medical Director (MD) hired as of 1.1.2016. Consulting Psychiatrist and 1 RN per region also hired. Hiring underway for 1 Medical Social Worker per Area Office (17 out of 29 hired to date).
Establish protocols for Social Workers and other DCF staff on when/how to seek medical consultations on DCF cases. (New)	FY16 Complete	Included in Supervision Policy.
Conduct statewide training for DCF staff (social workers and supervisors) on Healthy Child Development and signs of medical neglect. (New)	FY16-18	Plan to include in next round of clinical training in Fall 2018.

Establish an “expert panel” to provide support and consultation to DCF staff and medical personnel in difficult cases. (CWLA)	FY16-17	Priority task for Medical Director.
SW worker of record at the time the child enters the care of DCF should have direct contact with the PNP to report what is known about the child’s current status. (CWLA)	FY16-17	To be included in role of Medical Social Workers.
Establish a triage protocol for determining the urgency of screening and comprehensive exams/well-child visits and ensuring visits. (CWLA)	FY16-17	Priority Task for Medical Director; recommendations developed by working group.
Undertake statewide effort to educate staff and doctors at hospitals, medical offices, and community health centers to assure that requested information is made available quickly and efficiently. (CWLA)	FY16-18	Priority Task for Medical Director.

WORKFORCE AND PROFESSIONAL DEVELOPMENT

Recommendations	Status/ Timeline	Comments
Licensure and Training		
Legislature amend M.G.L. c. 112, § 131 and 134 to eliminate DCF staff’s exemption from social work licensing requirements. All clinical staff licensed in social work or in a related field. (CWLA)	FY15 & Ongoing	Chapter 165 of Acts of 2014 required all DCF social workers to be licensed within 9 months of hire; As of December 2016 more than 95% licensed; new support for license preparation available for new and current social workers.
MA legislature amend M.G.L. c. 112, § 131 and 134 to eliminate DCF staff’s exemption from continuing education and professional licensing requirements. All clinical staff required to meet continuing education standards. (CWLA)	FY15 & Ongoing	Chapter 165 of Acts of 2014 required all DCF social workers to attend 30 hours of training/year; Child Welfare Institute increased availability of in-service trainings to support attainment of new training requirements; tracking of training hours set up through PACE.
Establish standards for training and continuing education for all staff that are consistent with social work licensing requirements. (CWLA)	FY15 Complete	New requirements exceed this standard.
Increase opportunities for staff to participate in cross-training with sister agencies, community providers, and collaborative organizations. (CWLA)	FY15 & Ongoing	Mental health and substance use cross-training initiated with Dept of Public Health in FY17.
Professional development plans for each DCF employee as part of an annual performance evaluation. (CWLA)	FY15 & Ongoing	Existing annual performance evaluation processes include professional development goals.
Trauma-informed Approaches & Secondary Trauma		

All staff to have competency-based training in trauma-informed approaches. (CWLA)	FY15-17 & Ongoing	DCF received 1 year extension to 5 year federal grant – training staff and DCF foster parents on trauma-informed care for DCF involved children and families.
Each Area Office to establish a secondary trauma support team. (CWLA)	FY15-17 & Ongoing	Area Offices have or establishing Trauma Informed Leadership Teams, Wellness Committees and/or Staff Safety Committees.
DCF staff, placement resources, judges, court personnel, and CASA to receive training in trauma-informed services. (CWLA)	FY15-18	(see Trauma Grant above); Will require work with others to reach external parties.
Develop protocol for all contracted providers for trauma-informed engagement. (CWLA)	FY15 & Ongoing	With DMH implemented contract standards on trauma-informed care and in 7th year of initiative on reducing use of cohesive behavior management techniques.
Supervision		
Each DCF employee has regularly scheduled supervision -- establish and enforce baseline expectations for the provision of scheduled, dedicated time for supervision for each individual. (CWLA)	FY15-16 & Ongoing	New Supervision Policy finalized as of 11.17.2015 and implemented in Spring 2016.
Ensure Supervisors and Managers have supervisory training, current performance evaluation, and demonstrate the competencies required for their respective positions. (CWLA)	FY16-18 & Ongoing	Provided as part of training curriculum on Supervision Policy implementation.

STAFFING, CASELOADS AND OTHER RESOURCES NEEDED

Recommendations	Status/ Timeline	Comments
<p>Area Office Staffing</p> <ul style="list-style-type: none"> Area Director and ACM for each Area Office (CWLA) APMs to support a ratio of 1:4 (CWLA) Sufficient social worker and supervisory personnel to comply CWLA Caseload recommendations (CWLA) Medical Social Worker in each Area Office (CWLA) Administrative support for Area Offices (New) 	FY16-17	<p>Area Office Staffing updates:</p> <ul style="list-style-type: none"> As of June 2016, all area offices have a dedicated Area Director and Area Clinical Manager. The Department is in the process of hiring Area Program Managers to support a ratio of 1:4. Since August 2015, the Department has hired a net 262 additional social workers 17 (out of 29) Medical Social Workers have been hired Staff have been hired to restore appropriate administrative staffing ratios for area offices

Regional Office Staffing

- 5.0 FTEs for COI (CWLA)
- Restoration of 6 regions and 6 regional offices (CWLA)
- Backfill Boston RN, additional RN for each Region (CWLA)
- Additional Clinical specialist in DV, SA and MH for each Region (CWLA)

FY16-17

Regional Office Staffing updates:

- COI hires complete.
- DCF has restored 5 regions.
- An RN for each region has been hired.
- Additional DV and Substance Abuse staff have been authorized and have been hired or are in process of being hired.

Central Office Staffing <ul style="list-style-type: none"> • 2.0 FTE Policy Staff • 2.0 FTE for MCWI • Backfill key CO leadership positions in Foster Care, Programs and Planning, Hotline, Family and Community Engagement (Family Resource Centers) and Field Support. • Additional ERIP Backfills in key positions: Finance, Training, Family Resource Centers, Education, Foster Care Review, Ombudsman's Office, Hotline • Director of Continuous Quality Improvement (New) 	FY15-17 Complete	Key Central Office positions have been hired.
Fair Hearings <ul style="list-style-type: none"> • 2.0 FTE Fair Hearing Officers • 1.0 FTE Fair Hearing Supervisor • 9.0 Paralegals (including 5 dedicated to reducing Fair Hearing Backlog) 	FY16-17 Complete	Fair Hearings staff have been hired.
Assess fiscal and staffing needs within the MA Child Welfare Institute to support full implementation of/compliance with new laws on social worker licensing and ongoing training (30 hours/year). (New)	FY16-17 Complete	MCWI staff hired to oversee and track Social Work licensure and training requirements.
DCF, DPH, lawmakers, substance abuse programs, and others to work together to increase funding for substance abuse programs, especially for parents and expectant parents. (CWLA)	FY16-17	Training and outreach efforts underway in alignment with recommendations of Governor's Opioid Working Group.
Enhance foster care recruitment and support safety for DCF involved children living at home by increasing funding for Supportive Child Care Program. (New)	FY16-17	1500 children on child care waiting list; 600 new vouchers to be issued, in collaboration with EEC to be provided by end of FY16; additional planned for FY17.

Commonwealth of Massachusetts

Department of Children & Families

Population at Greatest Risk of Maltreatment

Population at Greatest Risk of Maltreatment

In the 2017 APSR, provide an update noting any changes or emerging trends in the populations the state has identified as at greatest risk of maltreatment. Describe the activities the state has undertaken since the submission of the 2016 APSR to target services to these populations and any changes in the services that will be targeted to them during the coming year.

DCF has identified the following as populations at greatest risk of maltreatment:

1. LGBTQ and Transgender Youth
2. Infants and children of substance-involved parents
3. Children and youth exposed to ongoing issues of Mental Health, Domestic Violence, and Substance Abuse
4. Family Homelessness
5. Children/parents with disabilities
6. Youth Transitioning from Foster Care

LGBTQ and Transgender Youth:

The LGBTQ and Transgender youth are at a greater risk of maltreatment due to discrimination, isolation and exploitation. Children/youth who are on the run or missing from care experience an increased risk for Human Trafficking (sex and/or labor). This vulnerability is amplified for LGBTQ and Transgender youth. MA DCF is a partner with My Life My Choice and the Suffolk County Support to End Exploitation Now (SEEN) on a federal 5-year grant to address Human Trafficking in our child welfare system. This grant work focuses on the vulnerabilities of the LGBTQ and Transgender populations within DCF through trainings and support to DCF staff, placement providers and the community. Multi-disciplinary teams across the state are increasing their understanding of Human Trafficking and the unique risks that our LGBTQ and Transgender youth experience. Additional funding from the MA legislature has allowed DCF to offer additional trainings (SFY 2017) to ensure that staff identify and respond appropriately. Within the past calendar year numerous policies within DCF have addressed particular vulnerabilities of our children.

Infants and Children of Substance Involved Parents:

Parental Substance Misuse and addiction continues to be a significant risk factor resulting in the maltreatment of children. The opioid crisis has escalated over the past year, contributing to high rates of overdoses, substance exposed newborns/neonatal abstinence syndrome, and abuse and neglect. In 2016, the Massachusetts Legislature authorized an Interagency Task Force on newborns with neonatal abstinence syndrome and substance exposed newborns to develop a unified statewide plan to collect data, develop outcome goals and ensure quality service is delivered. As part of another interagency effort, Department of Public Health and DCF were recently granted technical assistance from the National Center on Substance Abuse and Child Welfare to attend a Policy Academy to improve outcomes for pregnant and postpartum women with opioid use disorders and their infants and families. There continues to be strong collaboration between DCF and DPH to address the needs of families impacted by the ongoing opioid crisis. This includes partnering on federal grants, improving access to resources and communication between systems, identifying the needs of adolescents with co-occurring issues, and cross-systems

training. The DCF statewide Substance Abuse Unit has hired additional Regional Substance Abuse Coordinators over the past year, with four newly funded positions being filled in the upcoming months. There will be a total of 10 Regional Substance Abuse Coordinators and an additional statewide Coordinator position to focus on staff development and training needs of DCF social workers in this area. The Regional Coordinators roles are to provide case consultation to DCF social workers and work with community resources to improve access and communication. There has been increase in request for consultation to address the complex clinical needs of families, particularly as it relates to the ongoing opiate crisis.

In all policy development, DCF clinical units (Domestic violence, substance abuse and mental/behavioral health) have been utilized to incorporate clinical thinking and practice guidance related to these vulnerable populations.

Children and Youth Exposed to Ongoing Issues of Mental Health, Domestic Violence and Substance Abuse

Domestic violence continues to be a significant risk factor for children and their non-offending parent both within child welfare and in our communities. As part of an interagency effort with the Department of Public Health, the DCF Domestic Violence Unit has been in a primary leadership role of the re-procurement of \$35 million statewide domestic violence and sexual assault services. There was continued and renewed collaboration between DCF and DPH to address the needs of families impacted by domestic violence which resulted in this new procurement successfully incorporating into the requirements of these services:

- Addressing the unique needs of children and youth experiencing domestic violence
- Supporting survivors as parents
- Identifying risk and protective factors for children
- Assisting DCF involved families utilizing their services particularly concerning child visitation, reunification plans and working with DCF.
- Specific expectations for domestic and sexual violence programs to have active collaborations with local DCF offices.
- Continuing and enhancing specialized services for
 - Children exposed domestic violence
 - Survivors with addiction or mental health/trauma issues

Additionally, the DCF Statewide Domestic Violence Unit provides consultation on dangerous and/or complicated cases involving domestic violence & trauma to assist staff in identifying risk and safety factors, make recommendations and assist in developing action plans to increase the safety and wellbeing of children. These consultations inform a statewide perspective for the development of practice enhancements and training needs of DCF social workers in this area. To meet these needs the DCF statewide Domestic Violence Unit has hired additional Domestic Violence Specialists over the past year

increasing from 7 to 11 staff statewide to better meet the clinical needs of the DCF field staff. In all policy development DCF clinical units (Domestic violence, substance abuse and mental/behavioral health) have been utilized to incorporate clinical thinking and practice guidance related to these vulnerable populations.

Family Homelessness

The Department of Children and Families continues to expand our portfolio of services offered to families with issues of child maltreatment and who are experiencing housing insecurity and or episodic homelessness. The three primary means of supporting families plagued by housing insecurity is to offer Housing Stabilization Unit case consultation services, strong interagency collaboration with the Department of Housing and Community Development, and to collect and evaluate housing specific data.

In the current fiscal year, the Department has increased staffing levels to ensure each DCF region has an assigned Housing Stabilization Unit specialist and expanded the distribution of housing and economic self-sufficiency information with the creation of the Housing Services Unit Intranet page. In an effort to increase service delivery to homeless families the Department's Housing Services Unit enhanced the Family Unification Program with the option for families to access supportive housing services.

Additionally, a Memorandum of Understanding between the Department of Children and Families and the Department of Housing and Community Development was re-established in January of 2015 to support the transition of children from foster care to reunification with parents in the state's shelter system. The expansion of data collection comprised of the number of children reunified via the MOU and the success of families housed by means of the Family Unification Program positions the Department to better assess the services delivery needs of families facing poverty and housing insecurity.

Children/Parents with Disabilities

The Department has initiated work with the Massachusetts Commission for the Blind, the Commission for the Deaf and Hard of Hearing and the Special Commissioner for Autism regarding this population. Their input and expertise is being sought for future DCF policy development and training in this area. Staff across a number of DCF disciplines are involved in this effort. Outside of policy and training, the Department is in an assessment phase to determine if any specialized or additional services or programs are needed to support youth or parents with disabilities as it relates to the services delivered or needed by DCF to ensure child safety.

Youth Transitioning from Foster Care

DCF understands the challenges and risks facing transition age youth/young adults as they leave agency care and has developed an array of services to help prepare them with the skills and supports to successfully manage the struggles of adulthood. Using stakeholders' input, the agency has focused state and federal funded programming on assisting youth and young adults build strong foundations for success - addressing their needs for permanency, safety and the many facets of well-being. Educational achievement and life skill mastery with permanent connections to family and/or other caring enduring relationships with adults are the goals for our youth. These services span program models from foster care to congregate care as well as aftercare.

The Adolescent Outreach Program's strength-based approach to service delivery provides intensive, individualized life skill assessment and training to transition age youth/young adults from across the state to assist them in developing necessary skills and supports to achieve their potential. Youth and young adults are encouraged to practice newly acquired skills and utilize problem-solving techniques

effectively - within a safety net of adult supervision and support –allowing youth to make decisions, achieve goals, and sometimes make mistakes and experience failure. Supporting youth through these good and bad times is the key to successful transitions.

Aligned with the Fostering Connections law, DCF's Permanency Planning Policy encourages permanency, sibling connections, extended voluntary care for transition age youth to support optimal goal achievement. Pre-Service and ongoing training for DCF staff, foster parents and providers re-enforce these principles. Technical assistance provided to area office staff to strengthen understanding and practice of the policy.

Commonwealth of Massachusetts

Department of Children & Families

Services for Children Under the Age of 5

Services for Children Under the Age of Five: Describe the activities the state has undertaken since the submission of the 2016 APSR to reduce the length of time that young children under age five are in foster care without a permanent family. Describe the activities undertaken to provide developmentally appropriate services to this population. Provide the results of the activities and any updates to the previously submitted plan.

- Developed the curriculum for and facilitated the Early Childhood training (which has a primary focus on early childhood education, brain development, school readiness and success, and trauma informed care) at the quarterly “Foundations of Health and Wellbeing in Child Welfare” - an in-service training for new DCF Social Workers; over 50 staff in attendance per training.

- In FY 2016, DCF hired 252 new social workers who attended pre-service training that included: Child Development, Toxic Stress, Early Education and Supportive Child Care.

- In FY 2016, DCF de-coupled twelve Area Offices, providing full management teams to each. Increased availability of Area Directors and Clinical Managers allows for greater practice oversight, enhanced critical thinking, and informed decision-making.

- As part of the Agency Improvement Leadership Team process, DCF designed and implemented a supervisory training to accompany the implementation of the agency’s new Supervision Policy. The policy addresses the circumstances under which managers and specialists should be consulted by social workers and supervisors. The presence of children under the age of five is one criterion for such consultation. Specifically, the new Supervision Policy states:

Supervisors must seek consultation with a manager when there is:

- Disagreement between the Social Worker and Supervisor on case direction, especially as it relates to whether a child can safely remain in the home or placement;
- Conflicting information from collateral contacts, other professionals and/or family members, especially as related to child safety or well-being;
- A situation in which increased danger or risk to a child in Department care or custody has been identified.

Supervisors must seek a consultation with a manager and a Department Attorney when there is:

- A newborn whose siblings are currently involved in an open Care and Protection or other protective court proceeding;
- A newborn to a parent/caregiver(s) whose parental rights were terminated in a prior court proceeding; and
- A child whose parent/caregivers had a prior child adopted or a guardianship allowed for a prior child, whether the Department was involved or not.

Other circumstances when Supervisors may seek consultation with a manager include:

- A complex “case” where case direction is difficult to determine;
- A case involving a medically fragile child; or
- Other circumstances that either the Social Worker or the Supervisor identifies as warranting

managerial review.

Supervisors must request an Area Clinical Review under the following circumstances

- Disagreement, or when seeking agreement, among service providers who have differing opinions about safety of a child in the home;
- Disagreement among clinical staff units involved in managing the “case” concerning safety of a child in the home or the proper course of case management when the Social Worker, Supervisor and/or Area Program Manager have conflicting opinions about case direction or decision-making.

Supervisors may request an Area Clinical Review under the following circumstances

- Complex “case” where direction is difficult to determine; and
- Other circumstances identified in consultation with a manager or Department Attorney.

Offered trainings (in person and via webinars) to all 29 DCF Area Offices on the Supportive Child Care (SCC) Data Management Tool –The SCC data tool was created in 2014 to manage the utilization of SCC for over 7000 children at the 29 DCF Area Offices. This tool will capture each Area Office’s waitlist, referrals and enrollments to supportive providers as well as the demographical information for each child referred. Created the SCC Tool Guide (with screenshots and a set of Frequently Asked Questions) and additionally created a two page “SCC Tool Cheat Sheet” that has quick tips on using the SCC Tool.

- Creating and distributing additional 2000 Welcome Baby Bags for families with children from birth – six months statewide which included items for the health and safety of the child and family. (for e.g. information about safe sleep, swaddles for the child etc.)

- Statewide DCF policy revisions have been made to include children birth to five – such as the Education Policy (2014), Intake and Supervision Policies (2015).

- Early Childhood Policy Analyst was responsible for designing, uploading and managing all content pertaining to the Policy and Practice Innovations unit, including the Child Development, Early Education and Care page of the DCF Intranet.

- Early Childhood Program Coordinator was selected and began participation as a 2015 - 2016 fellow at the Rennie Center for Education Research & Policy.

As noted in the section on Populations at Greatest Risk of Maltreatment, the Department is focusing efforts on the number of children, many of whom are under the age of 5 who require DCF placement due directly to the opioid crisis. As of October 2015, the number of children removed from their homes increased 28 percent over the past three year. A significant number of child abuse and neglect cases can be attributed to parental opioid addiction. These cases also include infants born exposed to drugs. In 2016, the Massachusetts Legislature authorized an Interagency Task Force on newborns with neonatal abstinence syndrome and substance exposed newborns to develop a unified statewide plan to collect data, develop outcome goals and ensure quality service is delivered. As part of another interagency effort, Department of Public Health and DCF were recently granted technical assistance from the National Center on Substance Abuse and Child Welfare to attend a Policy Academy to improve outcomes for pregnant and postpartum women with opioid use disorders and their infants and families. There continues to be strong collaboration between DCF and DPH to address the needs of families impacted by the ongoing opioid crisis. More information is available in the Populations at Greatest Risk of Maltreatment section of the APSR.

Commonwealth of Massachusetts

Department of Children & Families

Program Support

Program Support

Training

The Department's staff development and training plan in support of its goals and objectives is outlined in detail in the Child Welfare Institute Training Plan section of the APSR. The primary goal of the Massachusetts Child Welfare Institute (MCWI) is to promote effective child welfare practice. MCWI activities strive to improve the knowledge and skills of individual social workers, the quality of supervision and the agency environment that promotes creativity and professional growth. The MCWI is committed to advancing the strategic goals and objectives of the Department of Children and Families. The Massachusetts Child Welfare Institute (MCWI) is the professional development and training division of the Department of Children and Families. The purpose of the MCWI is to improve child welfare practice in the Commonwealth. Through a focus on three interdependent responsibilities, the MCWI promotes a shared understanding of and agreement about the Department's core practice values, commitments and priorities; teaches the knowledge, skills, and tools of facilitative child welfare practice, which makes it more feasible for social workers to help families keep their children safe; and, supports the continuous learning of social workers, supervisors, and managers as they lead agency initiatives and practice innovations.

The MCWI is focused on a vision of providing high quality, evidence-informed, and relevant training programs that are helpful to the approximately 3,800 DCF social workers, supervisors, and managers across the Commonwealth in their efforts to insure the safety, permanence, and well-being of children and families. The MCWI consists of 8 full-time staff members focused on training and professional development programs (Associate Director, 4 Professional Development Managers, 1 Program Coordinators, 1 Administrative Assistant, and a Coordinator of Fellowship Programs) and a number of part-time contracted training specialists. The MCWI also employs a part-time librarian to manage the DCF child welfare library. MCWI training managers oversee the design, development and implementation of agency training programs, coordinate the work of external trainers, conduct a considerable amount of classroom training, and act as Practice Coaches in the field.

The MCWI has advanced and implemented a series of highly regarded programs. With a considered strategy to promote continuous learning and professional identity for child welfare social workers, supervisors and managers at DCF, the MCWI promotes organizational effectiveness by building on our many strengths of training. For details regarding DCF training in 2017, please refer to the Training Plan section of the APSR.

Technical Assistance

In past years, DCF has taken advantage of substantial technical assistance opportunities provided through the federal National Resource Centers as well as T.A. provided by national and local organizations. As part of DCF's continued commitment to assessing the impact of our work and to the inclusion of the family perspective in the Department's work, DCF and Casey Family Programs partnered to develop a multi-year process for gathering and incorporating DCF parent and family feedback into DCF policy and practice. This work will continue through FFY17.

Community Connections Coalitions, funded with Promoting Safe and Stable Families funds, continued to expand the significant base they established at the community level and to act as a bridge between the Department and the community. Coalitions have partnered in the establishment of 11 Family Resource

Centers (FRCs) across the Commonwealth. Our technical assistance, training and evaluation partnership with the Massachusetts Children's Trust Fund – the state's Community-Based Child Abuse Partnership (CBCAP) grantee – has allowed these FRCs to act as incubators for eventual statewide expansion. Because they are built on existing Community Connection coalitions, FRCs enhance DCF's partnerships with the community and aim to increase the Department's capacity to provide a flexible mix of family support services at the local level. This benefits not only the Community-connected practice of DCF but also serves as a catalyst for the development of a more broadly defined community-based continuum of care which focuses on the well-being and the promotion of a shared responsibility for at-risk children between DCF and the community.

DCF staff have participated in, and will continue to attend, technical assistance meetings facilitated by the New England Association of Child Welfare Commissioner and Directors on CQI/IT issues. Given the reliance on CQI for Round 3 of the Child and Family Service Reviews (CFSR), state agency staff have appreciated the opportunity to discuss their state models, strategies for success and challenges with their colleagues from across New England.

As needed, DCF will request federal technical assistance during FFY 2017 through the Children's Bureau following the development of its Program Improvement Plan, resulting from the 2015 Child and Family Services Review.

Research, Evaluation and Q.A. Systems

DCF is involved in two discretionary grant programs, each with its own evaluation component. DCF was selected to receive a grant from the Administration for Children and Families, Children's Bureau, to build capacity to provide trauma-informed casework practices and trauma-specific evidence based treatments (EBT). DCF has partnered with LUK, Inc., Justice Resource Institute Trauma Center, Boston medical Center's Child Witness to Violence Program and UMass Medical Center to provide basic and advanced training for DCF staff and to provide training to selected mental health providers. The Director of Evaluation for this grant chairs an Evaluation Committee and reports to the grant steering committee. This evaluation committee consists of consumers as well as stakeholders from DCF and provider agencies who assist with the evaluation planning, interpretation of results and recommendations for project improvement. The evaluation design includes a randomized control trial of the Breakthrough Series Model for implementing practice change and a quasi-experimental study of the effectiveness with or without the availability of evidence-based trauma treatments.

The Department is also a member of a team that successfully competed for federal funds to support development of statewide partnerships aim at alleviating child welfare trafficking. The Massachusetts team received confirmation that it was awarded one of the four grants nationwide. The grant proposed an action research model for evaluating the success of the project. Dr. Amy Farrell, Associate Professor of Criminology and Criminal Justice at Northeastern University, leads the evaluation and works with the grant leadership team and advisory board to assess the success of the proposed program objectives. Dr. Farrell will access administrative data to quantitatively assess the impact of grant activities. She will also collect qualitative data through observations and interviews to assess the successes and challenges of the program model. An annual evaluation report will be prepared for the project's advisory board.

Massachusetts Department of Children and Families (DCF) is one of 26 agencies nationwide that have received Title IV-E waiver project approval from the Administration for Children and Families (ACF) Children's Bureau since 2012. Under the waiver, child welfare agencies are allowed to use Title IV-E funds more flexibly than traditionally permitted to offer innovative services to build on family-driven,

child and youth focused care and community involvement. The waiver opens a window of opportunity for comprehensive child welfare finance and program reform based on outcomes of these waiver projects across the nation.

The Commonwealth implemented Caring Together as its five-year waiver demonstration project on January 1, 2014. DCF submits periodic progress reports to ACF throughout the life of the waiver. DMA Health Strategies, an independent evaluator contracted by DCF, is conducting a comprehensive evaluation of the demonstration project. **Evaluation in Process:** DMA has conducted focus groups and surveys with DCF staff, providers, and families to evaluate the implementation process for Caring Together.

The evaluation aims to assess:

- outcomes achieved in youth and family safety, permanency, and well-being;
- quality of services and satisfaction among youth and families;
- fidelity to Caring Together principles; and
- service utilization and fiscal impact.

In its CQI strategic planning, the Department assessed the benefits of building internal capacity for conducting case reviews; in lieu of, or in combination with contracted case reviewers. The recently established DCF CQI Unit was the end product of that planning. The Department anticipates the implementation of a comprehensive case review instrument in state fiscal year 2017. Interviews will be incorporated into the agency's case record review system.

Commonwealth of Massachusetts

Department of Children & Families

Consultation and Coordination Between States and Tribes

INDIAN CHILD WELFARE ACT

Annual Report

Commonwealth of Massachusetts

State Fiscal Year 2016

This report is submitted as part of the plan of the Commonwealth of Massachusetts for compliance with title IV-B of the Social Securities Act (the Act) and ICWA of 1978. The report includes the Annual Progress and Services Report.

Overview of ICWA for SFY'16

As of April 1, 2016 MA Department of Children and Families (DCF) served 112,770 open consumers, an increase from April 2, 2015 by 5.7%. The distinct count of consumers receiving services with some indication of Native American affiliation is 1499. This number indicates those who (simply) claim NA/AN heritage, and those who can demonstrate a family tree that links them to a named tribe. A family 'simply' claims NA/AN heritage by stating that they have been told (through extended family) that they are tribal. Often times the family is unable to name a specific tribe. Other families demonstrate an affiliation by naming family members who claim heritage to a specific tribe.

When custody is awarded to DCF of a child with NA/AN heritage, the social worker is required to notify the MA ICWA Coordinator. DCF has encouraged staff to ask families about their NA/AN heritage as soon as DCF responds to an allegation of abuse or neglect. Families are always asked to identify their race and ethnicity during the comprehensive assessment phase of their work with the Department. DCF encourages staff to ask the question about family ancestry throughout the life of the family case since; extended family members may embark on a history of the family tree after the initial question was asked or, the family may feel more comfortable talking about their heritage as their relationship with their social worker deepens.

Notices to federally recognized tribes across the United States are sent by the ICWA Coordinator. Copies of all responses from the tribes are forwarded to the DCF social worker, DCF attorney and to the Regional ICWA Liaison. These notices and subsequent responses are filed in the legal section of the family case record. The tribal affiliation for each consumer is documented in the demographic screen in the electronic case record.

DCF has further demonstrated its commitment to ICWA through its continued partnership with the Court Improvement Project. Funding was provided to hire a part-time DCF ICWA Coordinator to address the increased volume of ICWA inquiries received from across the state. This position was filled in November 2015 and has proven invaluable. Since 11/15, DCF has resolved 136 ICWA inquiries. This additional ICWA position allows DCF to increase its ICWA related training and education efforts. The forthcoming ICWA curriculae will provide DCF staff with options for a 1/2 day training or a 45 minute ICWA training. The release of the 2016 FAQ related to the 2015 ICWA Guidelines will be incorporated into DCF trainings and posted on the DCF intranet. DCF will be developing an Intranet page that is solely dedicated to ICWA. These varied forms of communication with DCF staff will undoubtedly increase ICWA knowledge and compliance.

DCF staffs across the state receive education about ICWA on a daily basis. Each (email) response to an ICWA inquiry includes educational material that links the reader to information about the Massachusetts Tribes and to other links that stress the reason/importance related to the ICWA law. Each DCF team that receives this information is urged to share it with their colleagues in order to increase DCF compliance with ICWA.

DCF has incorporated ICWA into current policies. These include the (11/15) Protective Intake Policy, drafted policy on Missing or Absent Children from Departmental Care or Custody, drafted policy for Social Media and upcoming Assessment and Action Planning policy, among others.

Coordination and collaboration with MA Tribes

Wampanoag Tribe of Gay Head (Aquinnah) – WTGH(A)

The Tribal contact is Bonnie Chalifoux, Human Services Director. This past year, DCF introduced additional opportunities for communication to improve between the state and the Tribes. This outreach for collaboration resulted in 7 monthly calls. DCF took responsibility for scheduling, managing the agenda and facilitating these monthly calls. These regularly scheduled meetings were designed to avoid gaps in communication and to provide clarity about the work accomplished by each Tribe and DCF.

DCF is looking forward to specific collaboration with the Tribes once DCF drafts a version of an ICWA PowerPoint for training. Additionally, DCF looks forward to the Tribes participation in all future ½ day trainings for DCF staff.

ICWA staff from DCF and the Tribes met twice (8/15 and 11/15) in SFY 2016 in order to provide updates and to plan for the coming year. DCF took responsibility for scheduling, managing the agenda and facilitating these 2 quarterly meetings through 1/16. DCF has communicated with each tribe via phone conversation, email and in person that DCF staff is prepared to schedule additional quarterly meetings at the suggestion of the Tribes. DCF (ICWA Coordinator) met with both Tribes in May and reminded Tribal staff of the ICWA work underway at DCF along with new developments related to ways in which DCF will ensure compliance. This meeting seemed to answer all Tribal questions and it was felt by all that shared responsibility around communication remains critical to our success as a team.

The WTGH(A) terminated its Intergovernmental Agreement (IA) with Massachusetts effective 2/5/13. DCF is anxious to collaborate on this very important piece of work. The IA would serve as clarification regarding expectations. There are ripe opportunities for the Tribe and the Department to educate each other, share lessons learned and collaborate around many issues. At this point in time, WTGH(A) works on 5 DCF involved cases.

Mashpee Wampanoag Tribe (MWT)

The Tribal contact is Catherine Hendricks, the ICWA Director. This past year, DCF introduced additional opportunities for communication to improve between the state and the Tribes. This outreach for collaboration resulted in 7 monthly calls. DCF took responsibility for scheduling, managing the agenda and facilitating the calls. These regularly scheduled meetings were designed to avoid gaps in communication and to provide clarity about the work accomplished by each Tribe and DCF.

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There are ripe opportunities for the Tribe and the Department to educate each other, share lessons learned and collaborate around many issues. At this point in time, MWT works on 30+ DCF involved cases. MA DCF was notified on October 23, 2014 that the MWT drafted IA had been approved by the MW Tribal Council. DCF is hopeful that additional discussions related to the clinical considerations in the proposed IA will occur in SFY 2017. DCF is anxious to collaborate on this very important piece of work. The IA would serve as clarification regarding expectations as we continue to work on ICWA together. At this writing, various levels of MA Government are reviewing the drafted IA.

DCF ICWA Coordinator Lori Ann Bertram recently participated in the Annual NICWA conference in Saint Paul, MN. During this conference, an additional connection with a member of the MWT and its Elders Judiciary Committee was established. DCF is hopeful that this relationship will serve to enhance the Departments collaboration with the Tribes newly formed (7/15) Juvenile Court. The Mashpee Wampanoag are implementing and developing their Juvenile Court and have intervened in 3 MA ICWA cases during this past year.

Human Trafficking – partnerships for prevention and intervention

Wampanoag Tribe of Gay Head (Aquinnah) – WTGH(A) and Mashpee Wampanoag Tribe (MWT)

DCF in partnership with Justice Resource Institute's My Life My Choice Program and the Suffolk County Child Advocacy Center's Support to End Exploitation Now Program were awarded a Grant in September 2014 from the Administration for Children and Families to address the Commercial Sexual Exploitation of Children (CSEC) within DCF. Grant work is in its second year of five and is addressing the identification of and response to CSEC at DCF. The Grants work will also provide guidance and support to DCF relative to its policies and practices along with a robust data collection system. The MWT and WTGH(A) committed, through letters of support to participate in future county CSEC training and the implementation of the safe harbor provisions in the MA human trafficking law. Both Tribes have been invited to participate in the quarterly meetings of the Grants Leadership Advisory Board. DCF and its Grant partners will continue to stress the value of the Tribes participation in this important effort to address CSEC since the data speaks to the particular vulnerability of minority children involved in state child welfare agencies as those at higher risk of exploitation. ICWA staff from both Tribes participated in the CSEC trainings and both Tribes have been encouraged to represent their Tribe on The Children's Coves' multidisciplinary team designed to address the Human Trafficking issue.

DCF collaborates with the Tribes in terms of Massachusetts Approach to Partnerships in Parenting (MAPP) trainings. The need for Tribal foster homes has been a focal point for DCF and the Tribes for years.

The ICWA trainings over the past six years has resulted in greater awareness by DCF staff who are now asking "the question" (re: NA/AN heritage). The direct result of this work is that the ICWA volume steadily increases.

Sharing the APSR with each MA Tribe

The goals discussed in the APSR speak to the common direction of each entity related to strengthening families through community services and informal supports. These goals are addressed at each meeting of the ICWA staff from both Tribes and DCF. Upon finalization of the MA APSR, a copy will be shared with both Tribes by the DCF liaison.

Notification of Indian Parents and Tribes

Representing a 9 month portion of the 2016 SFY (July 1, 2015-April 1, 2016) MA DCF received 135 ICWA inquiries. Of the 135 inquiries, 15 families were eligible for one of the two Tribes in MA. MA Tribes intervened with 3 of the families.

MA DCF received 182 ICWA inquiries between April 1, 2015-April 1, 2016. Of the 182, 25 families were eligible for one of the two Tribes in MA. MA Tribes intervened with 10 of the families.

As of April 26, 2016, there are 209 ICWA inquiries in process. Inquiries are in “process” when DCF works with the family and other collaterals to document a family tree that seeks to prove an official affiliation of a child to a named tribe.

The addition of another ICWA Coordinator has increased timely compliance with ICWA. This position afforded MA DCF with an improved response time to ICWA inquiries (immediately or within days), a capacity to engage in “real time” communication with DCF Attorneys (during Care and Protection court hearings) and the training and support of 2 newly assigned Regional ICWA Liaisons.

DCF is diligent about its process to uncover genealogy necessary for an ICWA notice. DCF enlists the assistance of the Attorney representing the appropriate parent to impress upon the parent the need to comply with this federal law. DCF also utilizes an Accurant search for missing family tree information. This is a data base that when demographic information is loaded into it, can search public records for information such as names, dates of birth, addresses, and phone numbers.

Special Placement Preferences

The Mashpee Wampanoag Tribe continues to recruit tribal members to become foster homes specifically to take tribal children. DCF works hard to notify the Tribe upon placement of children who ‘may’ be eligible for membership so that ICWA placement preferences are met.

DCF has expanded its number of ICWA Liasons this year. Tribes have 5 regionally based ICWA Liaisons available at any time to address questions or concerns that arise on specific family cases.

Active Efforts to prevent breakup of the Indian Family (past, present and future)

DCF is in the process of updating its ICWA FAQ to support the best practice recommendations outlined in the 2015 ICWA Guidelines. This document will be available to all DCF staff through the Intranet and will serve to underscore the importance (with specific examples) of active efforts.

The DCF Intranet ICWA page will provide DCF staff with calendar events received from each MA Tribe. DCF has requested that both MA Tribes submit information they feel would benefit the DCF staff in working with a Tribal family. DCF is hoping to receive information about Tribal culture and an updated list of services for Tribal members.

Use of Tribal Courts in child welfare matters, Tribal rights to intervene in State proceedings, or transfer proceedings to the jurisdiction of the Tribe

Since July 2015, the Mashpee Wampanoag Tribe has taken jurisdiction of 3 family cases to date. As Tribal policies and procedures develop, case transfers will become seamless.

Efforts to improve the compliance with ICWA, (past, present and future)

- DCF policies (draft and implemented) related to Assessment and Action Planning, Missing and Absent Children from Departmental Care and Custody, DA Referral and Protective Intake are being reviewed to include best practice relative to ICWA compliance. Native American/Alaska Native heritage questions and references throughout these policies will contribute to ICWA compliance and education.

An example of this work lies with the drafted policy on Missing and Absent Children from Departmental Care and Custody. This policy language is consistent with language that speaks to ethnically matched/sensitive supports and resources for children and youth who struggle with a variety of risk factors associated with running and exploitation

- All future policy updates, along with Tips of the Week, Commissioner Directives, FAQ's and iFamilyNet builds are vetted for particular language and compliance associated with ICWA
- The DCF ICPC 100A form (for interstate placement purposes) includes a section for ICWA eligibility; another mechanism to track and ensure compliance with ICWA
- In March 2014 DCF revised its ICWA notice form to meet the requirements of the ICW Act
- The DCF FAQ on ICWA will be rolled out in 2016 and posted on the DCF intranet as well as provided to the Tribes as reference material
- DCF and the Tribes will finalize an updated ICWA PowerPoint for future training purposes during 2017
- 28 various ICWA trainings occurred between 2011-2015. The audiences ranged from DCF staff, Foster Care Review staff, a DCF contracted provider and court personnel and Judges. These trainings proved successful as the number of ICWA inquiries increased after each training.
- DCF doubled its ICWA staff in October 2010 to 2 Coordinators. In 2011 the ICWA staff increased its reach to include 4 Regional ICWA Liaisons. In the year 2015 two ICWA staff were added with a Regional ICWA Liaison and an additional Central office ICWA Coordinator, bringing the total ICWA staff (as of 4/16) to 7.
- Ms. Bertram's position as Clinical Manager of Field Support provides for an array of opportunities to monitor ICWA compliance. Through her additional management of Critical Incident Reports, her role to manage the Departments response to Human Trafficking and her role as Liaison to the Office of the Child Advocate, Ms. Bertram is able to ensure that ICWA compliance is met.

Commonwealth of Massachusetts

Department of Children & Families

Monthly Caseworker Visit Formula Grant

Caseworker Visits

The Massachusetts Department of Children and Families (DCF) has been reporting monthly caseworker contact with children in placement since the inception of this federal measure. DCF recognizes the critical importance of caseworker visits and thus, has been working to systemically improve and strengthen the quality and frequency of caseworker visits through the development of policy and practice, improved worker safety measures and technology improvements and upgrades.

Current Strategies to Strengthen Quality and Increase Visits

Caseworker visits are strengthened via many areas that include but are not limited to worker safety and policy and practice. The agency has unequivocally stated that regular worker visits are a cornerstone of child welfare practice – one of the basic “nuts and bolts” of best practice when working with families. Operationally, this has been executed in the revision of many of the agencies policies and development of new policy.

To date, the policies that have been revised, negotiated and implemented are DCF's:

- Protective Intake;
- Permanency Planning, which addresses quality and frequency of visits for children in placement;

Additional policies that are revised, negotiated and scheduled for implementation in the coming year are:

- Family Assessment Action Planning, which addresses quality and frequency of visits for children in placement and in home;
- In Home, which addresses quality and frequency of visits for children in the home;
- Case Closing; and
- Supervision

Each policy clearly articulates the frequency for caseworker face to face visits and their relationship to safety, permanency and well-being. Metrics are being developed which will not only track caseworker face to face visits, but will also illustrate how these visits improve outcomes for children and families.

The Department has developed additional supports to monitor and strengthen quality and frequency of caseworkers visits. They include:

- “Daily Consumers to be Seen” dashboard is available to caseworkers and supervisors on iFamilyNet.
- I-Pads are configured with iFamilyNet, caseworkers are able to record consumer contacts immediately following the contact and access the daily Consumers to be Seen report remotely.
- Managers continue to receive the Consumers to be Seen data report weekly to monitor caseworker visits.
- An e-learning video is available on the Intranet to all field and managerial staff that outlines the process for proper entry of worker visitation data.
- The IT Training Unit and the Deputy Commissioner provide periodic follow up emails to the field regarding caseworker visits.

Practice challenges identified through cases that resulted in tragedies include inconsistent case worker contacts, lack of communication with other involved and informed stakeholders, limited access to current

electronic information and other antiquated systems. The Department began addressing these challenges with the assistance of the Governor, Secretary of Health and Human Services and State Legislature. Their commitment to improvement has provided resources targeted at reducing caseworker caseloads and providing mobile devices to workers. The FY15 state budget saw additional investments which included IT capital expansion and increased staffing. The commitment demonstrated by Governor Baker, HHS Secretary Sudder, and the Massachusetts Legislature continues to provide unprecedented support to the Department in its improvement efforts.

Enhancements to policy, practice, staffing and IT continue. They are expected to yield results in both the frequency and quality of caseworker visits. The dashboard in the iFamilyNet web-based application provides caseworkers and supervisors with a snapshot of the status of recorded caseworker contacts. It is a simple and clear picture of recorded frequency of face to face caseworker contact. The supervisor, as well as manager, have the ability to monitor frequency and compliance with new policy on face to face caseworker contact. This is a significant step forward for the agency.

Policy has been developed which directly addresses frequency and quality of face to face caseworker contacts. Along with this, a field guide was developed that provides a framework to guide staff in preparing for home visits, conducting visits with children and their families and documenting visits. These guides are now a part of new worker training and have been distributed to all casework staff. An electronic version is posted on the DCF Intranet.

Current Year Plan

DCF is onboarding an unprecedented number of direct service staff to compensate for the loss of staff the Department has suffered since 2008. Critical needs identified in the following areas will be addressed through the use of this grant include:

- Policy development, implementation and integration into practice;
- Training, including on boarding of high numbers of new staff and retention;
- Development of system capacity for all levels of staff;
- Development of metrics that illustrate how quality and frequency of face to face caseworker contacts improve outcomes for children and families;
- IT related to supporting quality and frequency of face to face caseworker contact;
- Corresponding infrastructure that supports consistent and quality casework, including resources to support the increased travel related to required visits by all agency staff.

DCF also intends to continue to utilize a portion of this grant for the distribution of Welcome Baby baskets to families with children under the age of one year. This includes foster, and kin. It is expected that the Caseworker Visits Grant, once again, will serve as the vehicle to redesign the basic bag contents to meet the needs of the expanded population and support the inclusion of specific developmentally appropriate content. These materials provide caseworkers with a richer opportunity to work with families during visits to ensure children are receiving appropriate care and stimulation.

Commonwealth of Massachusetts

Department of Children & Families

Adoption and Legal Guardianship Incentive Payments

Adoption and Legal Guardianship Incentive Payments

From FFY 2011 through FFY 2014, Massachusetts DCF did not receive funds through the Adoption Incentive Program. Late in FFY 2014, DCF learned that it would receive a small amount of adoption incentive funds. As with all federal grant funds, upon receipt of the grant award letter DCF program staff met with budget staff to set up a receipt account and plan for expenditure of these funds.

The Department received an award letter in the amount of \$9126.00 in adoption and guardianship incentive funds. This past year, DCF received an additional award letter in the amount of \$6,874 for FFY 2014 so the allocation totaled \$16,000.

During SFY15 and SFY16, a portion of the funds was used to support Department staff attendance at the Rudd Adoption Conference at the University of Massachusetts in Amherst. The topic was New Worlds of Adoption: Launching into Adulthood. Breakout sessions included the following topics:

- Talking to young adults about being adopted
- Emerging adulthood in Open Adoption
- African American adopted children launching into adulthood
- Navigating access to higher education
- Are we adequately preparing adoption professionals to work with young adult adoptees?

Additional funds were used to purchase camera equipment for use in child-specific recruitment activities, attendance at the National Adoption Conference and in support of recent adoption recruitment activities.

Approximately \$3000 in incentive funds remain unexpended. Program staff will meet with budget staff to plan for these funds to ensure that they are obligated and expended by the deadline specified in the grant award letter. The Department does not anticipate any barriers to achieving the goal of expending all allotted grant funds.

The Department acknowledges changes to the adoption and legal guardianship incentive payment program brought about by the enactment of PL113-183. The law extended from 24 months to 36 months the length of time states have to spend incentive payments earned under the program; also the law prevents states from using incentive payments to supplant federal or non-federal funds for services under title IV-B or IV-E. At present, these changes do not impact the Department's plans for use of the incentive funds.

Commonwealth of Massachusetts

Department of Children & Families

Child Welfare Waiver Demonstration Activities

Child Welfare Waiver Demonstration Activities

If the state has an approved child welfare waiver demonstration project under section 1130 of the Act, describe it must provide a description of its coordination efforts to integrate the activities under the demonstration with the goals and objectives of the 2015-2019 CFSP. In particular, the state must discuss in the 2017 APSR how title IV-B monies are used to maximize the use of flexible title IV-E dollars in the demonstration.

Since the implementation of the Department's waiver demonstration project on January 1, 2014, DCF has been serving children under the Caring Together system. This system offers families a continuity of services and providers whether a child is in a congregate care program or receiving services in their community in order to better support community transitions and strengthen child and caretaker capacity. The primary goals of the waiver demonstration project align with the goals and objectives of the 2015-2019 CFSP as they center on, increasing permanency, improving safety, and increasing well-being and positive outcomes in the community.

The Department uses Title IV-B monies and flexible Title IV-E funding under the waiver to support the joint management and governance of Caring Together between DCF and DMH, as well as cover costs for traditionally unallowable services under 45 CFR 1356.60 (c)(3) , such as counseling or other treatment to the child, family, or foster family to remedy home conditions, personal problems or behaviors.

Commonwealth of Massachusetts

Department of Children & Families

Quality Assurance System

Massachusetts DCF Quality Assurance System

Federal regulations at 45 CFR 1357.15(u) require states to describe in their CFSP the Quality Assurance (QA) system it uses to regularly assess the quality of services under the CFSP and assure that there are steps taken to address identified problems. On August 27, 2012, CB issued Information Memorandum ACYF-CB-IM-12-07 on establishing and maintaining Continuous Quality Improvement (CQI) systems.

A continuous quality improvement approach allows states to measure the quality of services provided by determining the impact those services have on child and family level outcomes and functioning. Such an approach also helps states determine the effectiveness of processes and systems in operation in the state and/or required by federal law. A well-functioning QA/CQI system is foundational for the CFSR process, as such a system can help inform the state's statewide assessment, support the state conducting its own case review and facilitate performance information for program improvement plan purposes.

In the 2017 APSR:

- Assess the state's current QA/CQI system. Describe any specific practices or system improvements the state has made based on QA/CQI;
- Include any training or technical assistance the state anticipates needing from CB resources or other partners;
- Provide an update on QA/CQI results and data that have been used to update goals, objectives, and interventions or use of funds in the 2017 APSR;
- For states that will undergo a CFSR in FYs 2016 – 2018, describe the state's current case review instrument and whether the state is using or plans to begin using the federal Onsite Review Instrument (OSRI) as part of the state's ongoing QA/CQI process.
- Describe how many and the type of cases that are reviewed annually as part of the state's ongoing case review process and any plans to increase or decrease the number of cases reviewed.

Describe child and family services related research, evaluation, management information systems, and/or quality assurance systems that have been implemented or updated since the submission of the 2016 APSR or will be implemented or updated in the coming year. Specify any additions or changes in services or program designs that have been found to be particularly effective or ineffective based on the state's evaluation of programs. (See 45 CFR 1357.16(a)(5).)

The Massachusetts Department of Children and Families underwent a CFSR in September of 2015. The development of a robust CQI program is a key PIP goal. Primary strategies include:

- Build the CQI Model
- Develop a case practice review system (structure and mechanisms) to gather qualitative and quantitative information.
- Improve training for DCF staff provided by MA Child Welfare Institute (MCWI).

Recognizing the need to advance its quality assurance system forward, the Massachusetts Department of Children and Families adopted a comprehensive CQI system in the Fall of 2016. This included the development of the following comprehensive CQI Plan.

Department of Children and Families

Continuous Quality Improvement Plan

Introduction

Continuous Quality Improvement (CQI) is both a management philosophy and a set of methods and tools used to improve an organization's operations and services. As a management method, CQI engages staff at all levels of the organization, as well as external stakeholders, in a continuous quest to (1) understand service delivery problems and the properties that underlie them, (2) collect and analyze those processes, (3) generate and test ideas about the causes of flaws, and (4) design and implement remedies to those problems. In that way, CQI functions as a program of systematic evaluation and ongoing planning to achieve excellence.

Central to the philosophy of CQI is the notion that the vast majority of service delivery problems result from systems and process rather than from individuals. CQI does not ask: *"Who caused this to happen?"* Instead, CQI asks, *"What is it about the system or the process that caused this to happen, and what can be done to improve this part of the work?"* This idea is crucial, as the success of CQI depends upon the meaningful and active engagement of those who are closest to the actual work of delivering services. If staff are reluctant to reveal why things go wrong because they fear being blamed, managers will end up acting without substantive knowledge about why a problem exists. Organizational leaders then, must recognize and emphasize that quality improvement offers an alternative *learning* model for addressing work problems, and that learning is a distinguishing feature of the *professional* organizational model.

...CQI asks, "What is it about the system or the process that caused this to happen, and what can be done to improve this part of the work?"

Federal Requirements for Quality Improvement Systems

The Federal Social Security Act (Section 471A-22) requires child welfare agencies to develop and implement standards to ensure that children in foster care placement in public or private agencies are provided quality services that protect their health and safety. In addition, federal regulations require states to develop a Child and Family Services Plan (CFSP) every five years and describe in that plan the quality assurance system they will use to assess the services delivered under the terms of the CFSP. The Children's Bureau requires state child welfare agencies to:

- Operate an identifiable program that evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and evaluates program improvement through implemented measures.
- Describe the methods used in measuring results, accomplishments and annual progress toward meeting systemic goals, and child and family outcomes.
- Have in place procedures to assure the production of valid and reliable data and information necessary to determine whether the interim benchmarks and long-term objectives of the CFSP are being met.

In 2000, the Children's Bureau published a final rule in the Federal Register to establish a process for monitoring state child welfare programs. Under the rule, states are assessed for substantial conformity with federal requirements for child welfare services. The Child and Family Service Reviews (CFSR) are structured to help states identify strengths and areas needing improvement within their agencies and programs. Ultimately, the goal of the reviews is to help states improve child welfare services and achieve the following seven outcomes for families and children who receive services:

Safety

1. Children are, first and foremost, protected from abuse and neglect.

2. Children are safely maintained in their homes whenever possible and appropriate.

Permanency

3. Children have permanency and stability in their living situations.
4. The continuity of family relationships and connections is preserved for families.

Family and Child Well-Being

5. Families have enhanced capacity to provide for their children's needs.
6. Children receive appropriate services to meet their educational needs.
7. Children receive adequate services to meet their physical and mental health needs.

Focused on the goals of safety, permanency, and well-being, the CFSR process also measures state performance on seven systematic factors related to the state child welfare agency's capacity to deliver services in a manner which supports improved outcomes:

1. Statewide child welfare information system;
2. Case review system;
3. Quality assurance system;
4. Staff and provider training;
5. Service array and resource development;
6. Agency's responsiveness to the community; and
7. Foster and adoptive parent licensing, recruitment, and retention.

To date, the Children's Bureau has completed two rounds of federal reviews: the first set of reviews were completed in 2004, and the second set in 2010. After each review cycle, no state/jurisdiction was found to be in substantial conformity in all of the seven outcome areas and seven systemic factors. Consequently, states/jurisdictions developed and implemented *Program Improvement Plans* (PIP) after each review to correct those areas not found in substantial conformity. Massachusetts successfully met the requirements of both sets of PIPs.

The third round of reviews began in 2015, and will run through 2018. Massachusetts DCF's round three onsite CFSR was conducted in September, 2015. As part of the CFSR process, the Children's Bureau evaluated DCF's *quality assurance system* to determine if it is functioning statewide, and to ensure that it:

1. Is operating in the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided,
2. Has standards to evaluate the quality of services—including standards to ensure that children in foster care are provided quality services that protect their health and safety,
3. Identifies strengths and needs of the service delivery system,
4. Provides relevant reports, and
5. Evaluates implemented program improvement measures.

These *quality assurance system* requirements exactly mirror the five benchmarks set forth in the 2012, Children's Bureau information memorandum (ACYF-CB-IM-12-07) on *Establishing and Maintaining Continuous Quality Improvement (CQI) Systems in State Child Welfare Agencies*.

Following its 2015 CFSR, the Department's *quality assurance system* was found "not in substantial conformity" with Federal Standards. Massachusetts received an overall rating of "Area Needing Improvement" for its *quality assurance system* based on information from the CFSR *statewide assessment* and stakeholder interviews. The following observations were noted in the Children's Bureau final report:

- "In the statewide assessment, Massachusetts described several components of the state's continuous quality improvement (CQI) system but was unable to demonstrate the integration of these components.
- Stakeholders confirmed that a functioning and integrated quality assurance system that uses data and information to inform practice changes or monitor performance is not yet in place."

DCF Continuous Quality Improvement Description

Recognizing that the Department's *quality assurance system* is an *area needing improvement*, the Department proposes the establishment of a robust CQI program that better equips DCF to measure the quality of services provided in Massachusetts. This CQI program will ascertain the impact those services have on child and family level outcomes and functioning, and the effectiveness of processes and systems in operation statewide.

The Department of Children and Families' vision for its CQI program, is that:

- Supports and services are designed and implemented based on evidence and knowledge;
- Practice is aligned with policy;
- Data collection is focused on measuring outcomes and achieving success through safety, permanency, and well-being;
- Continuous quality improvement is emphasized and supported throughout the agency; and
- Innovation is valued and encouraged.

DCF's Continuous Quality Improvement program is a systemic approach to advancing the agency's mission and achieving its goals through continuous and integrated efforts to improve service delivery and overall agency function.

The CQI process:

- Identifies, describes, and analyzes strengths and challenges;
- Tests, implements, and revises solutions;
- Relies on a culture that is proactive and supports continuous learning; and
- Is firmly grounded in the agency's mission, vision, and values.

The CQI program is dependent upon the active inclusion and participation of:

- Staff at all levels of the agency;
- Children, youth, and families;
- Community partners;
- Sister agencies and organizations, and
- Other stakeholders and community members.

DCF will work to establish outcome measures that reflect achievable positive impact on supports, services, policies and practices for children, youth, and families. The ultimate intent of supports, services, policies and practices, will be to improve children's safety, well-being, and permanence. Clearly articulated, measurable outcomes will be shared among DCF staff and its partners that support and provide services to children, youth, and families. Outcome measures will provide clear markers of success and of the need for alternative approaches and interventions when positive outcomes are not achieved.

Core Components of DCF Continuous Quality Improvement Plan

The Department's CQI Plan includes each of the following components:

- DCF's mission, vision, and values;
- Structure and mechanisms for gathering quantitative and qualitative information about work processes, practice quality, and case outcomes;
- Ongoing processes for examining, evaluating, and sharing information with those who need it, and for driving decision making;
- Mechanisms for making change based on findings of ongoing processes;
- Processes for evaluating the effects of change; and
- Multiple opportunities and mechanisms for reporting results, including regular reporting on key measures, and special reporting on emerging or urgent issues.

DCF leaders will cultivate a positive culture and climate in which accountability, responsiveness, communication, continuous learning, and commitment to improvement are valued and rewarded. DCF personnel's responsibility for quality improvement will be clearly articulated and integrated into DCF's policies and procedures, staff evaluation process, and customer/ consumer satisfaction surveys.

Transparent Continuous Quality Improvement Process

DCF will make its quality improvement process transparent to its partners:

- Families, children, youth, and young adults receiving services;
- Providers;
- Stakeholders;
- Legislators;
- The Office of the Child Advocate; and
- The general public.

Quality Improvement vs. Quality Assurance

Historically in child welfare, quality improvement approaches are built upon quality assurance programs. While quality assurance systems have traditionally served an audit function—monitoring and reporting on the extent of compliance with Federal and State regulations and requirements; quality improvement approaches are broader in scope—assessing child welfare practices and service outcomes as well as compliance. Moreover, quality improvement efforts are more utilization-oriented (i.e., data is used to improve and affect changes in service delivery). Finally, CQI programs engage a broader range of internal and external stake holders in the review and improvement process.

Quality improvement has benefits beyond an audit function:

- Quality improvement provides feedback on the performance of the system of care and whether the services provided are of sufficient intensity, scope and quality to meet the individual needs of children and their families;
- Quality improvement programs identify needs and recommends corrective actions necessary to improve services, capacity and outcome; and
- CQI programs confirm strength, identify successful strategies, and recommend ways in which effective practice and/or system performance can be replicated and/or improved.

DCF CQI Core Principles

Five core principles underlie the Department's CQI system. A good CQI system:

1. Provides for continuous learning at all levels of the Department and does not serve as either a compliance tool, or as an individual evaluation or accountability system;
2. Addresses the entire child welfare system as a whole, including both the Department's formal partners, such as its providers and foster parents, and its informal partners in family and community;
3. Identifies best or promising practices and promotes them for learning and appropriate spread across the Department;
4. Provides early warning of operational problems or challenges in any office or in the larger system of care, promoting a proactive rather than a reactive response system; and
5. Serves as the primary means by which the Department identifies needed program development or professional development to ensure the highest quality child welfare across the Commonwealth.

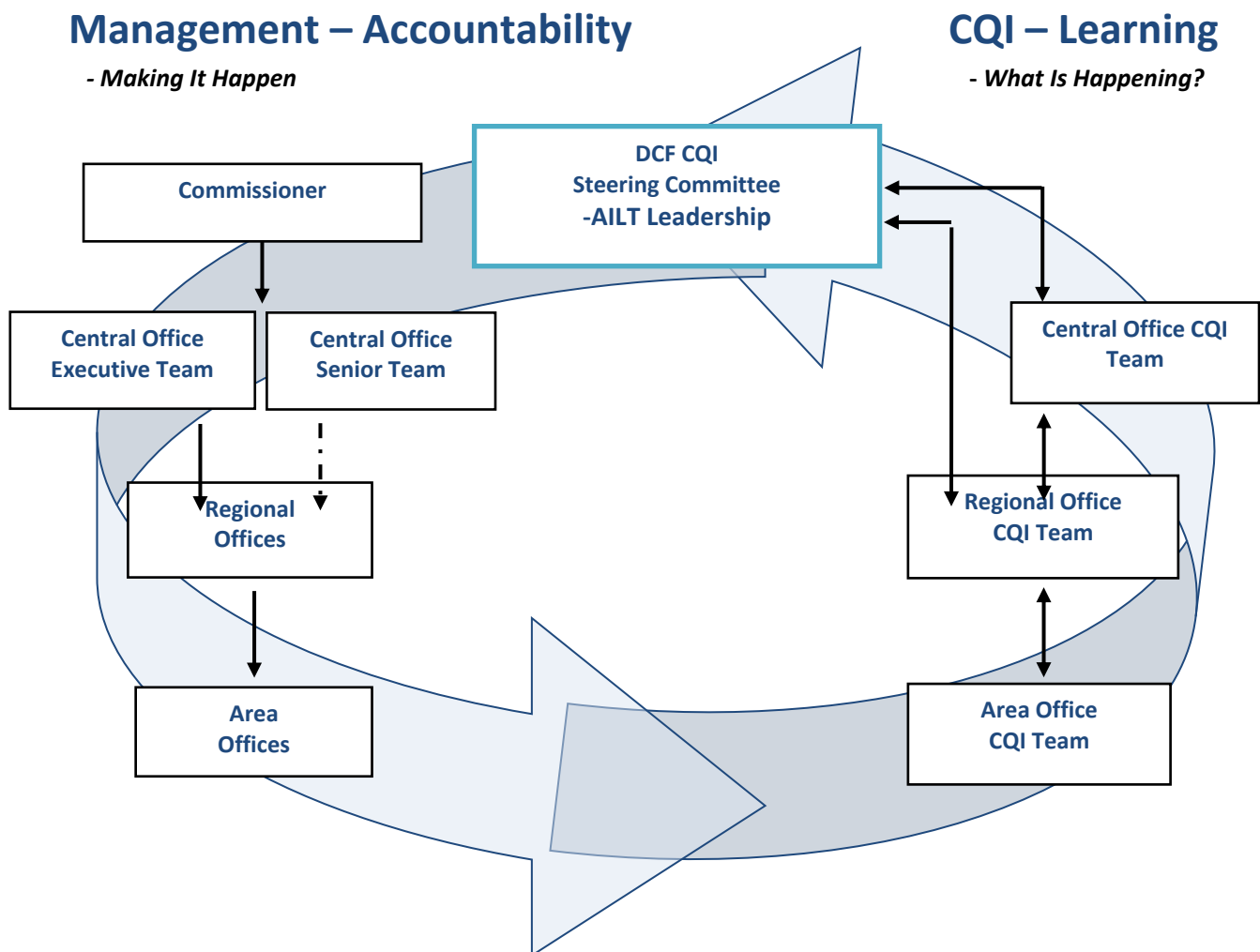
Case Practice Review System

A case practice review system is foundational to the DCF CQI process. The Department's case practice review system will incorporate an ongoing case review component that includes reading case files and evaluating case practice for children served by the Department, and interviewing parties involved in the cases. The Department's SACWIS (i-FamilyNet) will serve as the primary source for gathering quantitative data on both process and outcomes, as well as to identify representative cases for qualitative case review. A systematic methodology and comprehensive case review instrument will be developed by the CQI Unit (complemented by the Children's Bureau Onsite Review Instrument) and utilized for reviewing a representative sampling universe of in-home and out-of-home cases/children, and children/families involved in an intake and/or a response. These reviews will be completed by the Central Office CQI Unit.

Cyclical Relationship of Management and CQI

There is an integrated and cyclical nature between *Management* and *CQI*. The cyclical nature of this relationship is a critical foundation for positive outcomes; reflecting the substantive communication and information flow that sustains fidelity to the agency's vision and goals. The Management structures hold the **accountability** for ensuring that the processes and practices of the agency are efficient, effective and result in positive outcomes for children and families. The CQI structures hold the responsibility for facilitating access to quantitative and qualitative information about those processes, practices and outcomes, and ensuring that this information is used to enhance practice knowledge and promote **learning** throughout the agency. Figure 1 depicts the ongoing, integrated and cyclical nature of the relationship between *Management* and *CQI*.

- Figure 1.



Note: The arrows on the management side are unidirectional reflecting accountability within the system. The arrows on the CQI side of the cycle are bi-directional to reflect the importance of shared information and learning. The chart reflects the circular and continuous integration of these two critical activities and the foundational commitment to shared accountability and learning at each level of the agency.

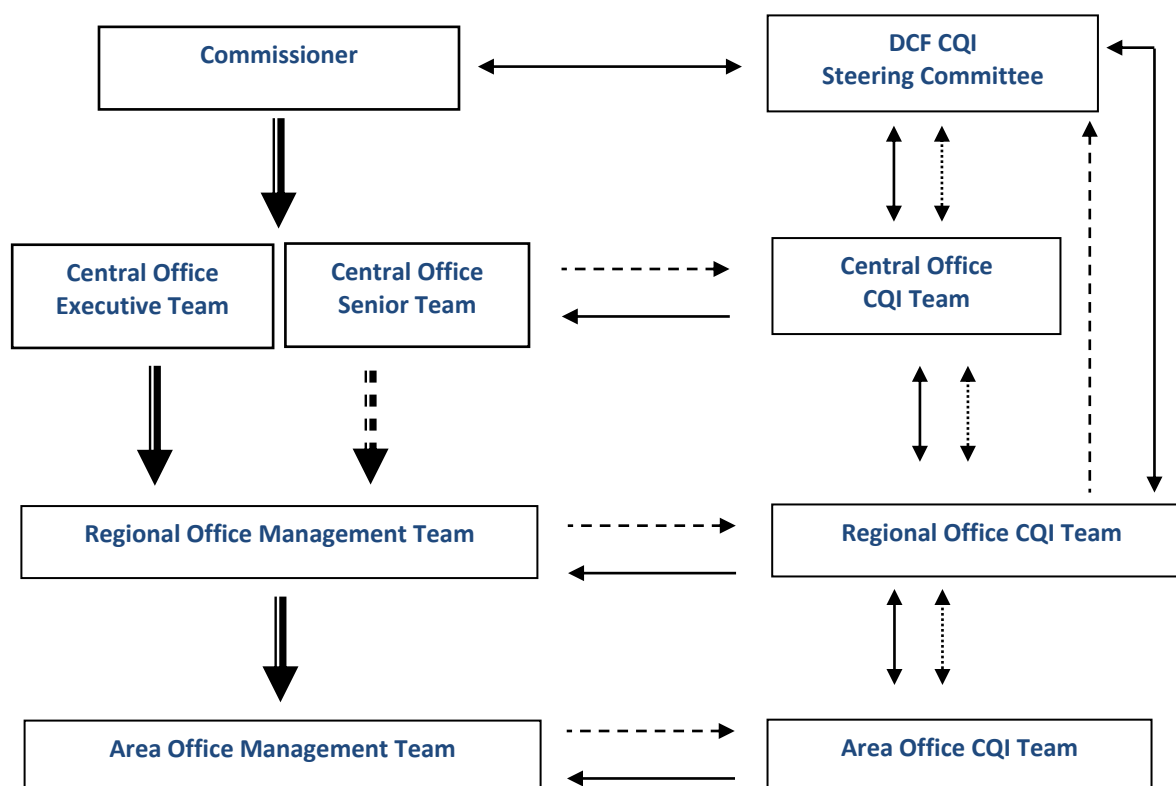
Accountability and Learning

There is an ongoing cyclical relationship and communication flow between the accountability of management and the learning promoted by CQI. Figure 2 reflects the functional integration of management and CQI structures through the exchange of data and responsive feedback occurring during management oversight, as well as formal and informal learning opportunities. The functional integration of these structures occurs at each level of the agency. The CQI Teams review qualitative and quantitative information on clinical, managerial and systemic practices and related outcomes to gain an understanding of trends, practice challenges and promising practices. The knowledge gained through these efforts is then used by the Management Team as they guide and refine clinical, managerial and systemic practices for which they are accountable.

- Figure 2.

Accountability Structures

Learning Structures



Management Accountability = **→**

Data = **- - - - -**

Responsive Feedback = **→**

CQI: Team Composition and Functions

CQI teams should be formed to include broad based representation. Membership on the DCF CQI Team is not specifically prescribed, but careful consideration of the team's composition is critical to ensuring a variety of perspectives and areas of expertise that relate to all facets of the Department's practices. The functions of the CQI Teams include a range of activities that focus on a review of practices and outcomes, development of improvement plans, and promoting a continuous learning environment.

CQI efforts are the most effective, when conducted by individuals/stakeholders closest to the locus of practice or process. Therefore, the DCF CQI program will benefit from local CQI teams established in each area, region, and Central Office. As outlined in Figures 1 and 2, local Area Office CQI Teams receive guidance/focus from Regional Office CQI Teams; *learning* is to flow in both directions. The CQI Steering Committee will guide/focus the work of the Central Office, Regional and Area Office CQI teams; *learning* flows in multiple directions.

AREA OFFICE CQI TEAM	
<i>Team Composition</i>	<i>Team Functions</i>
<ul style="list-style-type: none">• Area Office Managers• Lead Agency Representatives• Supervisors and Direct Service Staff – as indicated• Family Member(s)• Youth• Community Representatives• Area Board Member(s) – as indicated	<ul style="list-style-type: none">• Review data related to caseload, practice, systems performance, and child/family outcomes on a monthly/quarterly (TBD) basis.• Identify performance challenges and strengths and develop action plans in response to these.• Ensure that the review process is characterized by learning and reflection.• Develop and implement action/improvement plans, evaluate results, and modify plans accordingly in a process of continuous improvement.• Participate in monthly/quarterly (TBD) regional office reviews of performance and action plan status.• Disseminate learnings about successes and challenges.

REGIONAL OFFICE CQI TEAM	
<i>Team Composition</i>	<i>Team Functions</i>
<ul style="list-style-type: none">• Regional Office Managers• Regional Counsel(s)• Regional Office Specialists and Support Staff as indicated	<ul style="list-style-type: none">• Review Area Office data related to caseload, practice, systems performance, and child/family outcomes on a monthly/quarterly (TBD) basis.• Organize and provide staff support for Area Office CQI reviews as indicated.• Conduct monthly/quarterly (TBD) CQI reviews of Regional

<ul style="list-style-type: none"> • CQI Specialist(s) 	<p>Office functions and services.</p> <ul style="list-style-type: none"> • Ensure that the review process is characterized by learning and reflection. • Develop annual action plans addressing cross-area performance challenges. • Participate in quarterly/semi-annual (TBD) Central Office reviews of performance and action plan status. • Disseminate learning about successes and challenges.
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CENTRAL OFFICE CQI STEERING COMMITTEE	
<i>Team Composition</i>	<i>Team Functions</i>
<ul style="list-style-type: none"> • Executive Team • Senior Staff • AILT Leadership • CQI Director 	<ul style="list-style-type: none"> • Conduct monthly/quarterly/semi-annual (TBD) reviews of Regional/Area performance and action plan status. • Determine priorities for Area/Regional CQI Team Review as indicated. • Conduct quarterly (TBD) CQI reviews of Central Office functions and services. • Ensure that the review process is characterized by learning and reflection. • Ensure that training, agency policies, and other resources support identified Area/Regional practice and system changes. • Identify exemplary practice and system improvements, and disseminate across Areas and Regions, and internal/external stakeholders as indicated.

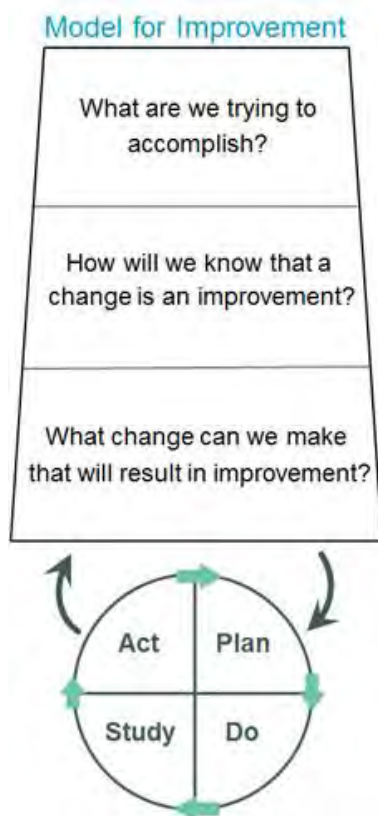
PDSA – Process and Content of CQI

CQI has at its central core the examination of process in relation to outcomes. The basic model of CQI is the “Plan-Do-Study-Act” (PDSA) method which was developed by W. Edwards Deming; an offshoot of Walter A. Shewhart’s original, “Plan-Do-Check-Act” (PDCA) cycle. The PDSA cycle guides the **test of a change** to determine if the change is an improvement.

Associates in Process Improvement developed a **Model for Improvement**² which accelerates the standard PDSA model. As depicted in Figure 3, this model employs two main components: Three fundamental questions, which can be approached in any order; and the PDSA cycle which guides the test of change to determine if the change is an improvement.

² Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

- Figure 3.



Setting Aims – the aim should be time-specific and measurable; it should define the specific process, system or outcome that will be affected.

Establish Measures – qualitative and quantitative measures are used to determine if a specific change leads to improvement.

Selecting Changes – ideas for change may come from internal or external stakeholders, or from the child welfare guidance/ literature.

Testing Changes – the Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned.

Implementing Changes – after testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the CQI team may implement the change on a broader scale—through consultation with the area/regional/central office management team.

Spreading Changes – after successful implementation of a change or set of changes within a unit or an area office, successful change is spread throughout the region or statewide—utilizing the management/CQI structure within the agency.

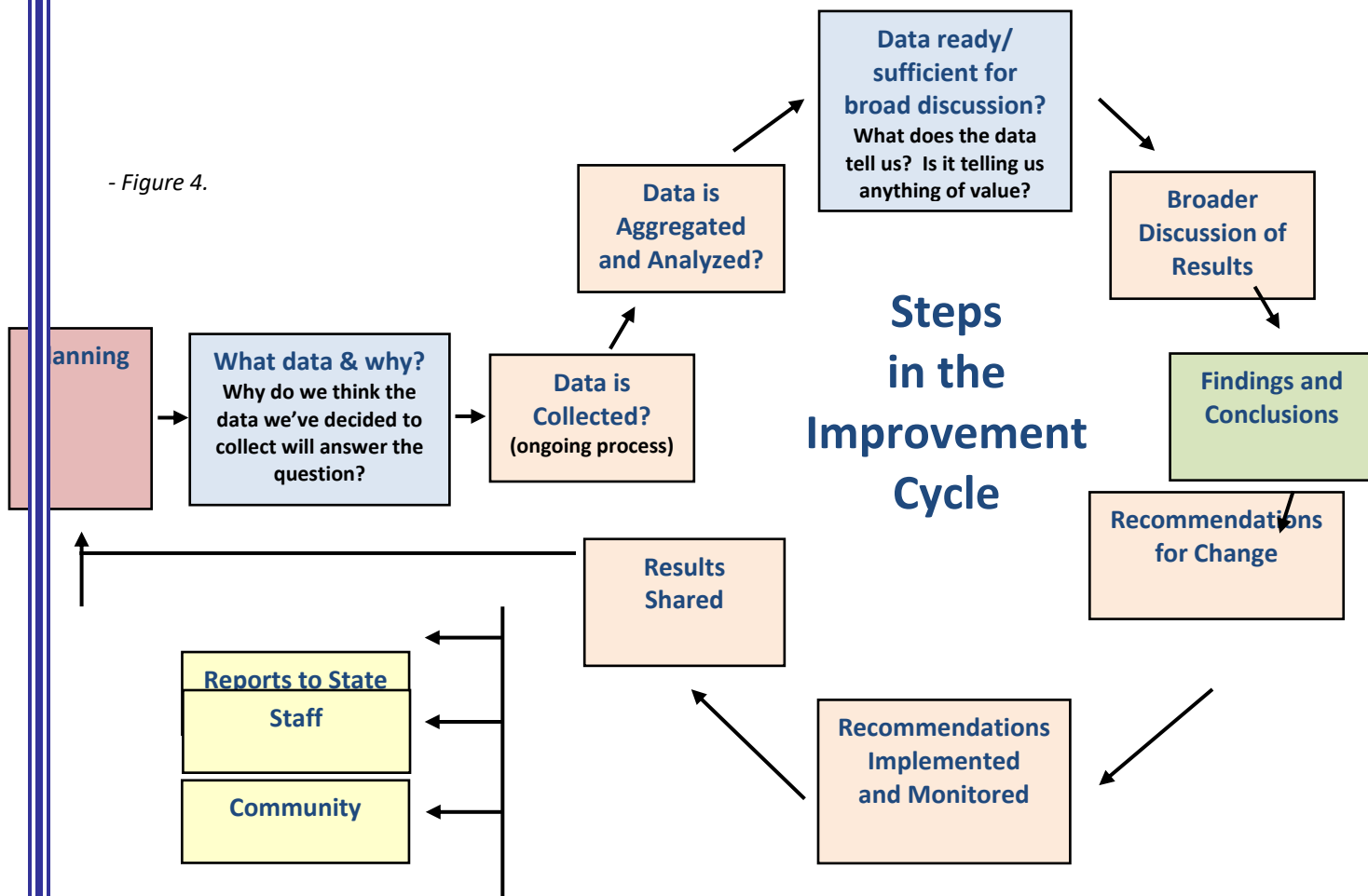
Starting the CQI Process

While the **Model for Improvement** serves as the guiding template for the DCF CQI process, the **setting aims** starting point may be directed by the CQI Steering Committee and/or by the DCF Central Office or Regional/Area Office management structure. Driven by the Department's strategic priorities, mandates, and outcome goals, the CQI Steering Committee (aka: AILT Leadership) will identify and establish areas of inquiry/improvement for the Department (e.g., outcomes to be addressed, or work processes/practices to be improved).

Data Informed CQI

The Department's CQI program is dependent on reliable and valid qualitative and quantitative data to inform its focus, activities, progress, and refinement. The *Council on Accreditation* (COA) provides a comprehensive framework for effective utilization of data within the PDSA cycle. COA's framework is described in Figure 4 below:

- Figure 4.



Managing With Data

Data are facts on which decisions are to be based. Without facts the Department would have nothing solid to base decisions upon. Managing with data consists of strategies which utilize facts to enhance the agency's work with children and families, as well as internal processes and practice.

Within a child welfare CQI structure, data is utilized to explore root causes for variations in clinical, managerial, and systemic practice. The Department's CQI program will use data to gain insight into the root causes for variation and performance on specific process and outcome measures related to safety, permanency, and well-being.

Data Fellows

The Department is exploring the **New Jersey Data Fellows** program with the intent of adapting it to support the agency's continuous quality improvement efforts.

Overview of the New Jersey Data Fellows program:

- Initially funded through a Children's Bureau grant. New Jersey contracted with a private firm and a non-profit to develop the program; Data Fellows program is currently self-sustaining and self-run.
- Externally evaluated and found to be successful in identifying solutions, developing staff data analysis and presentation skills, and creating buy-in for using data.
- Fellows are taught MS Excel, PowerPoint, and quantitative and qualitative analytical skills.

- Fellows work in groups using the agency's SACWIS data to answer questions posed by departmental leadership. They have opportunities to discuss the questions with co-workers who are not in the program, to brainstorm solutions in groups of Fellows, and to present their findings to departmental leadership.
- Fellows are encouraged to look at positive outliers for a "bright spots" analysis. Fellows may also lead co-workers in efforts to improve performance.
- Fellows work in teams which promote 'friendly' competition.
- Initially, the program ran 1-day per month, for 18-months. Program currently runs 3-4 days per month, for nine months; including time set aside for assignments. Presently in its 5th round of Fellows.
- Targeted for mid-level managers, participants apply to the program and commit to staying-on with the department a minimum of 2-years post-completion.
- Data Fellow graduates may be given the opportunity to assist in the training of future Fellows.

Commonwealth of Massachusetts

Department of Children & Families

***Child Abuse Prevention & Treatment Act Grant
State Plan Update***

**Commonwealth of Massachusetts
Department of Children and Families**

CAPTA FY2016 Report and FY2017 Request

1. Implementation of the DCF Casework Practice Model (CPM)

***CAPTA Priority Areas:** Improving the intake, assessment, screening and investigation of reports of abuse and neglect. Improvement of case management and delivery of services.*

FY2016 CAPTA Expenditures, Activities and Accomplishments:

For FY16, DCF budgeted \$65,000 in CAPTA funds to support training, coaching, facilitating and other critical implementation needs under the CPM. . In addition, \$49,500 in CAPTA funds was budgeted to support policy drafting, updating and implementation.

Policy Development: Alignment with CPM and Responding to Critical Incidents

The tragic events surrounding a high profile child death case continue to impact DCF operations, policies and practices. In response to policy and practice challenges identified through DCF's own internal investigation associated with this tragic case and preliminary engagement with the external review team from the Child Welfare League of America (CWLA), DCF is aggressively working on updates/revisions to the following policies: Children Missing from Care Policy, Intake Policy, Case Closing Policy, Family Assessment and Case Planning Policy and In Home Casework Policy.

In FY16, the Department completed and implemented the Protective Intake Policy and began training on the first ever Supervision Policy.

Intake Policy: The new Intake Policy became effective on February 28, 2016. The policy includes procedures for receiving, screening and responding to reports of abuse, neglect and sexual exploitation/human trafficking. The policy requires that all non-emergency screenings of 51A reports be completed within 1 business day. The policy also implemented a formal Screening Team within each area office to support consistent, collaborative and safety-focused decision-making in screening in or out allegations of abuse, neglect, sexual exploitation and/or human trafficking received by the Department. The findings on the reported allegations have also been updated to include Support, Substantiated Concern, and Unsupport. The Department removed the previous finding of No/Minimal Concern.

Supervision Policy: The Supervision Policy is in final stages of revision and was created to provide a fundamental, identifiable, and defined process for supervision of cases and staff at the Department of Children and Families. The purpose is to emphasize the value and importance of weekly individual supervision, monthly group supervision, and seeking consultation when necessary in order to prioritize child safety and compliance with the Departments case practice model and procedures.

Work is still ongoing towards the completion of the Children Missing from Care Policy, Case Closing Policy, Family Assessment and Case Planning Policy, In Home Casework Policy, Children Missing or Absent from Department Approved Placement Policy, District Attorney and Law Enforcement Referral

Policy, Online Search and Social Media Policy, Foster Care Review Policy and 51As in Certain Institutional Settings Policy.

Fourth Annual Massachusetts Fatherhood Leadership Summit: Changing Systems, Changing Lives: On April 27, 2016, DCF along with six state agency partners (MA Departments of Youth Services, Housing and Community Development, Public Health, Revenue, Corrections and Career Services), The Children's Trust, the US Department of Health and Human Services, Administration for Children and Families, and several family and community representatives, convened the Fourth annual Massachusetts Fatherhood Leadership Summit. This highly successful event drew a diverse group of participants, including DCF staff, fathers who have had experiences in Massachusetts' systems, and representatives from agencies that work with and serve fathers including community organizations and providers, schools, high level leadership and policy representatives from state and federal agencies, and judges from the juvenile and probate courts. The Summit sought to build on the success of the past annual summits to present panel discussions, a keynote speaker, and workshops designed to raise awareness about the need to change systems that create barriers for father engagement.

Family CQI Process: Over the long term, the multiple strategies and practice changes embedded in the CPM, are designed to improve outcomes for children and families, by:

- Stabilizing families so that children can safely remain at home;
- Strengthening parenting capacities and helping parents to connect to supports and resources in their own communities;
- Better engaging and empowering families in decision-making and planning for their present and future; and
- Reducing repeat maltreatment of children.

As part of DCF's continued commitment to assessing the impact of the CPM *and* to the inclusion of the family perspective in the Department's work, DCF and Casey Family Programs partnered to develop a multi-year process for gathering and incorporating DCF parent and family feedback into DCF policy and practice. During FY15, in collaboration with 10 members of the FAC, developed and administered the second parent satisfaction survey. Nearly 5000 former DCF consumers participated in this survey. Results of this survey were made available during the beginning of FY16. Some of the key findings included:

- 75% reported that overall, DCF helped their families.
- 80% reported satisfaction with the communication they had with the Department.
- 85% reported that their DCF worker paid attention to their children's needs and wants.
- 90% reported that their DCF worker respected their families' cultural traditions.

FY2017 Proposed Expenditures and Activities:

DCF is proposing that \$117,500 in FY16 CAPTA funds be used towards this priority area. \$68,000 for CPM training, coaching and facilitation; and \$60,500 for policy development, integration of policy into practice and consultation.

Through on-going training, coaching and facilitation, these funds will support DCF Area Offices and Regions to assist in the implementation of the new policies and integration of these new policies into practice. Additionally, coaches will continue to be deployed to assist with case reviews, quality

assurance activities and supporting the “on-boarding” of the significant number of new staff joining DCF.

Similarly, the Policy Consultant will continue to assist DCF in the urgent revision, development and alignment of new and existing policies and practices to address the needs/opportunities identified in the CWLA report.

2. DCF Central Office Nurse

***CAPTA Priority Area:** Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families with disabled infants with life-threatening conditions using existing social and health services.*

FY2016 CAPTA Expenditures, Activities and Accomplishments:

DCF hired a central office nurse in November 2014. Much attention has been paid to the need for DCF to ensure timely access to quality health care for children and youth coming into the custody of the Department. The central office nurse supervises and provides back-up support for DCF’s regional nurses in conducting case consultations, working with other state agencies, community health providers and hospitals. In addition, she is responsible for data tracking and analysis related to health and health care for DCF children and families.

In January, 2016 DCF hired its first Medical Director, who provides oversight of the health and medical services team. This position is not funded with CAPTA funds.

FY2017 Proposed Expenditures and Activities:

During FY17 DCF proposes to use CAPTA funds at approximately \$55,000, which will be a 50% match to state funds to support this critical position.

3. Regional Clinical Consultation

***CAPTA Priority Area:** Improvement of case management, including ongoing monitoring and delivery of services and treatment provided to children and their families.*

FY2016 CAPTA Expenditures, Activities and Accomplishments:

DCF budgeted \$74,000 in FY16 to purchase the services of qualified practicing clinicians, mostly clinical psychologists. Historically, these funds have been used in two ways: 1) to provide case consultation to staff in complex family situations, including clinical reviews required by policy under several different circumstances to support sound decision-making for and with families and 2) to purchase clinical evaluations of families or family members for which no other source of funding can be identified.

FY2016 expenditures and services for Regional Clinical Consultations were as follows:

Western Region

DCF’s Western Region is expected to spend approx. \$17,000 this year.

One provider is used in the region for all CAPTA consultations and evaluations, and utilization patterns have remained stable in FY 16 and similar to prior year. The specifics include:

1. Stabilization of children exposed to multiple and severe trauma
2. Prevention of higher-level/higher cost placements
3. Identification of clinical needs to keep children at home
4. Risk analysis to assist Social Workers review treatment options

Northern Region

The Northern Region spent approximately \$20,000 in CAPTA funding during FY'16 for clinical consultation to staff and for consultation to the Northern Region Clinical Review Team. This funding is utilized primarily for:

1. Individual case consultation to Area Office staff and
2. Consultation to the Northern Region Clinical Review Team.

Both individual and team consultation have proven to be an invaluable support as we deal with an increasingly intense caseload. The consultants provide a professional expertise and perspective not available through internal resources.

The Northern Region continues to actively seek and recruit clinicians to serve as Area Office/Clinical Review Team consultants and have placed a priority on clinicians who reflect the diverse populations served by the eight (8) Northern Region Area Offices.

Southern Region

In FY16 the Southern Region used the \$30,000 in allocated funds to continue the consultation relationship with Dr. Richard Bristol. As a result of the Regional Consolidation implemented several years ago, the two Metro Offices (Coastal and Arlington) each had the use of Dr. Richard Bristol for case consultation in their respective offices. In combining the budgets as a result of the regional reorganization, these two offices brought their allocations into the Southern Regional budget for continued use with Dr. Bristol. Dr. Bristol brings his expertise to Area Clinical Reviews, Family Team meetings, level of care discussions with youth being referred, and reunification discussions regarding youth in placement.

The remainder of the Southern allocation is used to staff the Regional Clinical Review team with Dr. Maureen Carnes who provides her expertise to the Regional Team on a range of complex and challenging cases that are reviewed. Dr. Carnes is a reliable and respected participant on the team and has a keen sense of how the Department functions enhancing her value to the team that meets twice a month.

Boston Region

The Boston Region will expend approximately \$4,000 in clinical consultation. This region has also had difficulty identifying appropriate vendors at the existing rate.

However, DCF regional staff continues to report that the use of clinical consultant, Dr. Richard Molin, has had a variety of positive effects. The evaluations of family members have provided information needed to assess risk to children in the home and plan services to stabilize children exposed to multiple and severe trauma so that they were able to remain at home or avoid placement in higher level, higher cost settings. Similarly, the use of the competent, outside practicing clinicians to provide case consultation and participate in clinical reviews has helped staff to identify or clarify their understanding of the mental/behavioral health issues families are experiencing and supported the development of more

appropriate service plans.

FY2017 Proposed Expenditures and Activities:

During FY17 DCF proposes to use CAPTA funds at approximately \$74,000 to continue to purchase clinical consultations and evaluations as follows:

Western Region: \$11,000

CAPTA funds will be used for clinical consultation as well as augmenting the capacity to provide evaluations; this region will spend its allotment primarily on the following:

- 1.) Stabilizing children exposed to multiple and severe trauma
- 2.) Prevention of higher-level/higher cost placements
- 3.) Identification of clinical needs to keep children at home
- 4.) Risk analysis to assist Social Workers review treatment options

Central Region: \$9,000

The Central Region, which was re-instated in February of 2016, will use their funds in the same manner as the Western Region. The Central Region was originally part of the Western Region with the combined CAPTA funding of \$20,000.

Northern Region: \$20,000

Funds will be used for clinical consultation to staff and for consultation to the Northern Region Clinical Review Team.

Southern Region: \$30,000

Funds will be used for continued use of clinical consultation and evaluative Services for the Regional Clinical Review and for a licensed Psychologist for Area based consultative services at Family team meetings as well as Clinical Review Teams.

Boston Region: \$4,000

The Boston region will continue to use Ron Molin for case consultation in the Harbor and Dimock Street Area Offices, which will support:

- 1) consultation on assessed risk to children in the home;
- 2) assistance with planning services to stabilize children exposed to multiple and severe trauma so that they are able to remain at home or avoid placement in higher level, higher cost settings; and
- 3) participation in clinical reviews to help staff identify or clarify their understanding of the mental/behavioral health issues families are experiencing to enable the development of more appropriate service plans.

4. Children's Charter Division of Key Program, Inc.

CAPTA Priority Area: Improving the intake, assessment, screening and investigation of reports of abuse and neglect. Improvement of case management and delivery of services.

FY2016 CAPTA Expenditures, Activities and Accomplishments:

For several years, DCF has contracted with Children's Charter, a division of Key Program Inc., to provide state-of-the-art forensic clinical evaluations for DCF's most complex cases of child maltreatment that need intensive, in-depth assessment and treatment services to children involved in criminal court

cases. As a statewide service, Children's Charter accepts referrals from any DCF area office. Children's Charter provides forensic evaluation services to children, between the ages of 3 and 17, who have experienced and/or witnessed trauma.

Between July 1, 2015 and June 30, 2016, Children's Charter received 115 referrals. Of the 115 referrals, 54 are related to parents and 56 are related to children, and 5 evaluations related to bonding. 30 evaluations have either been withdrawn or discontinued for varying reasons. To date 41 evaluations have been completed, 25 are ongoing, and 16 are currently pending. In fiscal year 2016, Children's Charter saw its forensic evaluation expand to serve a greater # of geographical areas in the commonwealth. The Western Region of Massachusetts continues to be a challenge in generating referrals. This is due primarily to the physical location to Children's Charter and the transportation issues that arise due to the lack of transportation assistance/resources. The Central Region and North Central region of Massachusetts have continued their upward trend of referrals indicating that Children's Charter has established a strong presence within the DCF area offices that cover these areas. Children's Charter continues their strong relationship in the Boston, Southern, and Northern regions of Massachusetts evidenced by the number of referrals received basis from the area offices within the regions on an annual basis. FY'16 data confirms that Children's Charter has made significant strides in expanding their forensic evaluation service. Historically the Boston Region was the primary referral source for the program. In FY'16 the Central/North Central Region of the state generated the greatest number of referrals. Overall the numbers of referrals generated were similar across most of Massachusetts excluding the Western Region.

Children's Charter FY'16 data shows that they remain committed to being a statewide resource. In FY'17 there will be an emphasis placed on identifying and strategizing how the program can be accessed by families in the Western Region of Massachusetts. Their team approach has also been critical in responding to the most difficult and sometimes "high profile" cases involved with the Department of Children and Families. The director of the forensic evaluation program reports that the families who participate with the evaluation service have diverse backgrounds. Because of the diversity of the families evaluated he believes that data would not reveal trends that might a focus for following fiscal years. DCF continues to be the primary referral source for forensic evaluations maintaining a 95% referral rate while community stakeholders, schools, and self-referrals total approximately 5% of referrals received annually.

Children's Charter continues to provide valuable expertise and consultation services in the areas of court testimony, case management, and investigative services. In addition to DCF, some of the organizations with which Children's Charter has exhibited a sound collaborative effort include but are not limited to: the police, district attorneys, courts, physicians, and other community collaborators. The Director of the forensic evaluation program reports that over 70% of the evaluations are utilized by the courts in assisting them with making court rulings on behalf of the children. The primary purpose of the court related evaluations are related to permanency of children. In addition to this evaluations aide the courts in determining critical services that must be in place to achieve the goal of reunification. In the past fiscal year a new trend developed. The program director stated that Children's Charter has seen an increase in referrals for bonding related issues. Data suggests that this is still a small percentage of the total # of evaluations however this is trend that will be tracked more closely in the coming fiscal year. Data and Outcomes continue to be a focus of the program. It is critical for there to be data based evidence that supports the intent and purpose of the forensic evaluation service. We will continue conversations and group meetings with the purpose of identifying methods of tracking outcomes related to permanency of children in court related cases. In addition to this we will develop and enhance

methods of tracking evaluations that are utilized by DCF with assisting in determination of child permanency.

FY2017 Proposed Expenditures and Activities:

DCF intends to maintain level CAPTA units for Children's Charter during fiscal year 2017. Children's Charter will continue to provide multi-disciplinary forensic evaluations for complex family situations, in which children may have experienced and/or witnessed trauma, to approximately 100 children and families. Children's Charter will continue to enhance their ability to integrate multidisciplinary expertise into their evaluations and provide consultation and court testimony as a means of augmenting the Department's capacity to respond to families who present a significant level of risk, with emphasis on protective issues. The vital services that Children's Charter provides have been, and continue to be, highly valued by DCF Area Offices, courts, healthcare professionals, and other community stakeholders. Also in FY'17 Children's Charter and DCF will continue to focus on strategies related to underserved priority geographical areas in Massachusetts; such as the Western Region. As is evidenced during FY15 and FY16 the increase in staffing has had a positive impact on reaching geographical areas that had not been reached in previous fiscal years. This is evidenced by the Central/North Central Region generating 37 referrals in FY'16. Boston 29, Northern Region 24, and Southern Region 20 also show evidence that the expansion of the service is growing from FY'15. Planning and Development for being a statewide resource will continue in FY'17. A continued focus will be placed on building relationships with community stakeholders in all the regions of Massachusetts, with an emphasis in the Western Region. In no way will these information sharing sessions impact the amount and/or level of direct care funding. Training was identified as a priority area for Children's Charter staff in FY'16. This again has been identified as a need for next fiscal year.

The Children's Charter contract is monitored by DCF's Domestic Violence Unit (DVU). One of the primary tasks of the DVU is to monitor contracted agencies fiscal and programmatic compliance. DVU contract staff will continue to focus on improving data collection and developing outcome measurements for the program. Due to continued budget constraints matriculation of the Children's Charter Program into our Virtual Gateway system continues to be delayed. We will continue our efforts to have Children's Charter included in the Virtual Gateway. This will enable the agency and DCF to have a more structured and valuable data collection system. This will reinforce the critical need for this service. Also we will continue to strategize the most effective way of gathering information about how Children's Charter evaluation services benefit the family, including whether families are receiving the necessary and appropriate services that may lead to them becoming independent of state services. This outcome focused data will enable the Department to analyze statistically the program's effectiveness with families who have different goals such as those who are remaining intact, those who are being reunified, and those families whose parental rights are being terminated.

5. Parents Helping Parents' Parental Stress Line

CAPTA Priority Area: Improving the screening of reports of abuse and neglect.

FY2016 CAPTA Expenditures, Activities and Accomplishments:

DCF has long supported the availability of a Parental Stress Line [1-800-632-8188] in Massachusetts. The Parental Stress Line's mission is *Empowering parents to nurture children and prevent child abuse.*

During FY16, DCF used CAPTA funds to contract with Parents Helping Parents (PHP) to pay for staff time and associated costs (space, supplies, etc.) to operate the Parental Stress Line and also to recruit, train and support volunteers.

PHP's Parental Stress Line plays a key role in the primary prevention work being done in Massachusetts to prevent child abuse before it occurs. The Parental Stress Line is a 24 hour helpline that offers support, empathy, and crisis intervention counseling to parents and caregivers who are having difficulty coping with the stresses of parenting. Information and referral to other services are provided, but the primary purpose is to provide parents with someone to talk to about their parenting problems. The Parental Stress Line receives approximately 4,000 calls during the year.

Calls to PHP's Parental Stress Line are answered by volunteers who are recruited and trained by Parental Stress Line staff. The training program covers child abuse and neglect prevention and intervention, child discipline, healthy parent-child communication and relationships, telephone counseling techniques and other relevant material. Counselors answer calls to the Parental Stress Line. All volunteers have access to a supervisor round the clock to answer any questions or talk through any issues that arise.

Who Calls the Parental Stress Line and What Happens

The Parental Stress Line uses a multi-faceted approach in assisting callers, providing support to draw on callers' inner resources and information and referrals to link callers to external resources. In each call, counselors attempt to look at the holistic nature of the caller's concerns, and then tailor the information and support provided to fit the unique needs of the caller's situation. Counselors use a reflective listening model to support the caller's emotional needs and ask open-ended questions to empower the caller to develop their own plan of action. Rather than providing advice, counselors assist callers in thinking through the steps that will help them move toward their identified goal.

Callers fall into 6 categories:

- *First time callers*;
- *Repeat callers* who mention having called the helpline before or discuss a situation that the counselor is familiar with;
- *Chronic callers* who use the hotline very frequently (several times per week) over a long period of time (many have been calling for years) and show no change in their situations over time;
- *Inappropriate callers* who are not calling within the purpose of the helpline; while this includes sexually inappropriate callers, it also includes people calling for reasons unrelated to parental stress;
- *Agency callers* who identify themselves as working for an agency, calling on behalf of clients or for information about the hotline;
- *Unknown callers* are most often callers whom the counselor is unsure of whether or not they have called before and are usually first time or repeat callers.

Caller Concerns

Callers often discuss several issues on each call. The top 10 areas of concern from callers are: The top 10 concerns that callers discuss are:

- Family Conflict
- Child discipline
- Partner conflict

- Parenting Burn-Out
- Teenager behavior
- Overburdened
- Communication Problem
- Mental Health - child
- Infant crying/behavior
- Community Resources

At the end of each call, PHP assesses whether the caller was satisfied, dissatisfied, or expressed no indication regarding satisfaction. To eliminate bias, satisfaction is based on either what the caller says (usually towards the end of a call) or how they sound (moving from crying to talking normally). Callers overwhelmingly end calls positively, saying “thanks for listening” more frequently than “thanks for talking.”

PHP’s tracking generally indicates that a vast majority of callers express satisfaction; while only a very tiny percentage expresses dissatisfaction.

FY2017 Proposed Expenditures and Activities:

During FY16 DCF proposes to use CAPTA funds at \$45,000 to continue contracting with Parents Helping Parents (PHP), the current vendor of the Parental Stress Line.

8. Family Engagement and Voice

***CAPTA Priority Area:** Improvement of case management, including ongoing monitoring and delivery of services and treatment provided to children and their families.*

FY2016 CAPTA Expenditures, Activities and Accomplishments:

Family Engagement at the Department happens at all levels. The Department makes its decision-making processes transparent by engaging former clients and other community members at all levels of decision-making.

In FY16, \$65,000 was budgeted in CAPTA funds to support parents and former consumers to participate in the decision making processes at the Department. Specifically these funds were used to provide stipends for their time. The funding also supports Parent Leadership Trainings to former consumers to prepare them to be confident participants and productive members of area boards and other forums where the voice of former consumers must be present. Finally, these funds supported DCF’s parent stipends associated with DCF’s Fatherhood Initiative. Detailed information about FY16 activities are listed below.

The Family Advisory Committee for the Department (FAC) is a diverse group of individuals who were once involved with DCF in a variety of ways, that advise the department on all matters of policy, practice, delivery and monitoring of services. FAC provides the opportunity for parents and other community members to have real input into the development of policies and decisions that effect families. FAC builds mutual accountability between the Department and the families it serves by creating opportunity for dialogue and learning on both sides.

FAC has a Leadership Team of 10 people representing the 4 regions of the state (2 per region) and two – the co-chairs for FAC - who sit at the senior staff meetings. Senior staff is the highest form of decision making in the Department. The function of the leadership team is to coordinate the activities of the FAC, decide on agenda items for the meetings, streamline and prioritize the work for the Work Plan. The leadership team also attends and participates as leaders in DCF's Statewide Managers Meeting, a monthly meeting with the top management for the Department.

FAC has two sub-committees: a Legislative Sub-committee and a Membership Sub-committee. The purpose of the Legislative Sub-committee is to track existing legislation to create community awareness and galvanize support for policies that support the well being of all families, birth, kin, adoptive, alumni, youth and children in the Commonwealth. The purpose of the Membership Sub-committee is to recruit new members who are committed to working together for the benefit of children and families and to support effective family engagement. They develop participation guidelines and protocols for the FAC and strive to maintain a membership of individuals who accurately reflect the diversity of Massachusetts families. This group ensures that all FAC members feel welcome and encourage each member's voice. They also make recommendations for family participation in local and regional groups/agencies that serve children.

During FY16, the Family Advisory Committee met seven times. The meetings focused on:

- Developing relationships with Area Directors/Area Offices to assist with board development and strategies for recruiting former consumers for area boards
- Assisting DCF in maintaining fidelity to Practice model.
- Assisting DCF with getting systematic feedback from the families it serves on the effectiveness of its interventions and practice.
- Assisting the Commission on the Status of Grandparents Raising Grandchildren in the implementation of their mission
- Cross system and secretariat collaboration
- Assisting DCF in increasing the quality of care and positive outcomes of children in the foster care system.

In FY16, The Leadership Team met 10 times and attended 10 Statewide Managers meetings. At these meetings the discussion on practice and policy changed considerably in content and outcome because parents are actively participating and providing, to top management, the feedback on how decisions affect families.

In FY16, The Membership Committee met three times. The goal is to maintain the FAC with a membership of 24. The Membership Committee also recommended that members who are not able to attend meetings or have consistent participation to continue as members under the understanding that when they can be involved they will. They will be called *Friends of FAC* and receive the information like any other member.

Some of the FAC Members serve on Area TILT (1) and FELT (5) Teams in the Lawrence, Chelsea, New Bedford, Park Street, Hyde Park and Worcester Area Offices. The FAC has a goal to develop

relationships with Area Directors/Area Offices to assist with board development and strategies for recruiting former consumers for area boards, FELTs and TILTs.

- **Fatherhood:** In FY16, FAC Members helped co-facilitate comprehensive training for co-facilitators of the Nurturing Fathers Program to an audience of DCF FELT Teams, Social Workers, Providers and other Community Members interested in co-facilitating a Nurturing Fathers Program. The training sessions is provided 3 to 4 times a year in different regions of the state.
- **TILT:** In FY16, FAC Members are represented on the Massachusetts Child Trauma Project Steering Committee parent/alumni perspective in the integration of trauma informed and trauma focused practice.

In FY16, The Ombudsman's Office worked with eight FAC members, as Liaisons, to assist parents who are in need of guidance and understanding of the state systems in their lives. Several of the liaisons have a special focus such as mental health, substance abuse, fathers and engaging kin. In FY16, DCF made some modifications and improvements to the Family Liaison Program including, advanced training and professional development, diversifying the Parent Group that provide peer support and increased hours on connection with families. Additional support will also be provided including clinical and administrative supervision.

FAC members are regular and ongoing trainers for new social workers joining the Department. Members of FAC are routinely engaged as part of the teams who trained DCF staff and managers on new policy.

Commission on the Status of Grandparents Raising Grandchildren

The mandate for the Commission is to address issues of concern raised by grandparents and other kin who are raising children. Since its inception in FY 09, the Director of Family Engagement or a member of the Community and Family Engagement Team has sat on this Commission as a member. In 2015 the Commission received an appropriation from the state in order to hire a full-time Program Coordinator for The Commission. In 2016 a Program Coordinator was hired and has joined the Community and Family Engagement Team at DCF. The work of The Commission, in conjunction with the Community and Family Engagement, team continues to guide the work of the committees, recruit generous donations of time and resources from community members, and continues to ensure that an increasing number of grandparents are involved. These efforts have resulted in many accomplishments, including:

- Providing correct and accessible information in order for Grandparents to access support and make knowledgeable decisions
- Creating and sustaining a website: <http://www.massgrg.com> including a 2016 update of the website
- Developing and revising tip sheets for grandparents regarding:
 - DCF
 - Available supports in the community
 - How to work with the courts, and

- Other legal issues that grandparents may face
- Information about the Commission and its mandate
- Substance abuse and its impact on families
- Assisting in the creation of, and support for, a model for Grandparents' Support Groups that are being implemented across the state and presenting to community partners, Family Resource Centers, and DCF staff.
- Creating a network of supporters and facilitators of support groups that meet quarterly
- Providing legislative advocacy on bills that affect the lives of children and their families.
- Plan an annual statewide conference for grandparents, kinship caregivers, and providers

The Grandparents Commission based its work plans on feedback received from Grandparents during its initial *Learning and Listening Tour*, through its annual conferences, and ongoing dialogue with stakeholders.

In FY16, three FAC members were actively involved with the Commission on the Status of Grandparents Raising Grandchildren. Two FAC members are facilitators of support groups that meet weekly in Lowell and Boston. John Laing the Chair of the FAC hosted the annual statewide conference for grandparents, kinship caregivers, and providers and chaired the conference committee.

We will focus our FY17 work plan in the following areas:

- Expanding consumer participation and membership on DCF local Area Boards.
- Providing oversight and tracking of the fidelity in practice to the CPM from the family perspective.
- Improve the Family Liaison program with the Ombudsman's Office and create trainings for future Liaisons regarding the Liaison Role, Trauma-Informed Practice, Managing Yourself (self-care and self-awareness), Meditation and Conflict Resolution, Court Process: Juvenile & Probate, Kinship Care and Grandparent's Rights, Recognizing Limits and Barriers.

CAPTA Coordinator (State Liaison Officer):

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Notification regarding substantive changes:

DCF does not have any substantive changes to report regarding state law or regulations that would affect the state's eligibility for the CAPTA State Grant.

CAPTA and SEN

In Massachusetts, mandated reporters are required to file according to Massachusetts General Law, chapter 119, §51A:

A mandated reporter who, in his professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from ... (iii) physical dependence upon an addictive drug at birth . . .

DCF Intake Policy

In February 2016, DCF implemented a new protective Intake Policy. This new Intake Policy was developed in the fall of 2015 with the goal of updating and clarifying protocols for DCF's screening and investigation of reports of abuse or neglect. Substance Exposed Newborns (SEN) were defined in policy as "a newborn who was exposed to alcohol or other drugs ingested by the mother in utero, whether or not this exposure is detected at birth through a drug screen or withdrawal symptoms. A SEN may also be experiencing Neonatal Abstinence Syndrome (NAS), which are symptoms and signs exhibited by a newborn due to drug withdrawal. NAS is a subset of SEN. Fetal Alcohol Syndrome (FAS) as diagnosed by a qualified licensed medical professional is also a subset of SEN". SEN and NAS data is now captured separately as allegations of neglect within the screening and response. Details of the policy related to SENs include:

Screening:

- Information gathered from the reporter, as applicable, if known, the substance affecting the newborn; whether the newborn had a positive toxicology screen at birth; if the infant is experiencing Neonatal Abstinence Syndrome (NAS); if the substance affecting the newborn was prescribed and taken as directed by a medical professional; if the infant is diagnosed with Fetal Alcohol Syndrome; and/or if there are concerns from the reporter about the impact of substance use/misuse on the mother's ability to safely care for her infant.
- The ability to screen out SEN reports when there are NO other protective concerns, and the only issue is maternal use of appropriately prescribed medication resulting in a substance exposed newborn AND the only substance affecting the newborn was appropriately prescribed and used medication, AND the mother was using these medications as prescribed which can be verified by a qualified medical or other provider.

Response:

- Includes an assessment of parental capacity by evaluating whether the parent understands how to keep the child safe, uses appropriate discipline methods and provides for the family's basic needs, among other criteria
- Mandates use of the Department's standardized Risk Assessment Tool to assess future risks to the child's safety.
- Mandates a referral to Early Intervention for allegations where there is a substantiated concern or a supported allegation of abuse or neglect involving a child under the age of 3.

As part of the training for DCF staff on the Intake Policy, a Clinical Tip Sheet was provided to assist them in gathering information related to domestic violence, mental/behavioral health and substance use. Part of this Tip Sheet included additional guidance on information that should be gathered when the report alleged a SEN.

There is ongoing collaboration with the hospitals and mandated reporters related to SENs. DCF has drafted guidance to stakeholders on when to file a report on a SEN. This guidance will be rolled out to community stakeholders in the upcoming month.

DCF Training

The following trainings which specifically address SEN/NAS within a child welfare context have been offered over the last year:

- *Medication Assisted Treatment/Substance Exposed Newborns*: This training provides an overview of the opioid crisis in Massachusetts as well as the efficacy of Medication Assisted Treatment (MAT) while being mindful of red flags associated with drug addiction. Information on Substance Exposed Newborns/Neonatal Abstinence Syndrome, as well as best practice guidance when formulating Safety Plans is also discussed. Family-centered services for newborns and parents are reviewed. Attendance statewide included 733 staff as of June, 2016.
- *Methadone, Buprenorphine and Vivitrol – Clinical, SEN/NAS and Provider Issues*: This training was offered in each of the DCF regions in partnership with Department of Public Health/Bureau of Substance Abuse Services and Boston Medical Center. An overview of Medication Assisted Treatment was presented. Special attention was given to SEN/NAS with information to assist DCF social workers in assessing and intervening when SEN/NAS is present.
- *DCF New Worker Staff Development*: In new worker training, staff receives content on Substance Use Disorders, including SEN/NAS and MAT during pregnancy. The Early Childhood Program Coordinator facilitates a training on Child Wellbeing, Trauma, The Protective Factors, Toxic Stress, Early Education and Care. The new worker training is offered monthly.
- *Investigations/Intake Training*: All staff interested in becoming Response Workers must attend 8 days of training that includes information about DCF policy, safety and risk assessment, signs of abuse and neglect. The Integrated Clinical Practice day addresses SEN policy and the clinical guidance that informs decisions about level of risk to newborns. Safety planning during the 51B response is addressed in terms of how best to mitigate risk to child. This training is offered twice a year.

DCF and Interagency Initiatives:

- DCF has continued the Welcome Baby project, last year we issued 4000 Welcome Baby bags to the area offices which will have been distributed to the DCF families with children from birth to 6 months. In our last round we included information on soothing SEN, as well as pacifiers.
- DCF continues to participate on numerous interagency councils and committees that address the needs of SENs and their families.

Plan of Safe Care:

In Massachusetts child welfare does not have responsibility for intervening prior to the birth event. Other state agencies and community providers must come together with DCF to develop the Plan of Safe Care for infants identified during the prenatal period to provide mothers the treatment services that are needed during pregnancy and immediately following the infants birth.

In FY 17 Massachusetts DCF will collaborate with other state agencies and community providers to develop the Plan of Safe Care which will coordinate and support the child and family-focused service delivery system, emphasize prevention, early intervention, and an array of community-based treatment services to mothers and infants. Massachusetts DCF has been selected to participate in the 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families and Caregivers in Baltimore, Maryland on February 7-8, 2017 facilitated by the National Center on Substance Abuse and Child Welfare. This affords DCF the opportunity to work very closely with their colleagues to initiate the steps necessary to begin for the process for the development and implementation of the Plan of Safe Care. DCF and their partners will receive six months of technical assistance from the Policy Academy to facilitate the development and implementation of the Plan of Safe Care. The need for further technical assistance will be assessed as we work through this with the Policy Academy.

Trafficking Amendments to CAPTA

The Justice Resource Institute, in partnership with the Department of Children and Families and the Support to End Exploitation Now (SEEN) Program of the Children's Advocacy Center of Suffolk County, was awarded a five-year grant from the Administration for Children Youth and Families to increase the capacity of the child welfare system to respond to child trafficking

The overall goal of the Massachusetts Child Welfare Trafficking Grant (CWTG) is, through infrastructure development, data gathering, awareness-raising and cross-system collaboration and outreach, to develop within the state's child welfare system sustainable methods for preventing minor trafficking, identifying trafficking victims and connecting them to support services. A detailed report on the activities undertaken through the grant is provided in the Appendices to the APSR. The state is not submitting signed Assurances at this time, but plans to submit them by the stated deadline (5/29/2017),

The Department's Regulations are currently being revised to include the definition of sexual abuse to reflect the new CAPTA requirement. We have started the promulgation of such and are currently in the public comment phase. At this time, the Department has not elected to apply the sex trafficking portion of the definitions of child abuse and neglect & sexual abuse to persons over the age of 18 but younger than 24. The Department does not believe it will need any technical assistance related to implementation of the amendments to CAPTA made by the Justice for Victims of Trafficking Act; however, should that be reevaluated the Department will contact the appropriate capacity building center.

Massachusetts Department of Children and Families
Activities to be Assisted with FY 2017 CAPTA Grant Funds

Description	2016 Budget	2017 Proposed
Salary (Nurse)	\$55,000.00	\$55,000.00
Fringe Benefits	\$16,956.50	\$16,956.50
Indirect	\$13,000.00	\$13,000.00
Space, Conference & Incidentals	\$25,000.00	\$25,000.00
Policy Development/Consultation	\$49,500.00	\$60,500.00
Coaching Consultants	\$30,000.00	\$68,000.00
Stipends for Management Team/SW Managers	\$5,500.00	\$5,500.00
Stipends for FAC Committees	\$4,500.00	\$4,500.00
Stipends for Parent Leadership Gatherings/Other	\$10,000.00	\$10,000.00
Parent Stipends for Fatherhood Initiative	\$25,000.00	\$25,000.00
Parent Stipends for Grandparents Commission	\$5,000.00	\$5,000.00
Parent Stipends for Family Advisory Committee	\$15,000.00	\$15,000.00
Key Program	\$95,675.42	\$95,675.42
Parents Helping Parents	\$45,000.00	\$45,000.00
Regional Clinical Consultants	\$89,000.00	\$74,000.00
Total	\$469,131.92	\$518,131.92

Commonwealth of Massachusetts
Department of Children & Families
Citizen Review Panel Reports

State of Massachusetts

Citizen Review Panels Annual Reports

July 1, 2015 – June 30, 2016

Massachusetts Department of Children and Families
Boston, Massachusetts
December 2016

Massachusetts Citizen Review Panels

Annual Reports

Background & Summary

- The Child Abuse and Prevention Treatment Act (CAPTA) was enacted in 1974 to comprehensively address child abuse and neglect issues. CAPTA, which authorizes the award of Child Abuse and Neglect Grants, Parts I and II was amended by the “CAPTA Amendments of 1996” on October 3, 1996. A new requirement was the establishment of three Citizen Review Panels. The Panels provide opportunities for citizens to have a role in ensuring that States are meeting their goals of protecting children from abuse and neglect. On December 20, 2010, President Obama signed Public Law 111-320, a new five-year reauthorization of the federal Child Abuse Prevention and Treatment Act (CAPTA). The CAPTA reauthorization in 2010 continues to include CRPs as part of their focus;
- The purpose of the Panels is to identify systems issues, barriers and trends, and develop recommendations for improving case practice, policy, training, service delivery and coordination.
- States are allowed to use existing panels for this purpose as long as each panel plays a role in evaluating the extent to which each State agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State plan, and offers recommendations on how child protective services can be improved and strengthened.
- Panel members may review specific cases of child fatalities and near fatalities, as well as state policies and procedures to evaluate the extent to which the Department of Social Services is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan.
- According to Federal requirements, Citizen Review Panels are to be made up of volunteer members of the community and include individuals with expertise in the prevention and treatment of child abuse. Each Panel is required to meet at least quarterly and produce an annual report containing a summary of its activities.
- In compliance with the CAPTA, the Department established its three Citizen Review Panels as of June 1999.
- In 2003, following a review of the panel functions, members of the CJA Task Force (one of the designated DCF review panels) elected not to participate as one of the state CRPs. It was the opinion of many on the Task Force that they were concerned about a conflict of interest if they were involved in any of the fatality/near fatality cases in their professional roles. Based on this change, a new configuration of the Citizen Review Panels was developed for 2003-2004. This plan continued through FY 2015 but changed CRP Three in FY 2015-16:
- Utilize the **Statewide Child Fatality Review Team** as Citizen Review Panel One.
- Utilize the **DCF Family Advisory Committee** as Citizen Review Panel Two.
- Utilize the **DCF Youth Advisory Board** as Citizen Panel Three.

Citizen Review Panel One

Massachusetts State Child Fatality Review Team

I. Summary

The child fatality review legislation enacted by the Massachusetts legislature in July 2000 was designed to bring professionals together from a variety of disciplines and experiences to examine individual fatality cases. The objectives of this review are to facilitate interagency networking and collaboration and to produce recommendations for changes that will protect the health and safety of children.

The law establishes the State Team within the office of the Chief Medical Examiner, and the Local Teams within each of 11 District Attorneys' offices. Members of the teams are drawn from state departments of public health, social services, mental health, mental retardation, education, and youth services. There is also representation from the American Academy of Pediatrics, the Massachusetts SIDS Center, the Massachusetts Hospital Association, state and local police, and the juvenile courts.

The most serious challenge facing the Massachusetts Child Fatality Review Teams was the continued lack of funding for case review and implementation of recommendations for changes to prevent future child deaths. The lack of any funding attached to the 2000 legislation has forced Local Teams to depend on in-kind staff and other resource contributions; this has limited and will continue to limit all team activity. One of the Teams applied for and was awarded a full-time Coordinator's position through grant funding. This position was created to assist the team with its mission of reviewing and preventing child deaths.

II. Mission

The Massachusetts Statewide Child Fatality Review Team (Citizens' Review Panel) is committed to reviewing and evaluating child fatalities and the child fatality reporting system, and to make recommendations relative to their findings to insure the safety and the appropriate placement of children in need of aid. The CRP will achieve this commitment by examining the policies and procedures of State and local agencies; examining, where appropriate, specific cases; evaluating the extent to which agencies are carrying out their child protection responsibilities; and preparing and making available to the public, an annual report.

The common goal of the State and Local Child Fatality Review Teams is to decrease the incidence of preventable child deaths and injuries. The Local Teams collect information on individual cases, discuss case information in team meetings and advise the State Team by making recommendations for changes in law, policy and practice that will prevent child deaths. Through the review process, child fatality review teams promote collaboration among the agencies that respond to child deaths and provide services to family members.

A principal responsibility of the State Team is to provide ongoing advice and support for the Local Teams through training, guidance and the dissemination of information pertinent to the protection of

children. A second responsibility is to review Local Team recommendations and combine them with its own research in making final recommendations to the governor, the legislature and the public.

III. Structure

The Massachusetts Child Fatality Review law establishes a State Team and 11 Local Teams. The State Team is under the direction of the Chief Medical Examiner, and the Local Teams are the responsibility of each of 11 districts headed by a District Attorney. These districts correspond to the state's counties, although two of the districts combine more than one county (Franklin and Hampshire Counties are combined, as are Barnstable, Dukes and Nantucket). Local Teams can meet as frequently as they want but the law mandates a minimum of four meetings per year. There is no meeting requirement for the State Team, but in practice the team meets quarterly.

The composition of the State and Local Teams is also mandated, but not limited, by the law.

Responsibilities of the State Team

The common goal of the State and Local Child Fatality Review Teams is to decrease the incidence of preventable child deaths and injuries. The State Team accomplishes the goal of fatality and injury prevention by meeting two objectives established by law:

- It develops an understanding of how and why children die based on Local Team experience; and
- It advises the governor, the legislature and the public on changes in law, policy and practice that will prevent child deaths.

A principal responsibility of the State Team is to review Local Team recommendations and combine them with its own research in making final recommendations to the governor, legislature and the public. A second responsibility is to provide ongoing advice and support for the 11 Local Teams through training and the dissemination of information pertinent to the protection of children.

Responsibilities of the Local Teams

The Local Teams prevent future child deaths by meeting four objectives established by law:

- They collect information on individual child deaths;
- They discuss this case information in team meetings and develop an understanding of the causes and incidence of child deaths;
- Through the review process, they promote collaboration among the agencies that respond to child deaths and provide services to family members; and
- They advise the State Team by making recommendations for changes in law, policy and practice that will prevent child deaths.

IV. Meetings and Activities

The Review Process

Notifications to Local Teams: Each Local Team receives two notifications of child deaths in their districts at least quarterly. One notification consists of copies of death certificates (which, in some cases, may not be finalized) that originate in the cities and towns of the Commonwealth and are sent to the Department of Public Health (DPH) Registry of Vital Records and Statistics. DPH sends these death

certificates to the Chief Medical Examiner, who in turn forwards them to the Local Teams. In the case of infants under one year of age, DPH attaches birth certificates to the death certificates, which facilitates a review of the infant death by providing critical information on the health status and prenatal care of the mother.

The second notification to the teams is a report from the Department of Public Health, which supplements the death certificates and contains the following information:

- deaths of children living in the district who died in the district
- deaths of children living in the district who died in another district
- deaths of children living in another district who died in the district

Case Selection: Any death of a child from birth through 17, from any cause, may be chosen for review by the team. It is recommended that, at a minimum, Local Teams review the following:

- any death from an injury, intentional or unintentional;
- any sudden or unexpected deaths, including SIDS;
- all cases accepted by the Office of the Medical Examiner; and
- All cases with previous DCF involvement or cases that have been prosecuted by the District Attorney's office.

Two types of deaths usually not reviewed are homicides under investigation and deaths ruled as "pending," both in cause and in manner, by the Medical Examiner. "Pending" as a cause and manner of death is applied to those cases in which further laboratory testing or other investigation is needed and is still incomplete.

Assembling Case Information: To accomplish the mandate of the child fatality review law, the legislature gave each local District Attorney the broad authority to collect all records and information relevant to the death of a child under review by a Local Team. This authority extends to records and information relevant to the child and their immediate family from:

- providers of medical or other care, treatment or services, including dental and mental health care;
- state, county or local government agencies; or
- Providers of social services.

The legislation also gives the Local Team the authority to obtain information covered under the Health Insurance and Portability and Accountability Act (HIPAA).

Case Review: Local teams conduct their meetings differently. However, most case reviews begin with the presentation of case details, including information provided by team members and other sources. Additional participants may be invited to the review if they have information pertinent to the case. The presenter may be the team coordinator or another member with knowledge of the case, but all members who have information concerning the case or the cause of death should contribute to the discussion. At the discretion of the team, a case may be held over to the next meeting if the information provided is unclear, or if more information is needed to complete the review. A case may also be held over if it is under investigation. Reviews are complete when the team agrees that no further information or discussion would add to the investigation of the death.

A child fatality review team does not function as a mechanism for criticizing family or agency decisions. Rather it is a forum for sharing and discussing information essential to the improvement of the state's

ability to protect children from preventable death. The critical question being answered by the review is “How can we prevent a death like this from occurring again?”

Confidentiality: The Child Fatality Review law makes the following provisions for maintaining confidentiality:

- The Chair will ensure that no information submitted for case review is given to anyone outside the Local Team.
- Team members may not violate confidentiality.
- Team members may not disclose team business, except as necessary to carry out their duties and responsibilities.
- Team meetings are closed to the public.
- All information and records acquired by the team for case review are confidential and may be disclosed only as necessary to carry out team duties.
- Statistical compilations of data may be disclosed to the public, provided they contain no identifying information.
- Team members or anyone else attending team case review meetings may not be questioned in any civil or criminal proceeding regarding information presented or opinions formed during reviews, and,
- Information or records of State and Local Teams will not be subject to subpoena, discovery, or introduction into evidence of civil or criminal proceedings.

Some Local Teams begin each case review session by signing a confidentiality form; others sign the form once, at their first meeting.

V. Massachusetts Child Fatality Review Program: Multi-Disciplinary Approach to the Prevention of Child Deaths 2015 Status Report

Executive Summary

A child’s death is a sentinel event that should urge communities to identify other children at risk for illness or injury. The purpose of Child Fatality Review (CFR) is to conduct a comprehensive, multi-disciplinary review of child deaths, to better understand how and why children die, and to use the findings to take action that can prevent other deaths and improve the health and safety of children. In Massachusetts, Local Child Fatality Review Teams examine the circumstances of child deaths under their jurisdiction to determine if the death was preventable and to formulate recommendations outlining education, policy, and prevention action steps to take to prevent similar deaths in the future. These local recommendations inform the statewide prevention efforts of the State CFR Team. During 2015, Local CFR Teams reviewed 117 child deaths and made more than 50 recommendations to the State CFR Team to prevent future deaths. Activities of the State CFR Team in 2015 included releasing a document on best practices for school districts to school swimming pools (<http://www.doe.mass.edu/cnp/resources/SwimmingPools.pdf>), revising the Sudden Unexpected Infant Death (SUID) investigation form used by state and local police for investigation of unexplained deaths among children under 3 years of age to better match national data collection standards, and developing an agenda for future work based on a needs assessment.

At both the state and local level, Child Fatality Review continues to be an unfunded mandate. Local Team coordinators struggle with balancing existing work responsibilities with coordinating Local Team meetings, developing Local Team guidelines, gathering records for the review, and submitting data to the State Team and the National Child Death Review case reporting system. Delays in both death certificate

and surveillance data also affect Local and State Teams' abilities to focus prevention efforts and measure progress. In 2015, a CFR improvement working group was formed to brainstorm challenges and opportunities of the Child Fatality Review process in Massachusetts. As a result of this working group, a retreat for all State Team members was held in 2016 and a set of action steps was created. These include: developing a process for immediate feedback on recommendations made by the Local Teams to the State Team, drafting a document that includes a list of barriers to the CFR process in Massachusetts and what an effective structure and budget would look like, and piloting more targeted child fatality reviews.

Looking forward, the State CFR Team plans to continue implementation in 2016 and 2017 of the action steps that resulted from the CFR improvement working group. Other future activities of the State CFR Team include continuing to work with the Office of the Chief Medical Examiner and the Department of Public Health to better understand the circumstances of SUID cases in Massachusetts and to work together to find ways and means of preventing child deaths in Massachusetts, including conducting a needs assessment among the local child fatality review teams state-wide

VI. Recommendations from Child Fatality Review 2015 Status Report

During 2015-2016, the State Child Fatality Review Team received and reviewed 50 recommendations from Local Child Fatality Review Teams. Below are recommendations formulated by the State Team based on common themes found in Local Team recommendations. The State Team recommends the following:

Sudden Unexpected Infant Death (SUID):

- Increase awareness and warnings to parents/guardians regarding any sleep aids and their effect on responsiveness to needs of infants/children;
- Premature babies: increased risk - increase awareness with co-sleeping even at 6 months of age;
- Increase awareness of risks consistent with developmental ages: infants easily suffocated; mobile child suffocates in sheets/bedding or wedging. Emphasize cultural sensitivity;
- Student awareness - early intervention and babysitting and first aid;
- Instruct culturally on sleep position;
- Sudden unexpected infant death case investigation form was included which helped with our understanding of the case.
- Continue education on safe sleep situations;
- Involve child products - marketing – TV;
- Reinforce no co-sleeping at doctor's appointments;
- Continued support for safe sleep practices and universal education of safe sleep practices which would include sleeping while napping;
- Prior recommendations on co-sleeping issues have been made - however, need to discuss getting information out to rural and suburban areas. Unlicensed daycare - Clarifying unlicensed daycares (use of family/friend vs. private). How many death cases come to the state team while in unlicensed daycares? Need to have Early Education and Care come to a meeting. Possibly have someone from DPH speak about visits;
- Data on socio-economic status data should be included in future SUID/SIDS studies;

- It is recommended for hospitals and state agencies providing services to parents, families and caretakers to continue with their efforts in providing education regarding the risks of co-sleeping in relation to SUID;
- The State Team should consider the need to expand current practices of public education on the risks of smoking to include the effects of third hand smoke on infants and children.
- The State Team should take measures to assure that standardized assessment for infant death investigations is adopted and implemented statewide to improve the quality of the data being obtained through interviews. It is recommended that initial and periodic re-training is offered to all law enforcement on SUID and SIDS;
- Hospitals need to include full messaging about safe sleep practices (when to stop skin to skin contact and put baby in crib). Do more monitoring and feedback for moms about how well they're doing with safe sleep practices while in the hospital;
- Approach news programs about doing special features on safe sleep for 6/11pm broadcasts to reach grandparents and other audiences;
- Increase appropriate and consistent exposure to safe sleep messaging: Ask DPH to use social media to out safe sleep messages and find a famous champion to do this-someone with a lot of followers;
- Require safe sleep info to be part of babysitting class curricula;
- Reach out to film/TV production that occurs in MA about including modeling safe sleep when a scene is relevant;
- Improve timeliness of OCME findings (36 2014 pending cases and some still pending from 2011 and 2012 at time of meeting). Middlesex recommends setting up a qualified commission to conduct a needs assessment with the OCME to help them advocate for what they need - determine what the workload requirements are, what resources are needed to improve function of office and turnaround time for cases. As part of this process, talk to families, law enforcement, and others regarding impact of delays in case processing including child fatality review teams;
- Expand infant safe sleep awareness efforts through social media (Twitter campaign, Instagram, etc.);
- Broach balance between attachment parenting and recommended infant safe sleep practices;
- Expand educational materials and provide training to Doula's and Midwives;
- Have birth hospitals emphasize the difference between "bed sharing" and "co-sleeping";
- The Norfolk Team recommends that the safe sleep initiatives include references to the dangers of co-sleeping with dogs and the SUID investigation form include a box for data collection regarding dogs being present in home or in co-sleeping environment;
- For every placement by the Department of Children and Families of an infant (including kinship placements), DCF workers should view the sleep placement area, give a pamphlet and have a conversation about safe sleep. We encourage DCF to incorporate this policy/practice for workers placing infants, even in kinship or current foster placements.

Suicide:

- Increase awareness with children and families of benefits of therapy as an acceptable intervention for all ages;
- Review statewide data on suicides - by age; culture; "clustering";
- Communities to consider a plan after teen suicide occurs to prevent clustering;
- Plan when youth/teen suicides occur in the summer to provide a school based intervention;
- Provide additional screening programs for high risk students that address some of their needs;

- Have PCP/school refer a child for increased services once identified as at risk. Mandate summer plan;
- Prioritize high risk students for therapy;
- Recommend protocols to increase communication between probate court, school and DCF;
- Implement QPR with follow-up and data collection;
- Student awareness-health class;
- The Department of Education considers the need to develop a standardized, evidence-based, systematic suicide prevention and awareness educational program for students within the public school system. Every school district may have its own program. Also it should be taken into consideration that there may be some resistance with the religious communities;
- The State Child Fatality Review Team should seek change in Child Fatality Review legislation to allow communication between local CFRTs and people who responded to cases regarding lessons learned to allow some sort of feedback mechanism - the backlog in release of statewide report was cited here. Also, report was viewed as not sufficient for local needs. Look to Florida's Intimate Partner Violence homicide review as a model;
- Enhance the availability of the texting service offered by Samaritans;
- DESE should increase the availability of training for recognizing and reporting what you observe in peers for students (e.g., the SOS training);
- Enhance the availability of screening in schools and make it part of policy that students who transfer to a new school are screened;
- State Child Fatality Review Team should request state funding for implementation of Chapter 284, Acts of 2014 An Act Related to Gun Violence (Section 12) for training of school personnel. Include funding for training students and require schools to set up protocols with community providers. Students have reported that they want access to a school-independent source of help to turn to;
- Request that the MA chapter of the National Honor Society provide suicide prevention materials to all applicants and their parents;
- Increased communication avenues between agencies involved including school personnel / school resource officers and funding related to intervention and post-intervention;
- Students who have lost a close family member to suicide within the year should be closely monitored by their school system, including counselors and teachers. We recommend that be included in statewide policies for dealing with suicide in schools.

Homicide:

The State Team should consider reviewing current evidence-based home-visiting practices and encourage their use statewide.

- Serious at-risk and antisocial behavior is the consequence of lifelong social dysfunction that can be identified as early as preschool. Evidence-based programs for dealing with these problems early exist, but correction becomes increasingly difficult as children age. The State Team should consider a concerted review at the state level of how we are dealing with at-risk children through the lifespan and beginning in preschool. There is a need for a multi-disciplinary approach to address the issue of youth violence, which should include services being offered to children and families and involvement from local school departments. Local faith communities, cultural groups, early education and care organizations, medical care providers, and social service agencies can be a safety net for families in distressed communities and should be included as part of the effort. It is further recommended to monitor the development of executive functioning and intervening early with children;

- The State Team should consider the need to expand the scope of intervention-based programs, build the capacity of current incentive-based programs, and consider behavioral health programs that address stigma and utilize non-conventional methods to address this problem. Current practices aimed at reducing desensitization to youth violence and enhancing positive youth development should be promoted statewide. Unfortunately, there is limited funding for children with behavioral/emotional regulation programs-agencies do not have sufficient resources to reach and educate all youth with behavioral/emotional regulation problems;
- DPH and the Children's Trust Fund have implemented the All Babies Cry Program, which is an evidence-based media intervention designed to prevent child abuse during the first year of life by encouraging healthy parenting behaviors. A recent study of this program found that it is significantly effective with improving behaviors of first-time/new parents. Problem - Management of infant crying. It is recommended for the State Team to review the current state of the All Babies Cry Program; it is presently geared toward first-time/new parents. The scope of the program should also include such training for other types of caregivers, i.e. babysitters. On DPH's website there are fact sheets available in several languages. However, the media educational materials are not universally accessible. Furthermore, these programs should be specific and financially practicable for hospitals as there is the need for more financial resources to implement these programs. To prevent future untimely deaths, there is the need for a funded, well-constructed, and universal training program.

Injury:

- Additional funding for education on bicycle safety and helmet use geared toward adolescents;
- Provide bike rental companies information on bike helmet use including having helmet and bike rented together (with possible incentive);
- Add signage at strategic location for bike riders (i.e. bike trails);
- Public awareness campaign to bike stores, bike rental companies, rails to trails, ferries to islands;
- Junior operators are allowed, but not required, to obtain both Class D and Class M permits at the same time. In order to receive a Class M license, a junior operator must meet all of the requirements for a Class D license but the same is not a prerequisite when obtaining a learning permit. To prevent future untimely deaths, it is recommended for the State Team to review our Junior Operator Law (JOL); it presently allows children under the age of 18 to operate motorcycles on the road unsupervised prior to mastering the necessary skills for operating both automobiles and motorcycles. The risk of injury, particularly death, is significantly higher within a motorcycle versus an automobile;
- The State team should consider a concerted effort to encourage the use of current evidence-based psychotherapeutic practices by Children's Behavioral Health Initiative providers. The State team should also consider a concerted effort to allow psychotherapeutic practices in which the therapist primarily works with the parent/guardian, when the identified patient has disruptive or dysregulated behavior problems;
- The State team should consider the standard protocols for state truck inspections, should require truck drivers to check/inspect trucks pre-trip, including brakes, in addition to annual inspections;
- The State team should consider reviewing current practices of bike safety and education for children and families;
- We recommend that parents be reminded about the importance of first aid and CPR, including the Heimlich maneuver. We would like for community education and opportunities for training on first aid to be more readily available;

- We recommend that physicians and pharmacies instruct patients and their families to whom they prescribe MAOI drugs about the hazards of mixing those drugs with others. We recommend that verbal and written instructions accompanying the prescription for MAOIs mandate that the drugs be kept in a locked, secure place. We would recommend that DPH and/or the proper governing authority make these needs clear to physicians and pharmacists;
- For these tragic accidents, we recommend the addition of constructive places for recreation for teens and tweens to play in urban areas, like skate parks and fields;
- We recommend the facilitation of more community swim lessons and water safety education for underserved populations, especially those with special needs. We urge the State Team to continue its discussion about and action around making natural bodies of water safer.

Natural:

- Hospitals should make referrals to home visiting programs for high medical risk infants/children;
- DPH and/or Children's Trust should fund home visiting for high medical risk infants for first year of life (8-10 visit minimum);
- Polysubstance abusing mothers - What is the number of pre-mature/early infant death cases on an annual basis in MA where mom is a suspected user of prescribed or illegal narcotics (high risk situations)? Concerns of sub Oxone use with other prescribed or illegal narcotics - Need to educate both physicians and their patients as to the lethal mix that can occur if there is sub Oxone use and patient does not reveal such use to a prescribing physician. Education campaign warning of the dangers of co-mingling additional narcotics with Suboxone use;
- The State Team should consider the need to increase the capacity of the Department of Children and Families' (DCF) involvement with Parent Aides. More parental and familial support is needed in the home pre and postpartum. Currently, Parent Aides are not employed by DCF; they are trained service providers contracted from outside agencies. Multiple problems exist with this arrangement: 1) DCF has a limited number of contracted "spots" 2) There is a waitlist with cases assigned to families by priority 3) Low pay and high turnover of staff hinders the effectiveness of this program 4) Although Parent Aides are mandated reporters, their alliance with the family could contribute to delays in reporting to DCF. Increasing these resources and placing them closer to, or within the agency, will improve prevention services and speed identification when prevention services are inadequate or breaking down;
- Have DPH calculate how many allergy deaths there have been for children in the Commonwealth. Reach out to community organizations dealing with allergies to help in outreach and messaging surrounding awareness and best practices for parents of children with allergies. Recommend medical team working with high-risk patients conduct home inspections to ensure environment is appropriate for the child and won't exasperate their medical condition. Recommend medical team working with families who have children with allergies talk to the family about the importance of taking medications on time, recognizing the signs of an attack, understanding how quickly an attack can turn fatal, and having parents closely monitor and supervise the use of medication. Develop application to monitor asthma for children at risk of hospitalization. Doctors would be able to check levels, refill prescriptions & have open line of communication with parent/child;

Other:

- It is known that there is a significant backlog in the processing of rape kits statewide. The State Team should review current practices and consider the need for a concerted effort to process rape kits in a timely and expeditious manner.

Citizen Review Panel Two

DCF Family Advisory Committee

I. Summary

In 2004, DCF assembled its first Family Advisory Committee (FAC) to meet quarterly with the Commissioner. The FAC is a group of individuals from across the Commonwealth who are diverse in race, culture, language, age and sexual orientation. They also bring a wide range of first-hand experience with the Department. Some have been foster and/or adoptive parents; some, with their families, have had open DCF cases, including those whose children were in foster care and/or residential placement. Some, as children, lived with foster families or in an orphanage.

The FAC addresses such issues as: putting the DCF core values into practice; staff training and support; building good rapport with communities; developing informational materials that are user-friendly; and recruiting and retaining neighborhood foster homes.

Recognizing the importance of including the family voices in their processes, DCF created the position of Family Representative to assist the Family Support Team in recruiting, orienting, and mentoring parent leaders for a variety of local and statewide decision making bodies, including the Department's: Area Boards; Procurement Review Panels; Policy Work Groups; Teaming Initiatives; Patch Teams; and the Commissioner's Family Advisory Committee. These individuals play a vital role as bridge-builders to the Department.

II. Mission

The goal of the Family Involvement Project is to promote a partnership between DCF and community members on behalf of families and children and facilitate family involvement in the planning, delivery and monitoring of DCF services. To achieve this goal, a Family representative works in partnership with regional and area offices under the guidance of the DCF Assistant Commissioner for Planning and Program Development to achieve the following objectives:

- Assemble a Family Advisory Committee proportionately representative of the diverse cultural and linguistic groups served by DCF that will meet quarterly with the Commissioner to ensure that the Department is held accountable for making progress in closing the gap between espoused theory and actual practice.
- Gather baseline data on parent involvement in current initiatives such as Family Based Services, Family Group Conferencing, Foster Care Review Teams, Continuous Quality Improvement Teams and Area Boards.
- Recruit from diverse cultural and linguistic groups at least 25 community representatives with a broad range of experiences and knowledge about DCF to participate in one or more of the DCF planning, service delivery and monitoring groups.
- Conduct an assessment of the Department's current efforts to include parents in individual case planning, service design, delivery and monitoring.

- Establish a system for routinely obtaining consumer feedback from parents served by DCF and its contracting agencies, regularly reporting results to the DCF Commissioner, area offices, lead agencies and community partners; and monitor how those results are utilized to enhance on-going, substantive involvement of parents.
- Assist in the redesign of systems of care, intake and assessment, publications and other efforts to incorporate core values into case practice and to enhance parents' experiences with DCF.

II. Family Advisory Committee ~ Action Plan for 2015-2017

Goal: Assist DCF with the inclusion of community/parent participation to ensure that parent input happens at all levels in the Department including program planning, policy development, and the delivery and monitoring of DCF services.

Objective 1: Parent participation in Area Boards and all areas where decisions are being made that impact the lives of families and children.

Activity 1.1: Develop relationships with Area Directors/Area Offices to assist with board development and strategies for recruiting former consumers for area boards, FELTs, TILTs and other areas where family voice helps the work

Activity 1.2: Assist Area offices/Director of Family Engagement, with the interview process/nominating committee for the engagement of community representatives in all areas of DCF work. (Caring Together proposals, Permanency Planning Training, Area Boards, etc.)

Activity 1.3: Provide support and mentoring to new recruits and learning opportunities to all members
All FAC members are responsible for mentoring and helping the new members along.

Activity 1.4: Do quarterly reviews of the tracking tools on area board participation

Objective 2: Assist the Department in maintaining fidelity to Practice model

Activity 2.1: FAC members will participate on the area CQI teams. (Check with Ruben to see status of CQI teams)

Activity 2.2: To Assist the Ombudsman's Office with complex cases, 7 Family Liaisons will receive referrals from the Ombudsman's office and assist clients navigating the system

Activity 2.3: Represent Family /Alumni perspective on Regional Clinical Review Teams (CRTs) to assess social work practice and re-evaluate case determination. (Currently only have representative on Northern team)

Activity 2.4: Co-facilitate Foundations of *Health and Wellbeing* trainings for new social workers, supervisors and Area Program Managers to highlight the interconnection of protective factors

Activity 2.5: Co-training for the CWI in the training of new Social Workers, training the field on changes in policy, facilitating interactive learning and dialogue regarding culture, resiliency, child/youth, fathers' inclusion in the family and birth family perspective

Activity 2.6: Represent on the *Massachusetts Child Trauma Project* Steering Committee family voice/alumni perspective in the integration of trauma informed and trauma focused practice

Activity 2.7: Represent Family/Alumni voice at the Central, Regional, and Area Office TILT teams in the development of infrastructural change that may include dissemination of information on resiliency and building practice points

Activity 2.8: Assist the department in the implementation, training, and coaching of the use of the Assessment and Action Plan tool, including the collaboration with families

Objective 3: Assist the Department in the practice of engaging fathers who have children involved in the child welfare system.

Activity 3.1: Identify and recruit fathers for the FAC and other leadership roles (such as participation in Father Speak at Area Offices and membership at statewide meetings)

Activity 3.2: Support the Family Nurturing Center (FNC) Nurturing Fathers trainings throughout the state

Activity 3.3: Provide training in facilitating support groups—this will be available as requested

Activity 3.4: Assist DCF in identifying, opening, and providing services for all fathers.

Activity 3.5: Assist DCF in developing a system to measure and assess progress on all aspects of fatherhood engagement

Activity 3.6: Address trauma and domestic violence in the work with fathers

Activity 3.7: Develop an action plan for fatherhood engagement in DCF.

Activity 3.8: Work with the Interagency Fatherhood Working Group to maximize engagement with fathers throughout all state agencies

Objective 4: Assist the Department with getting systematic feedback from the families it serves on the effectiveness of its interventions and practice.

Activity 4.1: Administer survey to families involved with DCF

Objective 5: Assist the Commission on the Status of Grandparents Raising Grandchildren in the implementation of their mission

Activity 5.1: identify local or statewide funders to maintain the support groups

Activity 5.2: Assist the Commission on the Status of Grandparents Raising Grandchildren in convening the leadership of grandparents groups on a quarterly basis

Activity 5.3: Quarterly update on the Support Groups List

Activity 5.4: Provide Support, information and referral to grandparents who seek assistance

Activity 5.5: Responsibility for maintenance and update on the Grandparents Raising Grandchildren Website

Objective 6: Cross system and secretariat collaboration centered on improving the wellbeing of children and families through public policy initiatives

Activity 6.1: Established and supports the Mother/ Father Clinic at the Suffolk Family Court in conjunction with Chief Justice Ordonez

Activity 6.2: Working with Department of Revenue Family/Father Engagement to understand their culture and how it may impede their ability to effectively engage and serve fathers and consequently families.(DOR Workgroup with Director of Fatherhood Engagement)

Activity 6.3: Work across the Secretariat to identify collaboration efforts to address the needs of families throughout the Commonwealth. (Ask John)

Activity 6.4: Participation on the Massachusetts Strengthening Families Coalition (SFC) for the purpose of creating legislative awareness to the needs of families involved with the child welfare system, with the focus on family stabilization and preservation.

Activity 6.5: Gubernatorial Appointment: Chapter 257 Providers and Consumer Council to address the Acts of 2008 to create outcome measures for service providers that are inclusive of customer satisfaction.

Activity 6.6: Support the development of Pilot initiatives to reformat the parent child visitation model

Activity 6.7: Provide Family Representation on services procured by DCF

Activity 6.8: Nurturing Fathers Groups at Recovery Homes: With Substance Abuse as the most prevalent issue amongst our families – Engaging the recovery community to better understand the challenges and how we may best respond

Activity 6.9: Representation in the Statewide Diversity Leadership Workgroup (DLW) to help set statewide goals in accordance with the DCF Diversity Plan and to align DCF's Diversity goals with the agency's vision.

Activity 6.10: Representation in the Governor's Domestic Violence and Homelessness Integration Task Force.

Activity 6.11: Participation on the Massachusetts Child Welfare Reform Committee (Child Welfare Task Force Think Tank) to increase public awareness of positive child welfare practice and publish educational materials for practitioners.

III. Annual Report

The past year has been a transition period for the Family Advisory Committee with the retirement of the Director of Family Engagement. The FAC committed most of the year to activities to assist DCF with the review of proposed policies and the inclusion of community/parent participation, including:

- Assist the Department in maintaining fidelity to Practice model. Assisting the department in the implementation, training, and coaching of the use of the Intake Assessment tools.
- Assist the Department with getting systematic feedback from the families it serves on the effectiveness of its interventions and practice.
- Assist the Commission on the Status of Grandparents Raising Grandchildren in the implementation of their mission
- Cross system and secretariat collaboration centered on improving the wellbeing of children and families through public policy initiatives
- Assist the department in increasing the quality of care and positive outcomes of children in the foster care system.

FAC members sit on all management teams from the Commissioner's Senior Staff, to Statewide Managers, to Area Office Clinical Teams.

Activities in 2016

Strategic Sharing:

In 2008 a number of Family Advisory Committee members participated in Training, and a Train-the-Trainer (TOT) module of Strategic Sharing, a curriculum-based workshop developed by the Casey Foundation. The training is designed to help parents with telling their stories. "Strategic sharing is telling our life stories in a way that is meaningful, effective, and safe."

In 2015 -2016, members of the Family Advisory Committee hosted Strategic Sharing Training with the DCF and the Department of Mental Health's Caring Together Family Advisory Council 23 members of the Council received training certification and will be participating in the TOT next spring.

Annual Retreat:

The Family Advisory Committee Annual Retreat is a gathering of parents from the five Regions of the state, who provide Family Representation at multiple levels of the agency. Approximately, 25 parents who have been involved with DCF in Massachusetts participate in this Annual Meeting. The FAC Members provide information, training and advisement on best practices with family engagement in child welfare and social services settings. It affords DCF an invaluable opportunity engage the parent leadership in strategic planning to improve practice.

The Retreat is an all-day planning session and end of year acknowledgement, which generally includes adopting the Action Plan, and participation by the Commissioner and members of Senior Staff.

This year's retreat feature newly hired Assistant Commissioner Theodora Savas, Deputy Commissioner Danielle Ferrier and Commissioner Linda Spears. 20 FAC Members participated with 14 DCF Staff members.

The purpose of the Family Advisory Committee (FAC) is to engage a diverse group of individuals to work with the Department of Children and Families in order to provide counsel to the Department. The FAC is comprised of foster and adoptive parents, parents who have formerly had open protective cases with DCF, people who were involved with DCF as youth, and community members invested in the safety and well-being of children across the Commonwealth.

Support to Area Boards:

FAC members support Parents participation in Area Boards and all areas where decisions are being made that impact the lives of families and children. Developing relationships with Area Directors/Area Offices to assist with board development and strategies for recruiting former consumers for area boards, and other work groups like Father Engagement Leadership Teams (FELTs), Trauma Informed Leadership Teams (TILTs).

Family Liaison Program:

Supports and assists the Ombudsman's Office with complex cases. Some FAC members serve as Family Liaisons and receive referrals from the Ombudsman's Office. This year the FAC is working with the new Ombudsman to diversify the program and enhance the program by providing additional skilled parents with professional and lived experience from other systems to support families struggling with Mental Health, substance Use and Domestic Violence issues.

Citizen Review Panel Three

Youth Advisory Boards

I. Summary

- The Department's Youth Advisory Board has been active for more than 16 years. Presently, there are 35 members of the Regional Youth Advisory Boards who are committed to promoting change for future foster youth through their voice, advocacy, and action.
- The Youth Advisory Boards provide recommendations to the Department on services, policy and practice. Additionally they want to ensure that foster youth are known for their strengths, achievements, goals and not labeled negatively;
- The Regional Youth Advisory Boards generally meet monthly, providing a medium for youth in out-of-home placement to voice their concerns and offer suggestions to the agency on issues facing youth in care. Delegates from each Regional Board sit on the Central Office Advisory Board; they are statewide representatives for their peers' interests, concerns, and questions. The agenda topics for each meeting are jointly developed by the Board members based upon their own ideas/concerns or

those of the youth they represent and by DCF administration – often seeking youth input on policy, programming, etc.;

- DCF understands the challenges and risks facing transition age youth/young adults as they leave agency care and has developed an array of services to help prepare them with the skills and supports to successfully manage the struggles of adulthood. Using stakeholders' input, the agency has focused state and federal funded programming on assisting youth and young adults build strong foundations for success - addressing their needs for permanency, safety and the many facets of well-being. Educational achievement and life skill mastery with permanent connections to family and/or other caring enduring relationships with adults are the goals for our youth. These services span program models from foster care to congregate care as well as aftercare;
- Ongoing feedback from the youth and young adults, themselves, provides the DCF with the knowledge and understanding to shape policy and practice that effectively addresses the needs of our youth. The Regional Youth Advisory Boards and the MA Network of Foster Care Alumni are vital partners guiding agency service planning and delivery. The efforts of the Board members over the years have resulted in the Foster Child Tuition and Fee Waivers, the Foster Child Grant, core aspects of the "sustaining connections with transition age youth" in the Permanency Planning Policy, foster parent recruitment/training as well as guidance to both DCF and the state Department of Housing and Community Development (DHCD) in the creation of the subsidized housing program for former foster youth – Youth Transitioning to Success Program.

Youth Leadership Achievements

19. The Youth Advisory Boards are often asked to offer feedback on a number of issues relevant to the Department. This year they were asked to provide feedback on the issue of youth running from care. Members offered suggestions to the agency to help prevent running and lessen run time.
20. Board members provided feedback for Millbrook Scholars Program and for the DCF Handout on Student Debt.
21. Board members participate on the Youth Panels at the area offices to review applications from former foster youth wishing to return to agency care.
22. Board members assisted in the planning for the Youth Leadership Institute last July and are working now on this year's Youth Leadership Academy and Youth Summit to be held on July 20 and 21.
23. The Southern Region Youth Advisory Board members met with the DCF Area Board. The Area Board recruited two of the youth sit on their Area Office Board. The Youth Advisory Board members were asked to assist the Area Board in designing and redecorating two DCF visiting rooms.
24. The Central Region Board members are working on a project to develop drawstring bags for adolescents when they come into care. They are identifying funders/donations and expect to have 30 bags for each Central Region office soon.
25. Northern Region Board members presented at a training of staff on the importance of permanency and life-long connections for foster youth.
26. DCF maintains its participation in the New England Youth Collaborative – a regional youth group dedicated to improving the services/resources and outcomes for foster youth. Each New England state has 3-4 youth representatives. This year the group has been working on normalcy rights for youth in congregate care.
27. DCF Youth Advisory Board members participated in the production of the annual graduation video that was presented at the Jordan's Furniture Youth Achievement Celebration this May 15th, 2016. The video is also used for training new social work staff, foster parents and as a recruitment tool for adoptive and foster parents.

28. Members of all the regional Boards continue to participate in MAPP trainings and regional recruitment events, sharing their experiences to help train and recruit Foster and Adoptive families. Board members also participated in the DCF Adoption Option event this past September to assist in recruiting foster/adoptive homes for transition age youth.
29. Members spoke at Area office legislative breakfasts to present the youths' perspective on foster care.
30. Members assisted with the Education Open Houses at the area offices for younger foster youth interested in post-secondary education.
31. Youth continue to participate in trainings, including CORE training, for social workers and supervisors to talk about the needs of youth in DCF care/custody.
32. Again this year, Board members have given back to their communities by volunteering at homeless shelters and hosting food drives.
33. Board members have been very helpful in assisting DCF with strategies for reaching out to foster youth regarding the NYTD surveys (see below).
34. Again this year members planned activities with a local nursing home - craft projects with the elderly residents around the Halloween, Christmas, and Easter holidays. This intergenerational project was a rewarding experience for both the youth and the residents, and the youth look forward to continuing similar projects in the future.
35. Board members also planned and hosted an Easter Egg Hunt at one of the Boston area offices for foster children.
36. The Department's teen newsletter, *The Wave*, has continued to provide a voice for youth in care and is an effective means of informing youth of the opportunities/services available to them both in the agency and the community. THE WAVE is available on the DCF Intranet.

NYTD Surveys:

The Department contracts with the Judge Baker Children's Center to assist with the NYTD surveys. The DCF Outreach staff locate and survey the youth and young adults who are in agency custody/voluntary care as well as young adults who are no longer in agency placement, but whose contact information is known to DCF.

NYTD outcome data has been shared with the members of the Youth Advisory Boards. Staff has asked these youth leaders for their suggestions for strategies for engaging youth/young adults to complete the surveys. They have also helped staff to determine which survey questions needed more explanation to avoid misunderstanding and incorrect responses. The feedback from the members of the Youth Advisory Boards has been valuable –from their recommendations that youth need better education around Mass Health eligibility and coverage to recommendations that more vocational training options be available to foster youth who struggle with academics.

**Citizen Review Panels
Department Response
2016**

July 1, 2015 – June 30, 2016

Massachusetts Department of Children and Families

Boston, Massachusetts

2016 Citizen Review Panel (CRP) Response from the Massachusetts Department of Children and Families Central Administration

In 2015-2016, the Massachusetts Department of Children and Families continued to work on the programmatic and statutory results of the bill, *An Act to Protect Children in the Care of the Commonwealth* with provisions that significantly increased the Commonwealth's effectiveness regarding protecting and strengthening families. In addition, the Professional Advisory Committee has been replaced by the Department-wide Youth Advisory Boards as the third citizen review panel. The Citizen Review Panel's recommendations and the Department's response are included below.

Massachusetts State Child Fatality Review Program

Recommendations from the Statewide Child Fatality Review Program

During 2015-2016, the State Child Fatality Review Team received and reviewed 50 recommendations from Local Child Fatality Review Teams. Below are recommendations formulated by the State Team based on common themes found in Local Team recommendations. The State Team recommends the following:

Sudden Unexpected Infant Death (SUID):

- Increase awareness and warnings to parents/guardians regarding any sleep aids and their effect on responsiveness to needs of infants/children;
- Premature babies: increased risk - increase awareness with co-sleeping even at 6 months of age;
- Increase awareness of risks consistent with developmental ages: infants easily suffocated; mobile child suffocates in sheets/bedding or wedging. Emphasize cultural sensitivity;
- Student awareness - early intervention and babysitting and first aid;
- Instruct culturally on sleep position;
- Sudden unexpected infant death case investigation form was included which helped with our understanding of the case.
- Continue education on safe sleep situations;
- Involve child products - marketing – TV;
- Reinforce no co-sleeping at doctor's appointments;
- Continued support for safe sleep practices and universal education of safe sleep practices which would include sleeping while napping;
- Prior recommendations on co-sleeping issues have been made - however, need to discuss getting information out to rural and suburban areas. Unlicensed daycare - Clarifying unlicensed daycares (use of family/friend vs. private). How many death cases come to the state team while in unlicensed daycares? Need to have Early Education and Care come to a meeting. Possibly have someone from DPH speak about visits;
- Data on socio-economic status data should be included in future SUID/SIDS studies;
- It is recommended for hospitals and state agencies providing services to parents, families and caretakers to continue with their efforts in providing education regarding the risks of co-sleeping in relation to SUID;
- The State Team should consider the need to expand current practices of public education on the risks of smoking to include the effects of third hand smoke on infants and children.
- The State Team should take measures to assure that standardized assessment for infant death investigations is adopted and implemented statewide to improve the quality of the data being obtained through interviews. It is recommended that initial and periodic re-training is offered to all law enforcement on SUID and SIDS;

- Hospitals need to include full messaging about safe sleep practices (when to stop skin to skin contact and put baby in crib). Do more monitoring and feedback for moms about how well they're doing with safe sleep practices while in the hospital;
- Approach news programs about doing special features on safe sleep for 6/11pm broadcasts to reach grandparents and other audiences;
- Increase appropriate and consistent exposure to safe sleep messaging: Ask DPH to use social media to out safe sleep messages and find a famous champion to do this-someone with a lot of followers;
- Require safe sleep info to be part of babysitting class curricula;
- Reach out to film/TV production that occurs in MA about including modeling safe sleep when a scene is relevant;
- Improve timeliness of OCME findings (36 2014 pending cases and some still pending from 2011 and 2012 at time of meeting). Middlesex recommends setting up a qualified commission to conduct a needs assessment with the OCME to help them advocate for what they need - determine what the workload requirements are, what resources are needed to improve function of office and turnaround time for cases. As part of this process, talk to families, law enforcement, and others regarding impact of delays in case processing including child fatality review teams;
- Expand infant safe sleep awareness efforts through social media (Twitter campaign, Instagram, etc.);
- Broach balance between attachment parenting and recommended infant safe sleep practices;
- Expand educational materials and provide training to Doula's and Midwives;
- Have birth hospitals emphasize the difference between "bed sharing" and "co-sleeping";
- The Norfolk Team recommends that the safe sleep initiatives include references to the dangers of co-sleeping with dogs and the SUID investigation form include a box for data collection regarding dogs being present in home or in co-sleeping environment;
- For every placement by the Department of Children and Families of an infant (including kinship placements), DCF workers should view the sleep placement area, give a pamphlet and have a conversation about safe sleep. We encourage DCF to incorporate this policy/practice for workers placing infants, even in kinship or current foster placements.

Suicide:

- Increase awareness with children and families of benefits of therapy as an acceptable intervention for all ages;
- Review statewide data on suicides - by age; culture; "clustering";
- Communities to consider a plan after teen suicide occurs to prevent clustering;
- Prioritize high risk students for therapy;
- Recommend protocols to increase communication between probate court, school and DCF;
- Implement QPR with follow-up and data collection;
- Student awareness-health class;
- The Department of Education considers the need to develop a standardized, evidence-based, systematic suicide prevention and awareness educational program for students within the public school system. Every school district may have its own program;
- The State Child Fatality Review Team should seek change in Child Fatality Review legislation to allow communication between local CFRTs and people who responded to cases regarding lessons learned to allow some sort of feedback mechanism - the backlog in release of statewide report was cited here. Also, report was viewed as not sufficient for local needs. Look to Florida's Intimate Partner Violence homicide review as a model;
- DESE should increase the availability of training for recognizing and reporting what you observe in peers for students (e.g., the SOS training);

- Enhance the availability of screening in schools and make it part of policy that students who transfer to a new school are screened;
- State Child Fatality Review Team should request state funding for implementation of Chapter 284, Acts of 2014 An Act Related to Gun Violence (Section 12) for training of school personnel. Include funding for training students and require schools to set up protocols with community providers. Students have reported that they want access to a school-independent source of help to turn to;
- Request that the MA chapter of the National Honor Society provide suicide prevention materials to all applicants and their parents;
- Increased communication avenues between agencies involved including school personnel / school resource officers and funding related to intervention and post-intervention;
- Students who have lost a close family member to suicide within the year should be closely monitored by their school system, including counselors and teachers. We recommend that be included in statewide policies for dealing with suicide in schools.

Homicide:

The State Team should consider reviewing current evidence-based home-visiting practices and encourage their use statewide.

- Serious at-risk and antisocial behavior is the consequence of lifelong social dysfunction that can be identified as early as preschool. Evidence-based programs for dealing with these problems early exist, but correction becomes increasingly difficult as children age. The State Team should consider a concerted review at the state level of how we are dealing with at-risk children through the lifespan and beginning in preschool. There is a need for a multi-disciplinary approach to address the issue of youth violence, which should include services being offered to children and families and involvement from local school departments. Local faith communities, cultural groups, early education and care organizations, medical care providers, and social service agencies can be a safety net for families in distressed communities and should be included as part of the effort. It is further recommended to monitor the development of executive functioning and intervening early with children;
- DPH and the Children's Trust Fund have implemented the All Babies Cry Program, which is an evidence-based media intervention designed to prevent child abuse during the first year of life by encouraging healthy parenting behaviors. A recent study of this program found that it is significantly effective with improving behaviors of first-time/new parents. Problem - Management of infant crying. It is recommended for the State Team to review the current state of the All Babies Cry Program; it is presently geared toward first-time/new parents. The scope of the program should also include such training for other types of caregivers, i.e. babysitters. On DPH's website there are fact sheets available in several languages. However, the media educational materials are not universally accessible. Furthermore, these programs should be specific and financially practicable for hospitals as there is the need for more financial resources to implement these programs. To prevent future untimely deaths, there is the need for a funded, well-constructed, and universal training program.

Injury:

- Additional funding for education on bicycle safety and helmet use geared toward adolescents;
- Provide bike rental companies information on bike helmet use including having helmet and bike rented together (with possible incentive);
- Add signage at strategic location for bike riders (i.e. bike trails);
- Public awareness campaign to bike stores, bike rental companies, rails to trails, ferries to islands;
- Junior operators are allowed, but not required, to obtain both Class D and Class M permits at the same time. In order to receive a Class M license, a junior operator must meet all of the requirements for a Class D license but the same is not a prerequisite when obtaining a learning permit. To prevent future untimely deaths, it is recommended for the State Team to review our Junior Operator Law (JOL); it presently allows children under

the age of 18 to operate motorcycles on the road unsupervised prior to mastering the necessary skills for operating both automobiles and motorcycles. The risk of injury, particularly death, is significantly higher within a motorcycle versus an automobile;

- The State team should consider a concerted effort to encourage the use of current evidence-based psychotherapeutic practices by Children's Behavioral Health Initiative providers. The State team should also consider a concerted effort to allow psychotherapeutic practices in which the therapist primarily works with the parent/guardian, when the identified patient has disruptive or dysregulated behavior problems;
- The State team should consider the standard protocols for state truck inspections, should require truck drivers to check/inspect trucks pre-trip, including brakes, in addition to annual inspections;
- The State team should consider reviewing current practices of bike safety and education for children and families;
- We recommend that parents be reminded about the importance of first aid and CPR, including the Heimlich maneuver. We would like for community education and opportunities for training on first aid to be more readily available;
- We recommend that physicians and pharmacies instruct patients and their families to whom they prescribe MAOI drugs about the hazards of mixing those drugs with others. We recommend that verbal and written instructions accompanying the prescription for MAOIs mandate that the drugs be kept in a locked, secure place. We would recommend that DPH and/or the proper governing authority make these needs clear to physicians and pharmacists;
- For these tragic accidents, we recommend the addition of constructive places for recreation for teens and tweens to play in urban areas, like skate parks and fields;

Natural:

- Hospitals should make referrals to home visiting programs for high medical risk infants/children;
- DPH and/or Children's Trust should fund home visiting for high medical risk infants for first year of life (8-10 visit minimum);
- Polysubstance abusing mothers - What is the number of pre-mature/early infant death cases on an annual basis in MA where mom is a suspected user of prescribed or illegal narcotics (high risk situations)? Concerns of sub Oxone use with other prescribed or illegal narcotics - Need to educate both physicians and their patients as to the lethal mix that can occur if there is sub Oxone use and patient does not reveal such use to a prescribing physician. Education campaign warning of the dangers of co-mingling additional narcotics with Suboxone use;
- The State Team should consider the need to increase the capacity of the Department of Children and Families' (DCF) involvement with Parent Aides. More parental and familial support is needed in the home pre and postpartum. Currently, Parent Aides are not employed by DCF; they are trained service providers contracted from outside agencies. Multiple problems exist with this arrangement: 1) DCF has a limited number of contracted "spots" 2) Although Parent Aides are mandated reporters, their alliance with the family could contribute to delays in reporting to DCF. Increasing these resources and placing them closer to, or within the agency, will improve prevention services and speed identification when prevention services are inadequate or breaking down;
- Have DPH calculate how many allergy deaths there have been for children in the Commonwealth. Reach out to community organizations dealing with allergies to help in outreach and messaging surrounding awareness and best practices for parents of children with allergies. Recommend medical team working with high-risk patients conduct home inspections to ensure environment is appropriate for the child and won't exasperate their medical condition. Recommend medical team working with families who have children with allergies talk to the family about the importance of taking medications on time, recognizing the signs of an attack, understanding how quickly an attack can turn fatal, and having parents closely monitor and supervise the use of medication. Develop application to monitor asthma for children at risk of hospitalization. Doctors would be able to check levels, refill prescriptions & have open line of communication with parent/child;

Department Response: The Department appreciates the collaboration between the Statewide Child Fatality Review Team and other state agencies (i.e. MDPH, DOT, DOE, etc.) and will continue to support inter-agency collaboration of behalf of consumers in all systems. The Department will continue to provide staff resources and continue to actively participate in these efforts to increase the capacity to reduce child fatalities and near-fatalities in the Commonwealth of Massachusetts. Recommendations are being reviewed and referred to the appropriate individuals/programs for follow-up.

Family Advisory Committee (FAC)

Recommendation 1: Continue to assist DCF with the inclusion of community/parent participation to ensure that parent input happens at all levels in the Department including program planning, policy development, and the delivery and monitoring of DCF services; Increase parent participation in Area Boards and all areas where decisions are being made that impact the lives of families and children.

Recommendation: Continue to develop relationships with Area Directors/Area Offices to assist with board development and strategies for recruiting former consumers for area boards, FELTs, TILTs and other areas where family voice helps the work. Assist Area offices/Director of Family Engagement, with the interview process/nominating committee for the engagement of community representatives in all areas of DCF work. (Caring Together proposals, Permanency Planning Training, Area Boards, etc.);

Recommendation: Continue to provide support and mentoring to new recruits and learning opportunities to all members. All FAC members are responsible for mentoring and helping the new members along.

Recommendation: To continue to assist the Ombudsman's Office with complex cases, 7 Family Liaisons will receive referrals from the Ombudsman's office and assist clients navigating the system.

Recommendation: To continue to represent Family /Alumni perspective on Regional Clinical Review Teams (CRTs) to assess social work practice and re-evaluate case determination. (Currently only have representative on Northern team).

Recommendation: To continue to co-facilitate *Foundations of Health and Wellbeing* trainings for new social workers, supervisors and Area Program Managers to highlight the interconnection of protective factors.

Recommendation: Continue co-training for the CWI in the training of new Social Workers, training the field on changes in policy, facilitating interactive learning and dialogue regarding culture, resiliency, child/youth, fathers' inclusion in the family and birth family perspective.

Recommendation: Continue to represent on the *Massachusetts Child Trauma Project* Steering Committee family voice/alumni perspective in the integration of trauma informed and trauma focused practice.

Recommendation: Continue to assist the department in the implementation, training, and coaching of the use of the Assessment and Action Plan tool, including the collaboration with families.

Recommendation: Continue to assist the Department in the practice of engaging fathers who have children involved in the child welfare system; Identify and recruit fathers for the FAC and other leadership roles (such as participation in Father Speak at Area Offices and membership at statewide meetings); Support the Family support groups—this will be available as requested; Assist DCF in identifying, opening, and providing services for all fathers; Assist DCF in developing a system to measure and assess progress on all aspects of fatherhood engagement; Address trauma and domestic violence in the work with fathers.

Recommendation: Continue to assist the Department with getting systematic feedback from the families it serves on the effectiveness of its interventions and practice; Administer survey to families involved with DCF. Assist the Commission on the Status of Grandparents Raising Grandchildren in the implementation of their mission; Identify local or statewide funders to maintain the support groups; Assist the Commission on the Status of Grandparents Raising Grandchildren in convening the leadership of grandparents groups on a quarterly basis; Quarterly update on the Support Groups List; Provide Support, information and referral to grandparents who seek assistance; Responsibility for maintenance and update on the Grandparents Raising Grandchildren Website.

Recommendation: Establish and continue to support the Mother/ Father Clinic at the Suffolk Family Court in conjunction with Chief Justice Ordonez; Work with Department of Revenue Family/Father Engagement to understand their culture and how it may impede their ability to effectively engage and serve fathers and consequently families.(DOR Workgroup with Director of Fatherhood Engagement); Work across the Secretariat to identify collaboration efforts to address the needs of families throughout the Commonwealth.

Department Response: The Department will continue to facilitate FAC meetings with Area Directors/Area Offices to identify strategies to recruit former consumers for area boards and FELT teams; FAC members should meet to confirm a plan for working with the Park Street Office. The Department also supports the development of a strategy for FELT teams in Area Offices and for the PAC to meet with 29 Area Board leadership to strategize vision and needs of the Department regarding community supports; The Department continues to support FAC members to recruit and recommend community representatives; The FAC will ensure that the interview process is the same for all consumers and community members; FAC members should continue to engage Area Offices in making recommendations of former consumers for the Boards. The FAC should continue to participate in training (since 2011 these trainings have been offered); Continue to conduct 7th Foundations of Health and Wellbeing; Continue systemic review of substance abuse protocol; and continue to work on the re-design of DCF intranet tools; The goals for the Department are in line with those for the FAC. The Department will continue to address the FAC's goal to improve the "disconnect between what the upper management says and what the middle management allows happening in the field". The service plan, as is, generated a lot of discussion. The Department believes that the service plan is where the commitment of family voice exists. A recent working group had done a lot of work regarding the service plan and will need follow-up. The Department also requests that the FAC to continue to discuss provider performance and how to make providers more accountable for the services provided. We appreciate all the work of the FAC, and their ongoing efforts to complete customer satisfaction surveys to incorporate consumer/family input.

Youth Advisory Boards

Recommendation: The Department's Youth Advisory Board has been active for more than 16 years. Presently, there are 35 members of the Regional Youth Advisory Boards who are committed to promoting change for future foster youth through their voice, advocacy, and action. As a new Citizen Review Panel, the Department should continue to support the Youth Advisory Board and allocate funds to expand services;

Recommendation: The Youth Advisory Boards should continue to provide recommendations to the Department on services, policy and practice. They should continue their efforts to try and ensure that foster youth are known for their strengths, achievements, goals and not labeled negatively;

Recommendation: The Regional Youth Advisory Boards should continue to meet monthly, providing a forum for youth in out-of-home placement to voice their concerns and offer suggestions to the Department on issues facing youth in care. Delegates from each Regional Board sit on the Central Office Advisory Board; they are statewide representatives for their peers' interests, concerns, and questions. The agenda topics for each meeting are jointly

developed by the Board members based upon their own ideas/concerns or those of the youth they represent and by DCF administration – often seeking youth input on policy, programming, etc.;

Recommendation: The Youth Advisory Board should continue to work with youth, their families and DCF staff to better understand the challenges and risks facing transition age youth/young adults as they leave agency care. The Board has developed an array of services to help prepare them with the skills and supports to successfully manage the struggles of adulthood. Using stakeholders' input, the agency has focused state and federal funded programming on assisting youth and young adults build strong foundations for success - addressing their needs for permanency, safety and the many facets of well- being. Educational achievement and life skill mastery with permanent connections to family and/or other caring enduring relationships with adults are the goals for our youth. These services span program models from foster care to congregate care as well as aftercare and should continue to be providing in the future;

Recommendation: DCF should continue to obtain ongoing feedback from the youth and young adults served, to help inform policy and practice that effectively addresses the needs of youth. The Regional Youth Advisory Boards and the MA Network of Foster Care Alumni are vital partners guiding agency service planning and delivery. The efforts of the Board members over the years have resulted in the Foster Child Tuition and Fee Waivers, the Foster Child Grant, core aspects of the "sustaining connections with transition age youth" in the Permanency Planning Policy, foster parent recruitment/training as well as guidance to both DCF and the state Department of Housing and Community Development (DHCD) in the creation of the subsidized housing program for former foster youth – Youth Transitioning to Success Program. The Department should continue to provide funding and staffing to continue to support these programs.

Department Response: The Department is pleased to add the Youth Advisory Boards as our 2016 citizen review panel. The input and feedback we obtain from the Board are a voice for youth within our system. We are committed to continuing to provide services to high risk youth and to support the continued work of the Youth Advisory Boards, MA Network of Foster Care Alumni and other stakeholders who serve youth and their families.

Commonwealth of Massachusetts

Department of Children & Families

Statistical and Supporting Information

Commonwealth of Massachusetts
Department of Children & Families
CAPTA State Annual Data Report

1. Information on Child Protective Service Workforce: For child protective service personnel responsible for intake, screening, assessment, and investigation of child abuse and neglect reports in the State, report available information or data on the following:
 - information on the education, qualifications, and training requirements established by the State for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;

**DEPARTMENT OF CHILDREN AND FAMILIES
SOCIAL WORKER QUALIFICATIONS**

Social Worker A/B: - Job Grade: 19, Bargaining Unit 8

MINIMUM ENTRANCE REQUIREMENTS

Required work experience:

None

Required education:

- A Bachelor's or higher degree.
- A Bachelor's or higher degree in social work, psychology, sociology, counseling, counseling education, or human services is preferred for positions in the Department of Children and Families.

Licenses:

- Current and valid licensure as a Licensed Social Work Associate, Licensed Social Worker, Licensed Certified Social Worker, or Licensed Independent Clinical Social Worker by the Massachusetts Board of Registration in Social Work **OR** certification as a child protective worker as permitted by state law is required.
- Based on assignment, a current and valid Massachusetts Class D Motor Vehicle Operator's license or the equivalent from another state may be required.

Social Worker C, Job Grade 20, Bargaining Unit 8

MINIMUM ENTRANCE REQUIREMENTS

Required work experience:

At least two years of full-time, or equivalent part-time, professional experience as a licensed social worker or after certification as a child protective worker as permitted by state law.

Substitutions:

- A Master's degree in social work, psychology, sociology, counseling, counseling education, or human services may be substituted for one year of the required experience on the basis of two years of education for one year of experience.

- A Doctorate in social work, psychology, sociology, counseling, counseling education, or human services may be substituted for the required experience on the basis of two years of education for one year of experience.
- One year of education equals 30 semester hours. Education toward a degree will be prorated on the basis of the proportion of the requirements actually completed.

Required education:

- A Bachelor's or higher degree.
- A Bachelor's or higher degree in social work, psychology, sociology, counseling, counseling education, or human services is preferred for positions in the Department of Children and Families.

Licenses:

- Current and valid licensure as a Licensed Social Work Associate, Licensed Social Worker, Licensed Certified Social Worker, or Licensed Independent Clinical Social Worker by the Massachusetts Board of Registration in Social Work is required.
- Based on assignment, a current and valid Massachusetts Class D Motor Vehicle Operator's license or the equivalent from another state may be required.

Social Worker D (Supervisor), Job Grade 23, Bargaining Unit 8:

Required Work Experience:

At least three years of full-time, or equivalent part-time, professional experience as a licensed social worker or after certification as a child protective worker as permitted by state law. Based on assignment to second-level supervisory positions, at least one year of experience must have been in a supervisory capacity.

Substitutions:

- A Master's degree in social work, psychology, sociology, counseling, counseling education, or human services may be substituted for one year of the required non-supervisory experience on the basis of two years of education for one year of experience.
- A Doctorate in social work, psychology, sociology, counseling, counseling education, or human services may be substituted for the required non-supervisory experience on the basis of two years of education for one year of experience.
- No substitution will be permitted for the required supervisory experience. One year of education equals 30 semester hours. Education toward a degree will be prorated on the basis of the proportion of the requirements actually completed.

Required education:

- Adoption, Foster Care, Assessment, Child Welfare Social Worker, Investigation, or Screening assignments: A Master's or higher degree in social work, psychology, sociology, counseling, counseling education, or human services is required.

Licenses:

- Current and valid licensure as a Licensed Social Work Associate, Licensed Social Worker, Licensed Certified Social Worker, or Licensed Independent Clinical Social Worker by the Massachusetts Board of Registration in Social Work is required.

**Demographic/Education Information – see chart on following page
and in Appendix**

Higher Education of Social Workers			
	1. number of social workers and supervisors who have a bachelors' degree in social work	2,783	Count of SW A/B, C, and D who have a bachelor's degree or higher. DCF does not have data on specific scope of study. Data as of 1/23/16 payroll snapshot
	2. number of social workers and supervisors who have a masters' degree in social work	743	Count of SW A/B, C, and D who have a master's degree or higher. DCF does not have data on specific scope of study. Data as of 1/23/16 payroll snapshot
Licensure of Social Workers			
	1. total number of social workers	2,883	Count of SW A/B, C, D as of 1/23/16
	2. total number of social workers holding licensure by level		
	LICSW	132	
	LCSW	399	
	LSW	659	
	LSWA	1,373	
	Total	2,563	

Caseloads

The Department's caseloads continue to remain at historically high levels driven by the increasing complexity of families with young children open with the Department exhibiting multiple risk factors, including substance abuse (opioids), mental health issues, domestic violence and unresolved childhood trauma. The recently revised Intake and Supervision policies should help address caseloads. More policies are in development for 'release 2' of the agency improvement initiative.

The Department continues its efforts to reduce caseloads for workers with the goal of achieving a weighted caseload standard of 18:1. To date the Department has hired 270 social workers. Budget proposals for FY17 include funding for a significant increase in social worker staff.

Additional Statistical and Supporting Information

1. Juvenile Justice Transfers

- **Report the number of children under the care of the State child protection system who were transferred into the custody of the State juvenile justice system in Federal FY 2015 (specify if another time period is used).**

DYS sent DCF a file of youths committed during cy2015. The file had 379 records of which 3 were duplicates based on DYS MID NUMBER and commitment status start date. The duplicates were removed. Of the 376 records, 318 were matched.

132 were never in DCF custody

103 - custody ended prior to the commitment date

67 - custody continued after the commitment date

16 - custody ended on the commitment date and are considered for federal purpose to have “transferred” to DYS custody.

2. Sources of Data on Child Maltreatment Deaths

- **Describe all sources of information relating to child maltreatment fatalities that the state agency currently uses to report data to NCANDS;**

Massachusetts reports child fatalities attributed to maltreatment only after information is received from the Registry of Vital Records and Statistics (RVRS). Information used to determine if the fatality was due to abuse or neglect also include data compiled by the Department of Children & Families’ Case Investigation Unit and reports of alleged child abuse and neglect filed by the state and regional child fatality review teams convened pursuant to Massachusetts law. As these data are not available until after the NCANDS Child File must be transmitted, Massachusetts reports counts of child fatalities due to maltreatment in the NCANDS Agency file.

- **If the State does not use information from the State’s vital statistics department, child review teams, law enforcement agencies and medical examiners’ offices when reporting child maltreatment fatality data to NCANDS, explain why any of these sources are excluded.**

Massachusetts does use information from the Massachusetts RVS, child fatality review teams, reports filed by law enforcement agencies and information from the medical examiner when reporting child maltreatment fatality data to NCANDS.

- If not currently using all sources of child maltreatment fatality data listed in the previous bullet, describe the steps the agency will take to expand the sources of information used to compile this information.

This is not applicable to DCF.

3. Education and Training Vouchers

- **Identify the number of youth who received ETV awards from July 1, 2014 through June 30, 2015 (the 2014-2015 School Year) and July 1, 2015 through June 30, 2016 (the 2015-2016 School Year). States may estimate totals if they do not have the total number for the 2015-2016 School Year.**

Please see the Chafee/ETV report section of the APSR for this information.

4. Inter-Country Adoptions

- **Report the number of children who were adopted from other countries and who entered into State custody in FY 2015 as a result of the disruption of a placement for adoption or the dissolution of an adoption, the agencies who handled the placement or the adoption, the plans for the child, and the reasons for the disruption or dissolution. (See section 422(b)(12) of the Act.)**

The Department reviewed the cases of children who entered care during federal fiscal year 2015 and who were previously adopted. The Department is not able to identify children who meet the criteria for entering as a result of a disruption of an intended international adoption and found 1 child who experienced a dissolution of an international adoption. This child was adopted from the Ukraine at 13 years of age. The name of the agency is listed as "UK"; no other information is available in regard to the agency. The adoption was dissolved because of the adoptive parents' inability to cope with child's aggressive and defiant behavior.

5. Monthly Caseworker Visit Data

- **States are required to collect and report data on monthly caseworker visits with children in foster care (section 24(f) of the Act). Data for FY2016 is to be reported separate from the 2017 APSR and will be due for submission to CB by December 15, 2016.**

DCF submitted the required information on December 16, 2016.

Services for Children Adopted from Other Countries 2016 Update

- Describe the activities that the state has undertaken to support the families of children adopted from other countries.
- Describe the activities the state plans to take over the next five years to support children adopted from other countries, including the provision of adoption and post-adoption supports.

The Department of Children and Families contracts with a lead agency to provide post-adoption services for all families in the Commonwealth, including families of children adopted from other countries. The contract with *Adoption Journeys* has been in place since 1997; it is anticipated that this contract will continue in effect from 2015-2019. *Adoption Journeys* provides services through private agencies; the Department believes that having a private agency provide post-adoption services is less threatening to families than requiring them to work directly with the state's child protection agency.

Adoption Journeys provides information and referral services to adoptive families. An "800" number is answered live 24 hours/day, 7 days/week. There is also a component of the contract designed to educate therapists, attorneys, judges and others who may work with adoptive families. *Adoption Journeys* has also conducted statewide professional conferences in collaboration with UMass Medical School's Office of Foster Care and Adoption.

Other contract services include:

- **Regional Response Team:** Offering post-adoption support in Massachusetts, the response teams are made up of adoption competent staff which include a social worker, parent liaison and team leader. These brief supportive services offer families joint problem-solving, coordination of services as well as home-based counseling.
- **Parent and Youth Support Groups:** Support groups are led or co-led by adoptive parents, adopted youth, social workers or clinicians. Most meet once a month and some are cosponsored with other organizations. All support groups are open to new members and additional support and psycho-educational groups are formed as need are identified.
- **Parent and Young Adult Liaisons:** Individuals and families requesting a liaison are matched as closely as possible according to the needs, interests and expectations of all involved. Geography, life experiences, diversity and the family's style of relating are some of the areas considered in making a match. Ongoing support and training are offered to families participating in this program.
- **Adoption Competency Training:** Training opportunities are available for professionals interested in enhancing their work with adopted children and their families.
- **Respite Care:** Respite care is available on a time-limited and planned basis for hourly, daily or overnight care. These brief supports can help to alleviate stress, strengthen family relationships or respond to an unanticipated family event. Limited respite services are available to families in or out of their home. These services are matched as closely as possible according to the needs and ages of the child(ren), geographic area, family characteristics and dynamics. Ongoing support is offered to families participating in respite.

Any adoptive family in Massachusetts can access the post-adoption services. Approximately 30% of the families working with *Adoption Journeys* in 2013 and 2014 were infant, private or international adoptions.

Commonwealth of Massachusetts

Department of Children & Families

Targeted Plans with the 2015-2019 CFSP - Updates

Commonwealth of Massachusetts

Department of Children & Families

Foster and Adoption Parent Diligent Recruitment Plan Update

Foster and Adoption Parent Diligent Recruitment Plan Update

In the APSR, describe the State's progress and accomplishments in implementing the state's 2016-2017 Foster and Adoptive Parent Recruitment Plan.

The Massachusetts Department of Children and Families continues its commitment to recruiting foster and adoptive parents that reflect the ethnic and racial diversity of the children in its care and custody. Local DCF offices are especially active in recruitment efforts at the grass roots level in order to identify resources which allow children to maintain vital connections in their communities, including kin, school, and other significant relationships.

It is through local community events and activities that the public is made aware of the Department's need for foster and adoptive families. DCF continues its partnerships with the Massachusetts Adoption Resource Exchange (MARE) and with Jordan's Furniture. Our private/public partnership has enabled the Department to improve the quality and effectiveness of our recruitment efforts.

Recruitment Events, held annually:

- Walk/Run for Adoption, MARE, May, 2016
- Adoption/Foster Care Information Weekend, June, 2016
- Summer Adoption Mixer, Assumption College, August, 2016
- Adoption Option, October, 2016
- National Adoption Day, November, 18, 2016
- Adoption Parties, across the state

While DCF continues to participate in large statewide adoption recruitment events with our private/public partners we also hold a number of smaller adoption parties in our five regions across the state. These smaller parties have proven to be successful venues which bring approved pre-adoptive families and children with a goal of adoption together.

In the months of May and June, 2016, DCF will hold one large recruitment event in each of our five regions, for the recruitment of foster families. To date three regions have held these events which brought together staff and foster families to talk about the need we continue to have for foster families. The message that we are trying to deliver is that there is a continuance need for foster families and we are trying to bring this awareness into the communities in which we serve.

During these events each area office within the region has had the opportunity to speak about their individual needs. One office needs foster families to care for infants; another office needs families to care for school age children, etc. At each recruitment event we talk about the need for foster families in specific cities and towns. The general public needs to hear that foster children come from all city and towns throughout our commonwealth and therefore foster families are needed in these communities.

DCF always gives first consideration to placement with a relative or member of a child's extended family. As reported in the 1st Quarter of FY 2015, 45% of children placed in departmental foster care were placed in kinship foster care homes. DCF has 2,113 kinship/child specific foster homes and 2,145 unrestricted foster homes, for a total of 4,258 foster homes under the direct supervision of DCF. This is a 4% increase in kinship/child specific homes and a 1% decrease in unrestricted foster homes, as compared with the 4th Quarter of FY'2014 report.

Over the course of this past year we have continued to offer MAPP TOT (Massachusetts Approach to Partnership in Parenting, Trainers of Trainers) to staff in order for our area offices to have an adequate number of staff trained and ready to provide training to our foster and adoptive applicants. Due to early retirements and the resulting turn over in our foster care units the need for TOT groups continues. MAPP groups can be organized to run on a continuance basis, referred to as Rolling MAPP. This allows for applicants to start training as soon as they are ready and not have to wait for a group to start. We have several offices conducting MAPP groups in this format. Other offices have opted to stay with the ten-week session, which they hold several times a year.

APSR 2017:

Department of Children and Families maintains a full time Foster Care and Adoption Recruitment Unit that is part of the Foster Care, Adoption and Adolescent Services Division. DCF had maintained two Recruitment Supervisors that assisted the Area Offices with their recruitment plans and activities. The supervisors were also responsible for coordinating statewide recruitment events, responsible for receiving calls through the 1-800 recruitment line; supervise the Foster Care Recruitment Ambassadors which are housed at each of the 29 Area Offices. One Supervisor had been promoted and we were fortunate to be able to hire two new recruitment supervisors, for a total of three recruitment supervisors to cover five regions.

With the Central Office Recruitment Unit now having three Recruitment Supervisors we have begun to conduct statewide recruitment outreach. For example: attending multi-disciplinary team meetings at several Boston hospitals, attending various statewide community groups, and overall attempting to conduct outreach that will benefit all of our 29 area offices.

A long term plan for DCF is to have recruitment social workers in each area office. This plan has not been finalized but is moving closer to finalization and should it come to fruition we would be in a position to have three Recruitment Supervisors, assigned here to Central Office, available to work with area office recruiters on a much needed focused recruitment plan.

As staffing changes have occurred, within our division, we are in a much better position to offer area offices the supports they need to be successful recruiters.

DCF has no restrictions in any of its recruitment policies that would limit our ability to recruit foster & adoptive families that reflect the diversity of the children in care. Both DCF's foster care and adoptive recruitment materials state the following:

“DCF does not discriminate on the basis of race, creed, color, religion, age, ancestry, marital status, sex, sexual orientation, gender identity or expression, language, disability, veteran status, or national origin.”

Indicate if there are any changes or additions needed to the plan. In a separate word document, provide information on the change or update to the Foster and Adoptive Parent Diligent Recruitment Plan, if any.

- There are no changes or additions needed for the DCF Foster and Adoptive Parent Diligent Plan

Commonwealth of Massachusetts

Department of Children & Families

Health Care Oversight and Coordination Plan - Update

Commonwealth of Massachusetts

Department of Children & Families

Health Care Oversight and Coordination Plan - Update

DCF HEALTH CARE OVERSIGHT AND COORDINATION PLAN

2016 Update

The DCF Health Care Oversight and Coordination Plan builds upon and revises previously submitted plans. The Department continues to strive to strengthen our efforts to ensure that children in the care and custody of the Department receive routine health care and that their specialized medical needs are addressed. These efforts have included increased collaboration with other state agencies and the medical community, as well as working toward enhanced integration of medical and behavioral health care.

I.A. Schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.

DCF Policy on Medical Exams for children entering DCF care or custody. In 1998, the Department established a directive that all children in DCF custody receive medical screening examination within 7 days of placement and a comprehensive medical examination within 30 days of entering out of home placement.

This directive was subsequently formalized in agency policy. The policy provides greater detail about the role of the social worker, foster parent, and healthcare providers in scheduling, coordinating, and communicating the findings. This policy also specifies that all children in DCF custody receive healthcare in accordance with the EPSDT periodicity schedule. The policy is reviewed with new social workers during pre-service training and is posted on the DCF intranet.

Foster Care Clinics The Department collaborated with Children's Hospital in Boston and U Mass Memorial Medical Center pediatricians to establish health care clinics that are specifically focused on providing the required medical screening and comprehensive examinations for foster children in Boston and central Massachusetts. Following the examinations, the clinic sends the DCF social worker the physician's written report summarizing the visit and any recommendations for follow up care. The UMass Clinic, called FaCES (Foster Children Evaluation Services), sees approximately 500 children who have been newly placed in foster care each year.

Compliance Reports The Department collects data to track which children have received the 7 and 30 medical appointments in compliance with DCF policy. Child-Specific data include each child who had a home removal episode within the last sixty days, whether appropriate examinations were done, and the date the examinations were documented in the electronic case record, FamilyNet. This report is sorted by Area and Region and includes the unit and social worker assigned to the case. The Aggregate Compliance data include the number and percentage of required exams that are documented in FamilyNet as having been completed. Timeliness of data entry of medical appointments and compliance with visits continue to be areas requiring ongoing focus.

Access to MassHealth EPSDT and Claims Data Children in DCF care or custody are eligible for Medicaid through MassHealth. The DCF Health and Medical Services Team (HSMT) has access to information from the MassHealth system regarding healthcare services provided to DCF involved children. The HSMT has the ability to request All Services Reports directly from MassHealth for children in DCF custody in specific cases where past provider or medical treatment information is not

accessible. The HMST collects child-specific data on an ongoing basis to track children who are in hospitals and group care placements needing a more appropriate disposition plan.

The HMST collaborates with healthcare providers, the Caring Together teams and community-based home care agencies to identify establish the necessary nursing services for children in group care placements. The HMST has identified youth with diabetes as a major healthcare issue for DCF-involved children and are tracking data on the youth statewide. DCF is working with MassHealth to obtain claims data on children in placement that provide information regarding the medical conditions of children and will allow identification of the degree to which appropriate healthcare services are being obtained, with a specific focus on areas such as diabetes and antipsychotic medications.

Areas for Enhancement / New Initiatives

- As the Department transitions from its legacy electronic case record FamilyNet to a web based electronic case record, i-FamilyNet, enhancements will be pursued to provide prompts to social workers to enter data regarding 7 and 30 day medical exams, and modify health care screens to gather additional information about the child's health and well-being.
- Training provided to new supervisors is being enhanced to strengthen supervisors' understanding of the importance of monitoring children's healthcare status in regular supervision with workers.
- The contracts for Caring Together (a joint initiative between DCF and DMH for congregate care services) set forth additional expectations regarding the availability of nursing staff within these programs. The Action Planning Group on Medical Exams and Services was convened in April 2014 and met over the next two months. The goals of this group were to :
 - a. Identify challenges and opportunities to improve access to health screening and medical services for children in DCF care and custody;
 - b. Increase compliance with the medical examination policy; and
 - c. Review and recommend any changes to existing health care-related policies to strengthen and/or reflect best practices

This group was led by Linda Sagor, DCF consulting pediatrician and Jessica Coolidge, DCF medical social worker and includes social workers, a DCF nurse, foster parents and representatives from DCF leadership. The final report, completed in June 2014, listed nine recommendations:

1. **Each area office should have one person who is responsible and accountable for ensuring that all relevant medical information** (chronic diagnoses, recent acute diagnoses, medications, allergies) is obtained and communicated to social worker and foster/kinship parent within 24 hours of child entering placement. During weekends and holidays this function might be performed centrally with an "on call" schedule. In addition to collecting necessary information, this person would be accountable for ensuring adherence to the medical examination policy.
2. **The importance of trauma-informed medical care and compliance with policy should be communicated in all forums**, from Area Office meetings with field workers to statewide managers meeting. The Commissioner and senior leadership need to stress that complying with

policy is **high priority**. Monthly statistics should be communicated to managers in their usual management report (in addition to the “Medical Visits Needed” report).

3. **An electronic system of communication from medical offices** and health centers to DCF should be developed so that information can be quickly and reliably transferred. In many offices with an Electronic Health Record system, a health form can be generated and sent via pdf. This would eliminate the current paper passport system which is outdated, inefficient, and simply does not work. The Massachusetts Health Information Highway (HIway) might be utilized for this purpose.
4. The current policy (with rigid guidelines for timing of screening and comprehensive medical visits) should be revisited and updated. Specifically, a system of **triage** should replace the current policy. An example of such a triage system is attached. Of course a triage system would require that DCF has current medical information on *every* child as soon as (but no later than 24 hours after) they enter placement.
5. **A policy on psychotropic medication utilization should be developed for our population of children.** The pharmacy section at Commonwealth Medicine/UMass has been working on an electronic algorithm to determine inappropriate medication prescribing practices. Several issues need to be resolved prior to implementation: Should this policy be instituted for all children on Medicaid insurance, or just children in foster care? What will be the protocol for prescriptions that do not meet criteria, i.e., what will be the levels of review (and who will be the personnel reviewing) to determine if medication prescription can be filled?
6. Efforts to **promote collaboration between the medical community and DCF** are essential. Strengthening this relationship would promote greater understanding of each other’s cultures and lead to a commitment among medical providers to understand the medical/behavioral health issues of children in foster care, to provide trauma-focused care, and to allow ready access for medical visits in healthcare providers’ offices. Currently a Center for Medicare and Medicaid Innovations grant is pending with a goal of developing **medical homes** for children in foster care in practices that are already seeing many of these children.
7. Additional **education and training** about medical/behavioral health issues should be provided to all DCF staff. Consultation about medical issues should be readily available from an Area Office RN, or Nurse Practitioner).
8. **Public health campaigns** should be undertaken, with DCF as the lead, to address medical issues of critical importance to our population; currently SIDS prevention is of high importance.
9. Consideration should be given to creating a position of **medical director** for the agency. This person would supervise all nursing staff, be available for medical consultation, and be a

participant in senior leadership team. This person would be accountable for compliance to medical policy throughout the state.

As a result of these recommendations, the Department developed an agreement with Commonwealth Medicine at the University of Massachusetts Medical School to hire a full-time medical director and medical data analyst as well as a part-time psychiatrist. In addition, they agreed to consider, on the advice of their pediatric consultant, hiring a medical social worker in each of the 29 Area Offices. This medical social worker, working with colleagues in the Area Office, would be responsible for ensuring that all children in DCF care and custody receive appropriate medical care.

In January 2016, Linda Sagor, MD, MPH became the first medical director of Massachusetts DCF. As a condition of her hiring she had requested funds to hire 29 medical social workers, one for each area office. Recruitment began immediately and on May 31, 2016, nine medical social workers began work in the Worcester East, Worcester West, Lawrence, and Cambridge, Fitchburg, Whitinsville, Lynn, Lowell, and Malden offices of the Central and Northern regions. Their initial training included presentations on the history of medical services at Mass DCF, the trauma issues of children in foster care, and information on various insurance concerns. On June 9 they reconvened for a second training which provided information on the medical issues that are managed by the nurses in the HMST, appropriate healthcare and medical issues to refer to the regional nurses, MassHealth and health insurance, care coordination, processes for obtaining medical records, and how to make appointments in medical offices. By December 1 2016, 18 medical social workers had been hired and started in their respective area offices. It is expected that all 29 will be hired by March 31, 2017. Compliance statistics for medical policies have improved greatly in all offices with a medical social worker, from **40-300%** in a few months time.

Dr. Sagor has been working with members of the DCF IT group to develop a statewide Home Removal Episode report so that medical social workers would have a daily report to keep track of the children coming into custody in order to ensure that they receive their initial screenings and their comprehensive medical assessments on time. This report is almost ready for production; the medical social workers got a preview at their training in June and were very optimistic that this would be a good tool for their work.

At the DCF Statewide Managers meeting in May and at the first presentation to the new medical social workers, Dr. Sagor stressed the current priorities:

1. Medical social workers will be the champions for all medical, psychiatric, dental, and developmental issues for children in DCF care and custody.
2. All children coming into custody should have an initial screening, ideally within 7 days, and a comprehensive assessment within 30 days, preferably with their own PCP. If this visit is scheduled with another doctor, the medical social workers will get the previous medical records and send to the new medical provider.
3. All visits, medical conditions, medications, immunizations, allergies, and immunizations should be documented in iFamilyNet promptly.
4. Medical social workers will coordinate all follow-up care and ensure that children receive recommended care at designated times.

She also noted that, though these are the priorities at this time, the group will be open to learning about new concerns and areas that will require the attention of the Health and Medical Services Team in the coming months and years.

Interviews for medical social worker positions were held in Boston region in April and in Southern region in June; six excellent candidates have been identified for those regions and will start in August. Interviews will begin in the Western region in July. After that time, the medical social worker position will be reposted for those Area Offices that did not get one in the first round. All positions should be filled by late fall.

- Researched national trends and other state regulations, policy and practice relative to health care for children involved with child welfare systems to identify current best practices and lessons learned.
- Dr. Sagor, chair of the Foster Care Committee of the Massachusetts Chapter – American Academy of Pediatrics, met with committee members to discuss issues related to compliance with health screening policy. In addition she has had discussions with the presidents of the Massachusetts Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. Though they both indicated that many of their physician members give high priority to caring for children in foster care, they pledged the support of their organizations to improve access to all medical offices and community health centers in a timely manner.

II. How Health Needs Identified through Screenings Are Monitored and Treated

Comprehensive Coverage through MassHealth DCF has the ability to directly enroll children in its care or custody into MassHealth. Enrollment occurs in real time facilitating immediate access to insurance coverage.

WIC Qualification DCF involved children are eligible to receive WIC services and social work staff are well versed in the process for applying for these services.

Treatment While the child's caretaker (e.g., foster parent, group care provider, etc.) schedules and transports the child to medical care, the social worker is ultimately responsible for ensuring that identified healthcare needs are met. The HSMT is available to assist social workers if they have questions about needed medical treatment. The HSMT includes the Supervisor and two medical social workers who are located at the Central Office, 5 Regional Nurses, and a full time DCF Nurse Liaison located at Children's Hospital..

Forms to Support Information Exchange The HSMT developed forms (Dear Doctor Affidavit) to ensure that the social worker is fully informed about a proposed treatment, benefits and risks and potential complications. The physician completes these forms and returns to the social worker to support providing informed consent as the child's legal guardian.

Monitoring The Department has established a process for monitoring treatment after screening and comprehensive examinations. Healthcare providers complete an Encounter Form. The social worker

is then responsible for entering this data into the FamilyNet system. Once entered into FamilyNet, a Medical Passport is printed out; the medical passport includes the new information along with the medical history. The Medical Passport is designed to follow children between placements and updated as new information is available. FamilyNet also includes a Medical History document that is provided to caretakers.

The nurses from the HSMT are available to assist social workers in determining whether a specific medical treatment is routine or extraordinary in individual cases. Treatments that are determined to be extraordinary per DCF regulations require judicial review.

Special Kids/Special Care Program This collaborative effort between DCF, MassHealth and Neighborhood Health Plan is designed to provide care management by pediatric nurse practitioners to children who have unstable and/or complex medical conditions and intensive medical needs. This is a statewide program with approximately 150 children enrolled.

Complex Foster Care/Medical Program

The Supervisor of the HSMT manages contracts with two foster care agencies for specialized foster homes that serve the children with most intensive medical care needs. Currently the capacity is 11 children and the hope is that there will be expansion of several homes by the end of 2016 and that more of these homes will be established ongoing.

This program is a model of foster care that is designed to provide care and treatment supports to children and youth who require intensive medical care management and coordination. Foster families recruited to serve as foster homes receive extensive ongoing specialized training. The profile of children and youth who require this level of service includes children who require regular skilled and non-skilled home care, medical advocacy, complex medical management, services by numerous medical specialists, and often need a range of medical equipment. Such children experience or are at risk for life-threatening events and require intensive ongoing monitoring. Examples of children requiring this level of care include but are not limited to children who:

- a) Have tracheostomies;
- b) Require oxygen supplementation;
- c) Are ventilator dependent for all or part of the day;
- d) Are diagnosed with cancer and are receiving treatment;
- e) Are diagnosed with serious birth defects that impair their functioning and require skilled care;
- f) Have serious medical conditions resulting from prematurity; or
- g) Require intravenous or tube feedings and have complex or unstable medical conditions

Individualized Care Plans The agencies that administer the Complex Foster Care/Medical Program submits reports about the medical status of children in these homes to the Supervisor of the HSMT. For the Special Kids/Special Care Program, Neighborhood Health Plan (NHP) submits quarterly individual care plans to the HSMT and to the PCP and the substitute caretaker.

Areas for Enhancement / New Initiatives

- Future enhancements to the IT system as the Department moves to web-based i-FamilyNet will include combining the Medical Passport and Medical History forms. It is hoped that this enhanced efficiency will improve timeliness and consistency of data entry.
- Medical Residence Foster Homes will be re-procured. This will provide an opportunity to review the standards and expectations established for Medical Residence Foster Homes and to strengthen those as needed.

III. How Medical Information Will Be Updated and Appropriately Shared, Which May Include Development and Implementation of an Electronic Health Record

Electronic case record As noted previously, medical information on DCF children are entered into the DCF electronic case record, FamilyNet.

Encounter Forms This form is provided to the caretaker and completed by the physician and returned to the DCF social worker who enters the information into FamilyNet.

IV. Steps to Ensure Continuity of Health Care Services, Which May Include Establishing a Medical Home for Every Child

Information on Past Providers The HSMT has access to past medical providers through the information in New MMIS and by accessing the All Services Reports from MassHealth.

HMST and School Nurse Collaboration Increased collaboration between school nurses and the HMST helps to support continuity of medical care/information and to facilitate appropriate school accommodations and the sharing of relevant health-related information between the agency and school system.

Areas for Enhancement / New Initiatives

As noted in a prior section the Department is in the process of applying for a federal grant that will assist us in establishing medical homes for children in DCF foster care. This application will be a partnership between DCF, MassHealth, and the University of Massachusetts Medical School.

V. Oversight of Prescription Medications

Access to Consultation

DCF social workers have access to a comprehensive array of professionals who are available to provide consultation on any medication questions that arise. Social workers have access to regional nurses surrounding medication related questions. Nurses now have access to child psychiatric consultation through the Office of the Medical Director to discuss complex medication regimes. Mental Health Specialists are available in each Region to provide consultation on behavioral health care needs, planning discharges from psychiatric hospitals, and psychotropic medications. There are eight Child Psychiatrists, 6 DMH area psychiatrists and two Caring Together psychiatrists, employed by the Massachusetts Department of Mental Health, all of whom are also available to the DCF Social Workers for case

consultation. In addition, the HSMT has access to a pharmacist from the Drug Utilization Review Program at MassHealth to obtain clinical information and advice when questions arise that pertain to use of prescription or illegal drugs.

Medication Administration in Congregate Care

The Caring Together contracts for all congregate care services established new standards related to the administration of medication within these programs. Each provider is required to implement the Medication Administration Program outlined in the contracts which sets forth specific requirements for staff training and administration of medications for any child in these levels of service.

Monitoring Psychotropic Medications

CONSENT: Authorization, oversight, and financing of psychotropic medications for children in foster care in Massachusetts is a shared responsibility across multiple state agencies and the courts. DCF is the agency primarily responsible for coordinating medical care for children in its custody. Children in DCF custody receive their medical and behavioral health care from community providers (physicians, nurse clinicians, or other clinicians). Authorization or consent for routine medical treatment is given by the DCF social worker/supervisor. The DCF Social Worker records the information in the child's medical passport, discusses the proposed medication with the prescriber, and renders consent or declines consent for administration of the medication. The HSMT nurses, the Regional Mental Health Specialists, or DCF consulting psychiatrist are available to the DCF Social Worker should she or he have need for consultation at the time of deciding whether to render consent.

OVERSIGHT: With respect to oversight of medication treatment, primary responsibility is shared between DCF and MassHealth, the state Medicaid Program. Children in foster care are enrolled in MassHealth when taken into custody to ensure access to medical assessments and treatment. Children in foster care are primarily enrolled in a MassHealth managed care carve-out, currently administered by the Massachusetts Behavioral Health Partnership (MBHP).

Massachusetts currently has two mechanisms for psychotropic oversight for youth in care and protection of DCF. The Rogers process is specifically for youth in custody of DCF and applies to youth when DCF retains medical decision making for the youth. Pediatric Behavioral Health Medication initiative (PBHMI) is for all youth in Mass Health, whether or not there is DCF involvement. The Rogers process is also specifically for one psychotropic class of medication, antipsychotics, while PBHMI covers all classes of psychotropic medications.

Pediatric Behavioral Health Medication Initiative: In November of 2014, the Mass Health Pharmacy Program, in collaboration with the Department of Children and Families (DCF) and the Department of Mental Health (DMH), developed the Pediatric Behavioral Health Medication Initiative (PBHMI). This is a medication review program for all children on Mass Health, which includes youth in foster care, that requires a prior authorization (PA) from a physician when a concerning combination of medications is being prescribed. High risk prescribing practices are reviewed. Below is a list the combinations that will flag a PA to be done by the provider for medications to be approved by Mass Health.

1. Behavioral health medication polypharmacy: pharmacy claims for any combination of four or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, bupropion, cerebral stimulants, hypnotic agents, and mood stabilizers) within a 60 day period for members under 18 years of age; Please see link for full table of therapeutic class table: <https://masshealthdruglist.ehs.state.ma.us/MHDL/pubtheradetail.do?id=273>
2. Antipsychotic polypharmacy: overlapping pharmacy claims for two or more antipsychotics for at least 60 days within a 90 day period for members less than 18 years of age;
3. Antidepressant polypharmacy: overlapping pharmacy claims for two or more antidepressants for at least 60 days within a 90 day period for members less than 18 years of age;
4. Cerebral stimulant polypharmacy: overlapping pharmacy claims for two or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for at least 60 days within a 90 day period for members less than 18 years of age;
5. Benzodiazepine polypharmacy: overlapping pharmacy claims for two or more benzodiazepines for at least 60 days within a 90 day period for members less than 18 years of age;
6. Mood stabilizer polypharmacy: overlapping pharmacy claims for three or more mood stabilizers for at least 60 days within a 90 day period for members less than 18 years of age;
7. Any pharmacy claim for an antidepressant, antipsychotic, atomoxetine, benzodiazepine, bupropion, hypnotic or hypnotic benzodiazepine, or mood stabilizer for members less than six years of age;
8. Any pharmacy claim for an alpha2 agonist or cerebral stimulant for members less than three years of age.

Rogers Process

Since 1987, by DCF regulation, the DCF in Massachusetts has elected to consider the use of antipsychotic medication as extraordinary treatment. By doing so, DCF established a requirement that DCF seek judicial authorization (a "Rogers Order") prior to the administration of antipsychotic medication to a child in its custody. Through the Rogers process, a medical guardian ad litem is appointed, a hearing is held, and the petition (specifying medication(s), dosages, and rationale for administration of same) is granted or denied, as is, or at a modified dosage, by the judge. A new petition and hearing is required in a given case should the prescriber determine a clinical need for a dosage outside the initial authorization, or a need for a different antipsychotic than those authorized by the judge.

Child Psychiatric Consultation:

DCF social workers / supervisors have access to child psychiatric consultation when there are questions around psychotropic medications. Regional nurses often provide first line consultation around basic medication questions. For more complex questions, DCF has access to a child psychiatrist within the

office of the medical director to help guide treatment. For complex psychiatric treatment questions requiring face to face consultation, DCF can request consultation from a DMH psychiatrist. Area offices do also have consulting child psychiatrists for help with complex cases that can be accessed as well.

PCP's who are often the front line treaters for mental health needs in the foster care population have access to child psychiatric consultation through the Massachusetts Child Psychiatry Access Project (MCPAP). Established in 2002 this first-in-the nation-program was designed to provide quick access to child psychiatrist consultation for primary care providers.

Psychotropic Medications Steering Committee:

This committee formed in 2012 following the GAO 2011 report flagging concerns for inappropriate psychotropic medication prescribing for youth in foster care. This report followed the 2008 Office of the Child Advocate report which recommended that the authorization process for psychotropic medications be improved by adopting a more responsive and effective consent process.

The purpose of the Psychopharmacology Steering Committee is to continue to assess the use of psychotropic medication for children in foster care and monitor access to psychosocial supports provided to youth in foster care. The Steering Committee is co-chaired by the Office of the Medical Director and the DCF Commissioner, with representatives from the Executive Office of Health and Human Services (EOHHS), DCF, DMH, and MassHealth.

Principles Established to Guide Work of Steering Committee

1. Maintain a focus on the whole child—medical/behavioral/social— promoting a holistic approach to prescribing practices.
2. Psychopharmacology should be matched to the strengths and of the child, family, and substitute family with a focus toward safety, permanency and wellbeing.
3. All partners involved in the care of and services to a child should be optimally informed of the emotional, medical and behavioral needs of the child.
4. Psychopharmacological regimens should be guided by scientific best practice.
5. Systematic State Agency oversight is needed to promote best practices related to authorization and monitoring of psychotropic medication.
6. Though clearly defined standards of care may not exist, there is enough agreement to define ranges for effective outlier management
7. Psychopharmacology should occur within a well-defined practice of Trauma Informed Care.
8. There is a system-wide commitment to “informed consent.”
9. Commitment to ongoing improvement of prescribing practices grounded in data and evidence.
10. Psychopharmacology is only one component of efforts to improve overall healthcare of children.
11. Youth are engaged in the management of his/her ongoing treatment plan.
12. Building consensus among stakeholders is fundamental to the success of any plan for authorization and monitoring of psychotropic medications.

PBHMI - Pediatric Behavioral Health Medication Initiative Activities

From 2012-2014 DCF worked closely with Mass Health and DMH to establish the current oversight system. The Pediatric Behavioral Health Medication Initiative is a prior authorization protocol developed by clinical pharmacists at MassHealth. This initiative required that prescribers complete a prior authorization form when prescribing regimes are high risk such as behavioral health medications for children under six years of age, children receiving two or more medications in same class (e.g antidepressants), and children receiving four or more psych meds of any kind.

The PBHMI is applicable to all children receiving MassHealth insurance. Youth who are identified as highest risk prescribing are reviewed weekly by a team of inter-disciplinary professionals including social worker, child psychiatrist, and clinical pharmacists called the TCM workgroup. This meeting is also an interagency meeting with DCF child psychiatrist and social worker as well as DMH child psychiatrists and Mass Health pharmacy team represented. Custody statuses of youth are reviewed by DCF within the TCM workgroup.

OFFICE OF THE MEDICAL DIRECTOR:

Within the Office of the Medical Director, a new data analyst has been created. With the position recently fill in November of 2016, psychotropic data will be easily obtained to ensure that all children in DCF care and custody are identified within this larger group of mass health. A new role of a consulting child psychiatrist has also been created to help guide psychotropic oversight within DCF.

Our new full-time data analyst will provide reports to measure our progress in meeting the medical, dental, behavioral health, and developmental needs of children in the care and custody of DCF. These reports will include:

- a. Weekly reports of all initial screening and comprehensive exams needed
- b. Weekly reports of hospitalizations for all children in foster care
- c. Monthly report of compliance statistics for screening/comp visits by area office
- d. Monthly report of all psychotropic meds for children in state custody
- e. Monthly report on antipsychotic medications use in youth in state custody
- f. Monthly report of all children in care or custody with diabetes and other chronic healthcare conditions
- g. Monthly report of all overdue physicals for children in foster care
- h. Quarterly report on chronic illness diagnoses
- i. Quarterly report on immunization delays for children in foster care
- j. Biannual report on demographics of medical providers of care

VI. How DCF Actively Consults with and Involves Physicians or Other Appropriate Medical and Non-Medical Professionals in Assessing the Health and Well-being of Children in Foster Care and in Determining Appropriate Medical Treatment for Children

Training Children's Hospital in Boston provides training for new DCF Social Workers and periodically provides additional workshops / in-service training opportunities on selected medical

topics. In addition, staff from Children's Hospital provide training for all DCF investigators on assessment of non-accidental trauma.

Staff from Children's Hospital Boston provided training for a group of Boston –area foster parents on the care of children with diabetes. The intent is to consider expanding this training for additional groups of foster parents.

DCF has collaborated with Children's Hospital and Boston Medical Center to institute the "Building Bridges" program. This unique program provides critical training and consultation between DCF social workers and psychiatrists.

Protocol for Life Sustaining Medical Treatment For proposed orders to forgo or discontinue life sustaining medical treatment DCF has established processes for accessing medical recommendations from providers in addition to the treating provider and from hospital Ethics Committees. Once these professional opinions have been obtained, the request is reviewed by the Commissioner, Deputy Commissioners and the General Counsel, and if approved, the Department seeks a judicial determination on the decision. Each orders to discontinue or forgo life sustaining medical treatment is reviewed by the child's current treating physician on an annual basis to determine whether the order is still medically justified.

Collaboration with Child Protection Teams(CPTs) The HSMT works closely with CPTs in hospitals statewide to collaborate regarding a range of healthcare and psychosocial issues for children who have experienced suspected physical or sexual abuse. Physicians and the DCF Nurse Liaisons from Children's Hospital CPT provide training to new social workers and investigators on assessment of non-accidental trauma. Regular meetings between HSMT and CPT staff statewide are held on a regular basis.

Areas for Enhancement / New Initiatives

The Department has obtained data from MassHealth that will assist us in identifying community pediatricians that are seeing a number of DCF clients. In partnership with the Massachusetts Behavioral Health Partnership, the Department will be reaching out to these providers to provide training (including trauma training utilizing the curriculum developed by Dr. Heather Forkey for pediatricians), providing a resource toolkit to pediatricians on special issues of treating children in foster care, and identifying strategies for improving communication between DCF and healthcare professionals. In addition, this effort is designed to improve access to healthcare services. See overview of this collaboration with MBHP in the Appendices.

Strategies to Build Capacity to Provide Trauma Informed Casework Practices and Trauma Specific Evidence Based Treatments

Integrated Casework Practice Model With the implementation of a new casework practice model in 2009 the Department established "trauma informed" as one of three key clinical approaches to be integrated into all aspects of our casework practice. The four cornerstones of our casework practice model are: 1) Positive Engagement; 2) Progressive Understanding; 3) Capacity Building; and 4) Consolidating and Sustaining Gains. Throughout each of these phases of casework, the Department utilizes Safety Organized, Trauma Informed, and Solution Focused Clinical approaches. Significant training has

occurred throughout the past three years of the implementation of the casework practice model on these clinical approaches.

ACF Trauma Grant Massachusetts is one of five states that was selected to receive an ACF grant to build system capacity to provide trauma informed care to children served within the child welfare system. The grant has been an exciting opportunity to enhance the state's efforts in this area. Specifically, through the trauma grant:

- DCF social workers receive Basic and Advanced Trauma training,
- Trauma Informed Leadership Teams are being established in each DCF Area Office to identify and disseminate trauma informed casework practices
- Mental Health providers serving DCF children are being trained on one of three evidence based trauma specific treatments (Child-Parent Psychotherapy, Trauma Focused-Cognitive Behavioral Therapy, or Attachment, Regulation and Competency)

Between November, 2012 and June, 2013 DCF social workers in the West and Northern Regions received Basic Trauma training and had the opportunity to participate in Advanced Trauma training utilizing the NCTSN Toolkit for Child Welfare Staff. Each of the Area Offices in these Regions have also established Trauma Informed Leadership Teams to enhance casework practices that are more trauma informed. Over that same time period mental health providers were selected to be trained on one of the evidence based treatments and have participated in an intensive learning community for additional supervision and coaching. To date, over 120 mental health clinicians have been trained and approximately 150 DCF children have been enrolled in one of the evidence based treatments.

In September, 2013, the Boston and Southern Regions engaged in the same process of training DCF staff and mental health clinicians. In November, 2013 DCF began a new program to provide training for DCF resource parents on the impact of trauma on children the care for. Additional detail on the efforts to build system capacity to provide more trauma informed care may be found in the Semi-annual Report on Enhancing Trauma Informed Care.

VII. Health Care Needs of Youth Aging out of Care

Planning for discharge and transition from placement and case closing can begin at many different points but the Department must, beginning 90 calendar days prior to discharge and case closing, provide a transition planning process in collaboration with the youth/young adult, based on an assessment of her/his readiness for living interdependently in the community, age and follow up supports. The discharge and transition planning process must include a discussion of the youth/young adult's education, employment or work skills development, housing, health insurance including the importance of a medical health care proxy, local opportunities for mentoring and other specific support services. The plan should be reflected in the Service Plan and/or dictation and must be reported in any Permanency Hearing Report filed with a court after the youth/young adult turns age 17 years and 9 months old. Any outstanding life skills needs are prioritized and addressed prior to discharge from placement and case closing. The Department must also provide written notice to the youth/young adult at least 30 calendar days prior to the anticipated date of discharge from placement and case closing (which may occur later). The scheduling of both steps should be planned.

- For the youth who intend to leave Department care or custody on her/his 18th birthday, the discharge and transition planning must begin 90 calendar days prior to discharge and the closing of the case. The written notice of discharge from placement and case closing should be sent within 90 calendar days and at least 30 calendar days prior to her/his 18th birthday. The notice must contain notice of the right of the youth to challenge the discharge from placement and the closing of her/his case through the fair hearing process.
- For the young adults who have continued sustained connections with the Department beyond age 18, the discharge and transition planning is completed within 90 days prior to the closing date. The dates for discharge from placement and case closing should be reflected in youth readiness assessment tool if being utilized and the current Service Plan. Written notice of the discharge from placement and/or case closing is sent at least 30 calendar days prior to the date of the discharge from placement or case closing accordingly
- More information about health care for youth transitioning out of foster care can be found in the CFCIP section of the APSR.

No changes or additions are needed for the current plan.

Commonwealth of Massachusetts

Department of Children & Families

Disaster Plan - Update

**Massachusetts Department of Children and Families
Continuity of Operations Plan
July 2015 – June 2016**

Disaster Plan Update

**Massachusetts Department of Children and Families (DCF)
Annual Progress and Services Report 2016**

Disaster Plan

This report is submitted as part of the plan of the Commonwealth of Massachusetts for compliance with title IV-B of the Social Securities Act (the Act). The report includes the Disaster Plan as required by Section 422(b)(16) of the Act.

Summary of disasters during 2015 – 2016, and DCF responses

During the past year, Massachusetts experienced one occurrence of severe winter weather that resulted in the partial activation of DCF's COOP and Virtual Coverage Plans. They were both successfully utilized during this event.

- Severe Winter Weather

The winter of 2015-2016 was relatively mild in respect to inclement weather and snow.

On February 8, eastern Massachusetts was hit with a significant snow storm. Blizzard conditions were reported in many areas along the coast. Travel by automobile became treacherous and hundreds of flights in and out of Boston Logan Airport were cancelled. Impacted towns recorded snowfalls that ranged from 5.5 inches to 11 inches.

Due to this weather event, the Governor directed that non-emergency Executive Branch employees living or working in the affected counties not report to their workplaces on Monday, February 8, 2016. Accordingly the Department of Children and Families immediately initiated its Employee Notification Plan.

DCF offices in the affected counties were closed for the day. The DCF Hotline was activated to be operational during normal business hours. The Virtual Coverage Plan was implemented, with Incident Command Center provided by the DCF leadership. Conference calls were regularly held with agency leadership to provide updates from MEMA, area offices, hotline, and programs.

Despite challenges posed by the weather, the Department was able to ensure a child protective response capability for emergency reports of abuse and/or neglect. The DCF Incident Command Center operated throughout the storm to ensure communication with management and employees.

The DCF 2015-2019 Disaster Plan

There are no changes or updates to the Children and Disaster Plan as of June, 2016.

Commonwealth of Massachusetts
Department of Children & Families
Child Welfare Institute Training Plan

DCF Training Plan

FFY 2017 DCF Training Plan Department of Children and Families Massachusetts Child Welfare Institute

The primary goal of the MCWI is to promote effective child welfare practice. MCWI activities strive to improve the knowledge and skills of individual social workers; the quality of supervision; and the agency environment that promotes creativity and professional growth. The MCWI is committed to advancing the strategic goals and objectives of the Department of Children and Families.

This state training plan as required by intersecting federal law, regulation, and Program Instructions (ACYF-CB-PI-04—01; 45 CFR 1356.60 (b); 45 CFR 1357.15 (t) (1); and 45 CFR 235.60-235.66), lays out the planned training activities for DCF to achieve a higher level of excellence in staff development in child welfare practice. The Department continues to employ the claiming mechanisms currently in place in the existing, approved training plan; however as additional information becomes available and curriculum changes are made, DCF plans to update its training plan and related cost allocation plan. DCF will work with the ACF Regional Office on the proposed changes and an updated Training Plan will be submitted separately at a future date.

Commonwealth of Massachusetts
Department of Children and Families
Financial Information

Financial Information

Payment Limitations – Title IV-B, Subpart 1

- States may not spend more title IV-B, subpart 1 funds for child care, foster care maintenance and adoption assistance payments in FY 2017 than the state expended for those purposes in FY 2005 (section 424(c) of the Act). The 2017 APSR submission must include information on the amount of FY 2005 title IV-B, subpart 1 funds that the state expended for child care, foster care maintenance and adoption assistance payments for comparison purposes. States are also advised to retain this information in their files for comparison with expenditure amounts in future fiscal years.

The Department of Children and Families has never used, nor does it plan to use, IV-B, subpart 1 funds for these programs.

- The amount of state expenditures of non-federal funds for foster care maintenance payments that may be used as match for the FY 2017 title IV-B, subpart 1 award may not exceed the amount of such non-federal expenditures applied as state match title IV-B, subpart 1 for the FY 2005 grant (section 424 (d) of the Act). The CFSP submission must include information on the amount of non-federal funds that were expended by the state for foster care maintenance payments and used as part of the title IV-B, subpart 1 state match for FY 2005. States are also advised to retain this information in their files for comparison with expenditure amounts in future fiscal years.

MA Department of Children and Families no longer uses state funds for foster care maintenance payments as a match for, IV-B, subpart 1 funds. In FY 2005, non-federal foster care maintenance funds used as a match totaled \$227,427.

Payment Limitations – Title IV-B, Subpart 2

- States are required to spend a significant portion of their title IV-B, subpart 2 PSSF grant for each of the four service categories of PSSF: family preservation, community-based family support, time-limited family reunification, and adoption promotion and support services. For each service category with a percentage of funds that does not approximate 20 percent of the grant total, the state must provide in the narrative portion of the APSR a rationale for the disproportion. The amount allocated to each of the service categories should only include funds for service delivery. States should report separately the amount to be allocated to planning and service coordination. States must provide the estimated expenditures for the described services on the CFS-101, Part II.

Rationale for Requested FFY 17 PSSF Funds

Promoting Safe and Stable Families Program (PSSF) grant dollars continue to allow DCF to pilot innovative responses to emerging needs on a scale that otherwise would be difficult to accomplish systemically. This approach has given us an opportunity to “try before we buy” – incorporating lessons learned during pilot development and implementation into a cogent, scalable program model more likely to attract support with state service dollars. The Substance Abuse Engagement program, which we piloted as part of the agency’s initial Program Improvement Plan using PSSF discretionary dollars,

continues in three DCF Northern Region area offices. It is now completely supported with state dollars through Family Networks.

In 1994, when these grant funds initially became available to states, Massachusetts was explicit in its intent to build a strong community infrastructure that would result in a fundamental shift in how the child welfare system related to families and communities. We continue to view this as a long-term change strategy - one that is yielding tangible results.

As we described in the body of the Five Year Child and Family Services Plan and this year's Annual Progress and Services Review (APSR), Massachusetts invests a significant portion of these grant funds to support Community Connections Coalitions in high-risk neighborhoods across the Commonwealth. Originally, these coalitions were envisioned primarily as family support entities in a traditional sense. Over time, they have evolved to also address the needs of families in the community who are involved with the Department as recipients of services. These include services to families whose children are in foster placement with a goal of returning home, support and enrichment activities for children in foster care, remedial experiences for families where escalating crises pose a significant risk of placement of the children, and foster and adoptive family recruitment grounded in the community, and initiated by community members themselves.

Several cases illustrate the intertwined and evolutionary nature of this work. One such example is the partnership that has developed between the Community Connections coalition, MSPCC's Connecting Families Program and the DSS Area Offices in the cities of Worcester and Fall River. Connecting Families provides outreach services to families where DSS has "screened out" reports of child abuse or neglect. It offers a preventive alternative to the more traditional avenue of families having to "fail up" before child welfare services are provided. Originally, MSPCC envisioned having challenges in handling demand for these services due to a flood of DSS referrals and "pull" for services by families. The actual experience initially was the opposite. Identifying potential families for referral by the area office was difficult as was engagement with those families who were referred. The expansion of the partnership to include the Worcester Community Connections Coalition ultimately was key in shifting this dynamic to a positive one. The Family Support Advocate and outreach staff of the coalition capitalized upon their relationships with both the office and families to address systemic barriers which impeded social workers from identifying and referring families early on and to help Connecting Families staff to tailor their engagement and outreach activities to better meet the diverse needs of families in the greater Worcester community.

The Worcester Community Connections Coalition expanded this work with families in the community by opening a Parent Resource Center. In the past two years, the early promise of it becoming a magnet to families from all parts of the city has been realized. As a result, DCF chose the Worcester site to be one of four Family Resource Center "proof of concept" sites in the spring of 2010 – continuing the testament of the relevance of the coalition to the community. Community Connections Coalitions will continue to be the foundation upon which we intend to expand community-based Family Resource Centers in the future.

In other parts of the state, the impact of Community Connections on other PSSF program areas has been similar. The Foster Care Task Force of the New Bedford Community Connections Coalition was formed as a community response to the perception that children in foster care were not provided with the same access to the kinds of opportunities afforded other children in the community. Activities originally were focused on fundraising to provide enrichment activities to children in foster care. The Task Force

learned early on that providing support to the youth in care also meant supporting foster families. This naturally progressed to helping support retention and expansion of fostering resources in the greater New Bedford area. In the ensuing years, the work of the Task Force has dramatically expanded to include development of a comprehensive strategy for neighborhood recruitment, which, for all practical purposes, has resulted in a melding of our agency foster and adoptive recruitment activities with our community capacity-building infrastructure, at least in this one community.

The work of the New Bedford Task Force has firmly taken hold in the neighboring community of Fall River, expanded to include Cape Cod and began to spread to other areas of the state. Fall River developed a template of recruitment materials that is easily modified to incorporate local information and made it available to the network of Community Connections coalitions. It effectively balances the need for having a statewide recruitment branding identity along with the kind of information that makes a campaign relevant for local communities - producing a win-win for everyone involved. Our joint planning work with our internal DSS foster care and adoption recruitment staff to strategically build linkages at community and regional levels continue to produce discernible results from these partnerships.

In 2009, we began broadening the work to include testing a planning framework by which coalitions, with their DCF Area Office partners, convene community forums on a specific issue related to safety, permanency or well-being. We were particularly interested in looking at issues that may be related to substance abuse, mental health, or domestic violence and using these forums as an opportunity to develop targeted responses that cross these multiple disciplines. In the fall of 2008, our first large-scale project was in response to a request from the Worcester Community Connections Coalition for targeted technical assistance. We funded a consultant to facilitate a community-based process to address an issue brought to the coalition by a group of mothers in the community who experienced a lack of response by the domestic violence services agencies, including the court system. The time-limited planning process resulted in an action plan to implement concrete changes in both the shelter system and recommendations for court system improvements.

In 2010, DCF partnered with the MA Children's Trust Fund, and Departments of Early Education and Care and Public Health in a subsequently awarded Strengthening Families AIM grant. Community Connections Coalitions and Family Resource Centers were key implementation points in our state strategy and were part of the initial training population included in the expansion of Parent Café work in 2012.

Given the ongoing integration of the work of the Coalitions with the work of the Department, the vast majority of the \$3.1 million in PSSF funds provided to the Coalitions is used to fund services and activities that cross one or more service categories. However, DCF still relies on PSSF grant funds as support for preventive Family Support programs due to a relatively small pool of state Purchase of Service (POS) dollars dedicated for this purpose. In SFY 2014, the State had annual expenditures in excess of \$44 million in POS dollars for Family Networks Support and Stabilization Services (FNSS) which is inclusive of Family Preservation and Adoption Support Services, but does not include any direct service personnel costs in these programmatic areas. In addition, for FY 14, the State targeted over \$1.4 million in State funds for time-limited reunification services and over \$14 million of State funds for crisis intervention services. Given the high level of State funds used to support various types of reunification services over the past several years, DCF has found that it is able to meet the demand for time-limited reunification services with the level of IV-B funds proposed.

We are of the understanding that the maintenance of effort level of \$41.7M dollars was established in 1993 using reports submitted by DCF to the Regional Office, for all non-placement services expenditures in 1992.

DCF preliminarily plans to spend approximately 35% of its total available FFY 17 PSSF grant funds in Family Support Services, followed by 20% in Family Preservation Services 16% in Adoption Promotion and Support, 10% in Time Limited Family Reunification Services, 9% in Administration, and 10% in Planning/Other Service Related Activities.

We expect that model programs implemented with these funds will continue to yield tangible results for families as well as serving as learning labs to inform continued program development on a broader scale – all without investments of additional federal dollars. As local partnerships with DCF both deepen and expand, we expect a continuing evolution of these kinds of creative service responses that meet the intent of the legislation and, more critically, the needs of families in communities across the Commonwealth.

- States must provide the FY 2014 state and local share expenditure amounts for the purposes of title IV-B, subpart 2 for comparison with the state's 1992 base year amount, as required to meet the non-supplantation requirements in section 423(a)(7)(A) of the Act.

Rationale for Final FFY 14 Expenditures

Promoting Safe and Stable Families Program (PSSF) grant dollars continue to allow DCF to pilot innovative responses to emerging needs on a scale that otherwise would be difficult to accomplish systemically. This approach has given us an opportunity to “try before we buy” – incorporating lessons learned during pilot development and implementation into a cogent, scalable program model more likely to attract support with state service dollars. The Substance Abuse Engagement program, which we piloted as part of the agency's initial Program Improvement Plan using PSSF discretionary dollars, continues in three DCF Northern Region area offices. It is now completely supported with state dollars through Family Networks.

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permanency or well-being. We were particularly interested in looking at issues that may be related to substance abuse, mental health, or domestic violence and using these forums as an opportunity to develop targeted responses that cross these multiple disciplines. In the fall of 2008, our first large-scale project was in response to a request from the Worcester Community Connections Coalition for targeted technical assistance. We funded a consultant to facilitate a community-based process to address an issue brought to the coalition by a group of mothers in the community who experienced a lack of response by the domestic violence services agencies, including the court system. The time-limited planning process resulted in an action plan to implement concrete changes in both the shelter system and recommendations for court system improvements.

In 2010, DCF partnered with the MA Children's Trust Fund, and Departments of Early Education and Care and Public Health in a subsequently awarded Strengthening Families AIM grant. Community Connections Coalitions and Family Resource Centers were key implementation points in our state strategy and were part of the initial training population included in the expansion of Parent Café work in 2012.

Given the ongoing integration of the work of the Coalitions with the work of the Department, the vast majority of the \$3.1 million in PSSF funds provided to the Coalitions is used to fund services and activities that cross one or more service categories. However, DCF still relies on PSSF grant funds as support for preventive Family Support programs due to a relatively small pool of state Purchase of Service (POS) dollars dedicated for this purpose. In SFY 2014, the State had annual expenditures in excess of \$53 million in POS dollars for Family Networks Support and Stabilization Services (FNSS) which is inclusive of Family Preservation and Adoption Support Services, but does not include any direct service personnel costs in these programmatic areas. In addition, for FY 14, the State targeted over \$1.4 million in State funds for time-limited reunification services and over \$14 million of State funds for crisis intervention services. Given the high level of State funds used to support various types of reunification services over the past several years, DCF has found that it is able to meet the demand for time-limited reunification services with the level of IV-B funds proposed.

We are of the understanding that the maintenance of effort level of \$41.7M dollars was established in 1993 using reports submitted by DCF to the Regional Office, for all non-placement services expenditures in 1992.

In our plan for FFY 14, DCF planned to spend approximately 38% of its total available FFY 14 PSSF grant funds in Family Support Services, followed by 23% in Family Preservation Services 16% in Adoption Promotion and Support, 7% in Time Limited Family Reunification Services, 9% in Administration, and 7% in Planning/Other Service Related Activities.

In actuality, the state spent approximately 35% of its total available FFY 14 PSSF grant funds in Family Support Services, followed by 20% in Family Preservation Services, 16% in Adoption Promotion and Support, 10% in Time Limited Family Reunification Services, 10% in Planning/Other Service Related Activities, and 9% in administration. The variances are due to the across the board impact of the sequester on the grant allocation and the purchase of service contracts funded through PSSF, savings accrued due to a staff vacancy and increases in parent stipends primarily attributable to the increase in fatherhood engagement programming and incorporation of supervised visitation as a priority activity. We also were able to support a one-time purchase of media to support an increase in adoption and foster care recruitment activities supported by state funds, leading to a higher projected expenditures in that category.

We expect that model programs implemented with these funds will continue to yield tangible results for families as well as serving as learning labs to inform continued program development on a broader scale – all without investments of additional federal dollars. As local partnerships with DCF both deepen and expand, we expect a continuing evolution of these kinds of creative service responses that meet the intent of the legislation and, more critically, the needs of families in communities across the Commonwealth.


- **States may spend no more than ten percent of title IV-B, subpart 1 funds for administrative costs (Section 422 (b)(14) of the Act).**

The Department certifies that it has not spent more than ten percent of title IV-B subpart 1 funds for administrative costs.

Commonwealth of Massachusetts
Department of Children and Families
CFS-101 Forms

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

Fiscal Year 2017, October 1, 2016 through September 30, 2017

1. State or Indian Tribal Organization (ITO): Massachusetts		2. EIN:	
3. Address: Massachusetts Department of Children and Families 600 Washington Street - 6th Floor, Boston, MA 02111		4. Submission: [X] New [] Revision	
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds		\$	3,732,463
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)		\$	370,000
6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.		\$	4,518,775
a) Total Family Preservation Services		\$	903,755
b) Total Family Support Services		\$	1,581,571
c) Total Time-Limited Family Reunification Services		\$	451,878
d) Total Adoption Promotion and Support Services		\$	723,004
e) Total for Other Service Related Activities (e.g. planning)		\$	451,878
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)		\$	406,690
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)		\$	284,639
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)		\$	
8. Re-allotment of title IV-B subparts 1 & 2 funds for States and Indian Tribal Organizations:			
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS \$, PSSF \$, and/or MCV(States only)\$.			
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS \$, PSSF \$, and/or MCV(States only)\$.			
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)		\$	469,920
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds		\$	3,143,968
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)		\$	
11. Estimated Education and Training Voucher (ETV) funds		\$	1,020,225
12. Re-allotment of CFCIP and ETV Program Funds:			
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out CFCIP Program		\$	
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program		\$	
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program		\$	
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program		\$	
13. Certification by State Agency and/or Indian Tribal Organization. The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.			
Signature and Title of State/Tribal Agency Official  6/28/2016		Signature and Title of Central Office Official	


CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services

For FY 2017: OCT 1, 2016 TO SEP 30, 2017													
State or Indian Tribal Organization (ITO):													
Massachusetts													
SERVICES/ACTIVITIES	(a) IV-B Subpart I-CWS	(b) IV-B Subpart II- PSSF	(c) IV-B Subpart II- MCV *	(d) CAPTA*	(e) CFCIP	(f) ETV	(g) TITLE IV-E**	(h) STATE, LOCAL, & DONATED FUNDS	(i) Number Individuals To Be Served	(j) Number Families To Be Served	(k) POPULATION TO BE SERVED	(l) GEOG. AREA TO BE SERVED	
1.) PROTECTIVE SERVICES	\$ 3,362,463			\$ -			\$ -	\$ 100,415,042	30,619		investigations children not in placement	Statewide	
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	\$ -	\$ 903,755		\$ -			\$ -	\$ 75,180,178	36,257			Statewide	
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	\$ -	\$ 1,581,571		\$ 469,920			\$ -	\$ 88,443,995	92,631		reports of abuse and neglect	Statewide	
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	\$ -	\$ 451,878		\$ -			\$ -	\$ 23,369,132	8,705		children in placement	Statewide	
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	\$ -	\$ 723,004					\$ -	\$ 33,198,851	704		goal of adopt, legal & match status	Statewide	
6.) FOR OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	\$ -	\$ 451,878					\$ -	\$ 65,971,208					
7.) FOSTER CARE MAINTENANCE: (a) FOSTER FAMILY & RELATIVE FOSTER CARE (b) GROUP/INST CARE	\$ -						\$ 50,983,647	\$ 80,761,011	8,589		children in foster care	Statewide	
8.) ADOPTION SUBSIDY PMTS.	\$ -						\$ 9,469,586	\$ 252,400,523	1,730		children in congregate care	Statewide	
9.) GUARDIANSHIP ASSIST. PMTS.	\$ -						\$ 27,271,967	\$ 45,594,012	7,979		adoption subsidies	Statewide	
10.) INDEPENDENT LIVING SERVICES	\$ -				\$ 3,143,968		\$ 3,515,461	\$ 21,121,120	2,654		guardianship subsidies	Statewide	
11.) EDUCATION AND TRAINING VOUCHERS	\$ -	\$ -			\$ -		\$ -	\$ 16,683,502	996		adolescents	Statewide	
12.) ADMINISTRATIVE COSTS	\$ 370,000	\$ 406,690	\$ -		\$ -	\$ 1,020,225	\$ -	\$ -	300		adolescents	Statewide	
13.) FOSTER PARENT RECRUITMENT & TRAINING	\$ -	\$ -		\$ -			\$ 21,072,727	\$ 18,273,862					
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	\$ -	\$ -		\$ -			\$ -	\$ 2,039,476					
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	\$ -	\$ -		\$ -			\$ -	\$ 100,000					
16.) STAFF & EXTERNAL PARTNERS TRAINING	\$ -	\$ -		\$ -	\$ -		\$ -	\$ 100,000					
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	\$ -	\$ -	\$ 284,639		\$ -		\$ -	\$ -					
18.) TOTAL	\$ 3,732,463	\$ 4,518,775	\$ 284,639	\$ 469,920	\$ 3,143,968	\$ 1,020,225	\$ 112,313,388	\$ 823,878,519					

* These columns are for States only; Indian Tribes are not required to include information on these programs.

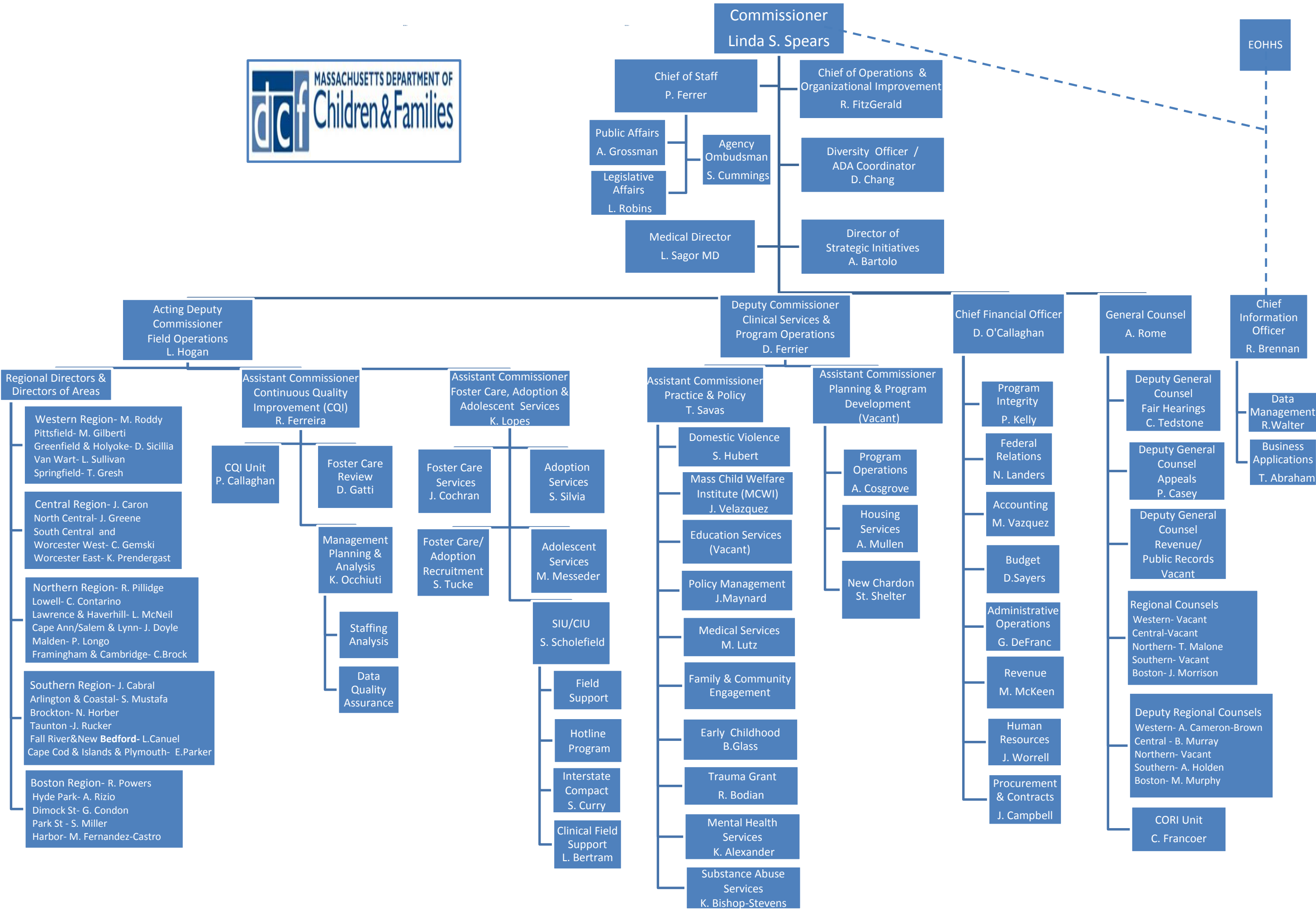
** Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (g), indicating planned use of title IV-E funds for these purposes.

**CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV) :
Fiscal Year 2014: October 1, 2013 through September 30, 2014**

1. State or Indian Tribal Organization (ITO): Massachusetts		2. EIN:		3. Address: Department of Children and Families, 600 Washington Street, 6th Floor, Boston, MA, 02111				
4. Submission: <input checked="" type="checkbox"/> New <input type="checkbox"/> Revision								
Description of Funds	Estimated Expenditures	Actual Expenditures	Number Individuals served	Number Families served	Population served	Geographic area served		
5. Total title IV-B, subpart 1 funds	\$ 3,725,612	\$ 3,725,612	365		open cases	Statewide		
a) Total Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	\$ 370,000	\$ 95,529						
6. Total title IV-B, subpart 2 funds (This amount should equal the sum of lines a - f.)	\$ 4,572,314	\$ 4,572,303	450		open cases	Statewide		
a) Family Preservation Services	\$ 1,051,632	\$ 914,461						
b) Family Support Services	\$ 1,737,479	\$ 1,600,306						
c) Time-Limited Family Reunification Services	\$ 320,062	\$ 457,230						
d) Adoption Promotion and Support Services	\$ 731,570	\$ 731,568						
e) Other Service Related Activities (e.g. planning)	\$ 361,213	\$ 457,230						
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment after October 1, 2007)	\$ 370,357	\$ 411,507						
7. Total Monthly Caseworker Visit Funds (STATE ONLY)	\$ 287,793	\$ 279,952						
a) Administrative Costs (not to exceed 10% of MCV allotment)	\$ -	\$ -						
8. Total Chafee Foster Care Independence Program (CFCIP) funds	\$ 2,841,594	\$ 2,841,594						
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$ -	\$ 64,552	62		adolescents	Statewide		
9. Total Education and Training Voucher (ETV) funds	\$ 914,417	\$ 914,308	516		adolescents	Statewide		
10. Certification by State Agency or Indian Tribal Organization (ITO). The State agency or ITO agrees that expenditures were made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.								
Signature and Title of State/Tribal Agency Official		Date		Signature and Title of Central Office Official		Date		
		11/10/2016						

Commonwealth of Massachusetts
Department of Children & Families
Appendices

Commonwealth of Massachusetts
Department of Children & Families
DCF Organizational Chart - June 2016



Commonwealth of Massachusetts

Department of Children & Families

DCF Service Taxonomy

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
Family Networks	Area Lead Agencies Lead a system of aligned and integrated strategies dedicated to fostering and protecting permanent families and lifelong connections for children. Includes designing and managing an integrated service system so that it supports more fully the clinical practice of the Department and its providers.	Management Operations	FNLA	2
	Area Lead Agencies	Flex Services Specialized funds to be used to further the purposes of family networks-managed by Area Lead Agency	FNLA	2
Family Networks - Network Services Integrated Service system for children and families serviced by the Massachusetts child welfare system.	Group Home NA as of 6-30-15 Provide 24-hour supervision and intensive treatment services in group care settings that do not usually include on-site education.	Behavioral Treatment Residences Campus or community based models that can provide staff secure treatment for children with serious emotional, developmental, cognitive and behavioral disorders who do not require an educational placement in an on-site school.	FNGH	24
	Group Home NA as of 6-30-15	Independent Living Program models include group homes as well as supervised or supported apartments, and are designed for older adolescents who are developing the skills to live in the community in their own homes or apartments.	FNGH	24
	Group Home NA as of 6-30-15	Group Home Designed for latency aged or adolescent children who have sufficiently internalized controls to be safe in a less staff intensive setting, and may progress to limited unsupervised time in the community.	FNGH	24
	Group Home NA as of 6-30-15	Other Sites/facilities which do not readily fall into previous model definitions. These should be defined by the DCF manager most familiar with the services being offered.	FNGH	24
	Residential NA as of 6-30-15	Residential school Designed to provide staff secure placement for children who have not sufficiently internalized controls and require a more highly structured setting to help them manage their behavior. These facilities are licensed by the Department of Education under "71B" regulations. Special education services are provided according to the child's Individual Education Plan (IEP) developed by the Local Educational Agency (LEA).	FNRE	24
	Residential NA as of 6-30-15	Non-766 Residential School	FNRE	24

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
		Similar to 766-approved facilities, this model also provides on-site educational programming that is approved by the local superintendent of schools rather than the DOE "71B" designation.		
	STARR NA as of 9-30-15	STARR (Stabilization, Assessment and Rapid Reunification) Short-term placement services that provide a single door for children that need shelter / respite-type services only as well as for children who require more intensive services.	FNST	24
	Intensive Foster Care Intensive Foster Care (IFC) programs provide therapeutic services and supports in a family-based placement setting to children and youth for whom a traditional foster care environment will not be sufficiently supportive; are transitioning from a residential/group home level of care and require the intensity of services available through this program; or discharging from a hospital setting.	IFC Skill Level 1 Rate includes basic support package – to be authorized automatically, not separately.	FNIF	11
	Intensive Foster Care	Sibling Rate Paid to support any sibling who does not need IFC but is placed in an IFC home in order to stay with a brother /sister who does require this level of service.	FNIF	11
	Intensive Foster Care	IFC Skill Level 1- Teen Parent Paid when a teen parent and child are placed in an IFC home	FNIF	11
	Intensive Foster Care	Recruitment Rate Paid for the recruitment, home-study, and use of a foster home.	FNIF	11
	Intensive Foster Care	One-time Resource Purchase Paid when a provider's IFC home becomes an approved adoptive home or guardian causing them to become ineligible to continue as an IFC home because of limits on the number of children in the home.	FNIF	11
	Intensive Foster Care	IFC - Other IFC programs which provide additional supports. These will be defined and approved by IFC Other Cmte.	FNIF	11
	Support and Stabilization	Comprehensive	FNSS	13

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Support and stabilization services encompass services currently known as family-based services; the service providers will 'unbundle' from their placement programs; and portable diagnostic and assessment services. These services are intended to be flexible, rooted in the community, and have the capacity to be shaped in a manner that will address the specific needs of each family.	Comprehensive program models are those that use teams whose staffing, interventions, and funding are blended in a manner that allows for varying levels of intensity, duration, and capacity for building strengths and managing risk with complex families.		
	Support and Stabilization	Parent Support Designed to provide assistance and support to parents and caretakers in building skills relative to safety, supervision, and nurturing.	FNSS	13
	Support and Stabilization	Youth Support Designed to provide assistance and support to youth in order to improve relationships with families, schools and other community systems.	FNSS	13
	Support and Stabilization	Family Stabilization Designed to provide assistance and support to families in keeping their children safely at home and in the community.	FNSS	13
	Support and Stabilization	Placement Diversion Designed to provide assistance and support to families whose children are at imminent risk of out-of-home placement in foster care, residential, or inpatient hospitals.	FNSS	13
	Support and Stabilization	Reunification Designed to provide assistance and support to families whose children are returning from out-of-home placement settings.	FNSS	13
	Support and Stabilization	Assessment Encompass evaluations, clinical assessments, and diagnostic services.	FNSS	13
	Support and Stabilization	Unbundled IFC Support Services Support service package unbundled and purchased for a Departmental home (e.g., kinship, child-specific, unrestricted).	FNSS	13
	Support and Stabilization	Support and Stabilization - Other Services which do not readily fall into previous model definitions. These should be defined by the DCF manager most familiar with the services being offered.	FNSS	13
	Family Residence	Family Residence	FNFR	11

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
		A foster care model that integrates a level of provider agency support commonly associated with group care programs into a foster care model. Foster families or caretakers recruited to serve as Family Residence Foster Homes receive an annual salary for the household and other benefits.		
Residential (non-Family Networks)	Group Home NA as of 6-30-15 Provide 24-hour supervision and intensive treatment services in group care settings that do not usually include on-site education.	Teen Pregnancy/Parenting Structured residential living programs with 24 hour supervision for pregnant and parenting teen/families; assessed as unable to live with their family of origin or other appropriate adult caretaker; with a focus on acquiring and strengthening skills of basic parenting and independent living, ensure the healthy growth and development of their children and with a goal of completing a high school education or G.E.D. The settings may vary but must provide 24 hour skilled staffing and supervision, access to licensed childcare. Teen living programs must provide living arrangements for up to 36 months. Services may also include counseling, case management or topically-oriented programs.	RESG	16
	Group Home NA as of 6-30-15	Transitional Living Small staffed apartment setting. Intervention intended to stabilize client and family in order to transition client to less restrictive setting. Service elements include daily living skills, social skills, money management, etc.	RESG	16
	Shelter Generally for emergency or immediate placement situations, shelters are short-term residential facilities for children and adolescents on 24-hour per day basis.	Alternative Lock-up Program This service provides an emergency or short-term alternative placement to incarceration or lock-up for juvenile offenders until they can be brought to court for arraignment on their charges.	RESS	26
Caring Together	Residential School	Residential school Residential placement services with an on-site school approved by the Department of Elementary and Secondary Education. Also includes services to help students and family transition to home and community.	CTRE	24
	STARR	STARR Short-term placement services for participants in the waiver.	CTST	24
	The Continuum	Community Wrap/Sub Contracted Wrap Wide range of comprehensive community based services for youth and their family to support them in learning skill needed to transition to or remain at home and live safely in their community. Non Placement service. Includes subcontracted services.	CTC0	24

Category	Program	Model	Activity Code	Index Number
	The Continuum	Adjusted GH 1:3/Sub Contracted Adjusted 1:3 This part of the Continuum array of services. Out of home residential placement with a 1 to 3 ratio. Youth are able to attend school off grounds. Includes subcontracted services.	CTC0	24
	The Continuum	Adjusted GH 1:4/Sub Contracted Adjusted 1:4 This part of the Continuum array of services. Out of home residential placement with a 1 to 4 ratio. Youth are able to attend school off grounds. Includes subcontracted services.	CTC0	24
	Group Home	Intensive 1:3 Out of home residential placement with a 1 to 3 ratio. Youth are able to attend school off grounds.	CTGH	24
	Group Home	Group Home 1:4 Out of home residential placement with a 1 to 4 ratio. Youth are able to attend school off grounds.	CTGH	24
	Respite	Respite A brief or short-term service for a youth provided by adults other than the birth parents, foster parents, adoptive parents or legal guardian with whom the child/ youth normally resides, typically used to give the parents/ caregiver and youth time away from each other in order to decrease stress and support the family system.	CTRS	24
	Group Home	Follow Along Group Home Services which assist with successful transitions from Group Home to home and community. Includes family treatment beginning while youth is still in the Group Home and continuing after return to home/ community.	CTGH	24
	Group Home	Stepping Out Group Home Community based services which assist with successful transition from Pre-Independent Living, Independent Living and Teen Parent Enhanced placement services to home/ community	CTGH	24
	Group Home	Pre-Independent Living	CTGH	24

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Group Home	Out of Home Residential Placement with a 1 to 5 ratio. Focus is on Independent Living Skills for youth ages 16 and up, youth is typically enrolled in school or GED program or has completed and is involved with vocational training. Independent Living Supported apartment living (scattered site or centralized). Staff provide outreach and care coordination, but are not on-site 24 hours per day. Youth are 17.5 and older	CTGH	24
	Group Home	Stepping Out -- Independent Living Provides continuation of care coordination services by the same provider after the child leaves the program in order to assist youth with a successful transition to the community.	CTGH	24
	Placement Add-On	Transition to IFC Add-On Provides short term services that assist youths in successfully transitioning to Intensive Foster Care within 3 to 6 months of admission to this program.	CTAD	24
	Group Home	Intensive Group Home with Expanded Nursing (specialty) Services are the same as those provided in Intensive Group Home with a ratio of 1:3 with additional nursing positions to support the medical needs of referred youth.	CTGH	24
	Group Home	Intensive 1:2 Group Home (specialty) Out of Home Residential Placement with a 1 to 2 ratio, designed for youth who have intellectual and developmental disabilities and/or autism with concurrent behavioral/emotional challenges.	CTGH	24
	Group Home	Intensive 1:1 Supported Living (specialty) Out of Home Residential Placement with a 1 to 1 ratio, designed for young adults (18 to 22) with a range of significant disabilities.	CTGH	24
	Group Home	Medically Complex Needs Group Home (specialty) provides services to youth with complex medical needs that require intensive out-of-home nursing, family driven, individualized and sensitive to medical and other forms of trauma and the resulting effects on families and caregivers; maximizes youth's functioning	CTGH	24
	Group Home	State College Preparatory Program (specialty) Provides young adults with the opportunity to attend a state operated university or college while receiving clinical, social, academic and daily living supports with tuition, room and board		
	Group Home	Outreach Independent Living (specialty)		

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Teen Parenting	An apartment living program for agency identified youth of the same sex with opportunities for education, assistance with employment and a support structure as youth transition from DCF foster care system to living in the community Enhanced Teen Parenting Out of Home Residential Placement with a 1 to 4 ratio for pregnant or parenting teens. Provides a higher level of supervision than other Teen Parenting services.	CTTP	
	Teen Parenting	Stepping Out -- Teen Parenting Provides continuation of care coordination services by the same provider after the teen parent leaves the Enhanced Teen Parent program in order to assist with a successful transition to the community.	CTTP	
	Placement Add-On	Behavioral Psychologist Additional services from a behavioral psychologist over and above services provided through the contract.	CTAD	24
	Placement Add-On	Canine Therapy Therapy dog.	CTAD	24
	Placement Add-On	Direct Care III Additional staffing hours provided by a DCIII staff person, usually to support 1:1 services for a specified period of time over and above the staffing provided through the contract.	CTAD	24
	Placement Add-On	Direct Care II Additional staffing hours provided by a DCII staff person, usually to support 1:1 services for a specified period of time over and above the staffing provided through the contract.	CTAD	24
	Placement Add-On	Direct Care I Additional staffing hours provided by a DCI staff person, usually to support 1:1 services for a specified period of time over and above the staffing provided through the contract.	CTAD	24
	Placement Add-On	Forensic Psychiatrist (DMH-designated, CJCC qualified) Additional services from a forensic psychiatrist over and above services provided through the contract.	CTAD	24
	Placement Add-On	Medical Consultation Additional Medical Consultation services provided over and above services provided through the contract.	CTAD	24
	Placement Add-On	Nurse	CTAD	24

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
		Additional Nursing services provided over and above services provided through the contract.		
	Placement Add-On	Psychiatrist Additional Psychiatry services provided over and above services provided through the contract.	CTAD	24
	Placement Add-On	Psychologist Additional services from a psychologist over and above services provided through the contract.	CTAD	24
	Placement Add-On	Forensic Psychologist Additional services from a forensic psychologist over and above services provided through the contract.	CTAD	24
	Teen Parenting	TLP 1:5 Services to help teens develop support systems including contact with baby's father, teen's parents, father's parents and other community supports. Facilities staffed 24 hours and are provided in group home and scattered apartment settings.		
	Teen Parenting	House Parent Same as TLP 1:5 but are provided in an apartment building or multi family home. Teens reside in shared apartments and the houseparent has separate living quarters on site.		
	Family Partner	Family Partner To provide support for full family engagement in all aspects of a youth's care and treatment during the course of residential service and strengthen the parent/caregiver's capacity to care for their youth at home and in the community		
	Teen Parenting	STEP (DTA Only) Target is 18 to 19 year olds who have completed treatment plans and are focused on job training and transitional housing services to assist in becoming self sufficient. Apartment setting with staff available 24 hours a day.		
	Teen Parenting	Emergency Bed Add-On Every STEP group home location must have ability to accept youth on an emergency basis.		
	Treatment Program Residential	IRTP DELETE DCF DOES NOT PURCHASE CIRT DELETE DCF DOES NOT PURCHASE		

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
Family Resource Center	Family Resource Center community-based, culturally competent program that provides evidence-based parent education groups, information and referral, mentoring, educational support and other opportunities for children and families; provide services specific to Children Requiring Assistance who are having serious problems at home and at school, including runaways, truants, and sexually exploited children, as required by Chapter 240 of the Acts of 2012	Family Resource Center - Full one location; provides all required Basic and Network Services; completion of no more than 1,000 assessments per year	FRCF	
		Family Resource Center - Micro (also known as a "Satellite" FRC) one location; provides all required Basic and Network Services at a reduced staffing and caseload level; based on completion of no more than 200 assessments per year	FRCM	
Foster Care Temporary substitute care placement for child(ren)/adolescents in the care or custody of DCF in a safe and nurturing community based family setting, approved/licensed and managed by DCF or provided through a purchase of service agreement with a DEEC licensed foster care agency and monitored by DCF.	Department Foster Care Temporary substitute care placement for child(ren)/adolescent(s) in the care or custody of DCF in a safe and nurturing community based family setting, approved/licensed and managed by DCF.	Tier I Unrestricted Temporary placement of children/adolescents who need a basic quality level of daily care in a family setting in an unrestricted DCF foster home, approved/licensed to provide Tier I foster care.	FOS0	11
	Department Foster Care	Tier I Kinship Temporary placement of children/adolescents who need a basic quality level of daily care in a family setting with a member of the family's kinship network who has been approved/licensed to provide Tier I foster care restricted for specific children who are kin.	FOS0	11
	Department Foster Care	Tier I Pre-Adoptive Placement of child(ren)/ adolescent(s) with the goal of adoption needing a basic quality level of care in a permanent family setting approved by DCF as a Tier I pre-adoptive family.	FOS0	11
	Department Foster Care	Tier I Independent Living	FOS0	11

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
		Payment made to an older adolescent who is in the Department's care, but who lives on their own in a structured setting.		
	Contracted Foster Care	Enhanced Therapeutic Foster Care Therapeutic foster care with additional supports and resources, and higher level of training and experience of foster parent.	FOSC	
	Foster Care Management and Supports	Foster Parent HELPLINE Through an 800 telephone line provides after hours support, guidance and assistance to foster/adoptive parents experiencing matters of urgency involving their placements, offering them the opportunity to speak with experienced Family Resource supervisory staff on call to provide assistance in order to minimize placement disruptions and maximize the retention of foster/adoptive parents, while still preserving the integrity of the placement and foster family whenever possible.	FOSC	
	Foster Care Management and Supports	Membership Services A contracted organization or program element representing and governed by foster and adoptive parents whose purpose is to provide support, education, recognition and advocacy on behalf of families providing foster care placement for children in the care and custody of DCF to increase foster and adoptive parent satisfaction and sense of value for services rendered on behalf of children in the Commonwealth.	FOSC	
	Foster Care Management and Supports	Training Pre-service and ongoing competency based education modules for the purpose of supporting, developing and retaining Level I, II and III family resources in the placement system to improve and enhance placement skill development, and develop family resources with specialized capabilities.	FOSM	
	Foster Care Management and Supports	Foster Home Recruitment Targeted media and community outreach activities specifically designed to promote and support inquiries to DCF from eligible individuals interested in becoming foster parents.	FOSM	

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
Comprehensive Foster Care	Intensive Foster Care Programs that provide therapeutic services and supports in a family-based placement setting to children/youth for whom a traditional foster care environment will not be sufficiently supportive. Youth may be transitioning from a residential/group home level of care and require the intensity of services available through this program; or discharging from a hospital setting. This service is only provided by licensed foster care agencies in accordance with the licensing requirements of DEEC and DCF.	Intensive Foster Care One ^a model provided in a foster home that has been licensed and credentialed by the provider agency as exhibiting an expertise compatible with IFC One. The model assumes a capacity to support sibling and teen parent placements and assumes an agreement to the terms of Purchasing a Home.	CIFC	
	Intensive Foster Care	Sibling sibling daily rate is for any sibling who does not need the IFC One service but is placed in an IFC One home specifically to stay with a brother /sister who does require that level of service. This rate includes both a payment of a regular Departmental rate to the foster home and a payment to the contractor in recognition that these placements, while not requiring the full level of support from the contractor, do require a level of support consistent with a Departmental Foster Care home	CIFC	
	Intensive Foster Care	Teen Parent Prior to a Teen Parent placement, DCF will clarify with the parties involved the responsibilities of the teen parent, the foster parent and the contractor with regard to the baby/child. Not all children of teen parents in these circumstances will be in DCF care or custody. It is not necessary for both the teen and the child to require IFC One in order to place them together in an IFC One home. As such, payment for both the teen parent and the child at the IFC One rate will be made only when both are in the care of DCF and both require this level of service	CIFC	
	Intensive Foster Care	Transitions to Adulthood an IFC model with family resources recruited and trained specifically on life skills needed by young adults to transition to adulthood	CIFC	
	Intensive Foster Care	Emergency Shelter Homes short-term (no more than 45 days) IFC model with family resources recruited and trained specifically for short-term/emergency placements and transitions	CIFC	
	Intensive Foster Care	Purchase of Home IFC One home becomes an approved adoptive home or guardian or a provider's recruitment efforts might identify a potential foster home that will not or does not want to meet the standards to provide IFC One but would be able to serve as a Departmental home	CIFC	
	Intensive Foster Care	Multiple Acute Level A specializes in serving children and youth with significant cognitive and/or physical impairments and mental health issues	CIFC	

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Intensive Foster Care	Multiple Acute Level B specializes in serving children and youth with significant cognitive and/or physical impairments and mental health issues; provides a significantly enhanced support package to the child or youth and has adaptive transportation available	CIFC	
	Intensive Foster Care	Child Home-Based Rehabilitation serves youth who are unable to live at home due to a history of fire setting and/or sexually reactive behaviors rooted in trauma	CIFC	
	Family Residential Foster Care	Family Residential A foster care program integrating a level of support commonly associated with group care programs into a foster care setting	FRFC	
	Family Residential Foster Care	Complex Foster Care Medical provides care and treatment supports to children and youth who require intensive medical care management and coordination	FRFC	
	Support Services Comprehensive Foster Care program that includes Respite and Unbundled Special Support.	Respite short-term service for a youth provided by adults other than the birth parents, foster parents, adoptive parents or legal guardian with whom the child/youth normally resides, typically used to give the parents/caregivers and youth time away from each other in order to decrease stress and support the family system. Respite may be provided in the home or in settings outside the home, and may include day or overnight support.	CFSS	
	Support Services	Unbundled IFC Special Support purchase of the IFC One support package separately on behalf of the Department's own foster homes (including kinship, child-specific, and unrestricted homes) when necessary to reduce disruptions and unnecessary moves. It can also be bundled with CFC placement services when necessary and recommended by the Family Team to (1) support transitions; (2) prevent transitions and support placement stability; or (3) maintain placement stability	FNSS	
Adoption	Subsidies Adoption subsidies consist of financial assistance, medical assistance, or both, provided at the time of legalization of the adoption in order to aid in the support of a child with identified special needs.	Adoption Pre-1997 Rate The Pre-1997 Rate is paid when the adoption finalization occurred prior to January 1, 1997.	ADCF	
	Subsidies	Adoption Tier I	ADCF	
	Guardianship subsidies consist of financial assistance to aid in the support of a child with his/her guardian.	Guardianship Pre-1997 Rate The Pre-1997 rate is paid when the guardianship occurred prior to January 1, 1997.	ADCF	
		Guardianship Tier I		

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Category	Program	Model	Activity Code	Index Number
	Adoption Management	Adoption Management and Support Varied services provided to individual children, sibling groups and individual adults and couples who are in the adoption process. These services include, but are not limited to, adoption assessments, home studies, education, consultation, adoption recruitment, public information, support groups, trainings, and workshops. Also, includes post adoption services.	AMSS	1
	Adoption Management	Product Based Adoption: Single Service The completion of a single specific task: Assessment of an identified child; adoptive home study of foster parent(s) where the child resides; adoptive home study for a relative of an identified child; MAPP training/home study of identified parent(s); adoptive home study of DCF employee.	AMSS	1
	Adoption Management	Product Based Adoption: Family Resource The transfer of an approved adoptive placement resource from an adoption contract agency to an area office responsible for the adoptive placement of an identified child.	AMSS	1
	Adoption Management	Product Based Adoption: Case Management Casework responsibility for assigned children with a Service Plan goal of Adoption, including the follow steps: case assignment and acceptance; adoption assessment of child; adoption home study; family development; placement; legalization; case closure.	AMSS	1
Domestic Violence Services Provide a continuum of services for individuals and families who are victims of domestic violence. Services provided under contracted Purchase of Service basis.	Community Based Community-based location for individuals and families to drop in for help and/or receive Domestic Violence services.	General Community Based Community-based location for individuals and families to drop in for help and/or receive Domestic Violence services.	DVCB	
	Community Based	Supervised Visitation Provider supervised visitation for children of families who have experienced, or are at risk of domestic violence.	DVCB	
	Community Based	Child Witness to Violence Programs which provide services to children who have witnessed Domestic Violence	DVCB	
	Community Based	Transition to Home Programs whose focus is to enable victims of domestic violence to transition to permanent housing. DELETE DCF NO LONGER USES THESE CODES	DVCB	
	Residential	Substance Abuse and Mental Health	DVRE	

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Facility-based services which include a residential or housing component.	Residential programs which focus on serving victims of domestic violence who have also experienced substance abuse and/or mental health problems.	DVRE	
	Residential	SSTAP1 Scattered Site Transitional Apartment Program. Provides services and financial support to maintain families in housing.		
	Residential	Emergency Shelter Provision of residential care on a limited and short-term basis in shelter facilities (up to 90 days) or safe homes. Shelter services include, but are not limited to, peer support groups, individual counseling, legal, financial, and housing advocacy, referral to health and social services, linkages to education/vocational opportunities, and children's services.	DVRE	
	Residential	Housing Stabilization Provide stable family housing and concrete support services that will help program participants access and maintain permanent housing, access employment and/or attend school, parent their children, and generally prepare for economic independence.	DVRE	
		Statewide Hotline 24 hours per day, 7 days per week staffed phone lines available to respond to victims of domestic violence, and arrange for an array of services on a rapid basis.	DVST	
		Training and Technical Assistance Training and technical assistance to agencies which provide domestic violence services.	DVST	
Family Based Services Family based services include a range of services intended to strengthen the ability of families to care for their children by offering treatment or support.	Family Based Services Programs designed to build family strength through the use of clinical supports such as Family, Individual, or Group counseling, Intensive Family Intervention, Evaluation/Consultative/Diagnostic Assessment, and Comprehensive services. Services may also provide specialized counseling to targeted concerns/populations.	Time-limited therapeutic services offered in a clinical setting or in-home, for the purpose of achieving and/or supporting specific outcomes identified in the DCF Service Plan; provided by a licensed social worker, psychologist or other individuals trained in human services. Services may also include short-term supportive, preventive, or topically-oriented programs or counseling to specific target populations in a group setting, provided by a social worker, psychologist, or other individuals trained in human services.	FBSC	
	Clinical Family Based	Sexual Abuse Intervention Network (SAIN)	FBSC	

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Clinical Family Based	<p>Coordination with District Attorney's office to conduct multidisciplinary team interview; investigating cases of reported child sexual assault, severe physical injury, or death; possibly leading to criminal prosecution. Facilitates interagency linkages to law enforcement, and other service providers/systems; lessens child trauma by reducing multiple interviews; assesses immediate needs of victim/family/offender critical to service planning.</p> <p>Comprehensive Integrated or blended set of services delivered to consumers sequentially or simultaneously, which draws upon more than one model and/or external service elements.</p>	FBSC	
	<p>Supportive/Preventive Programs Preventive and supportive programs designed to increase strength, stability, and competency of individuals and families. Services may include populations having unique service needs such as young parents and their children, families with adolescents, ethnic and linguistic minority groups, etc.</p>	<p>Parenting Aide/Support/Education Home-based supportive and preventive services, intended to guide and teach parents, improve family functioning, and enhance child development. Family-focused services may utilize techniques such as role modeling to develop parenting skills and behaviors, advocacy, may include parent support programs, teaching home management, etc. Services may also include time-limited group or individual instruction with a structured approach for the purpose of imparting topical skill or knowledge; usually in a center-based setting.</p>	FBSS	
	<p>Supportive/Preventive Programs</p> <p>Supportive/Preventive Programs</p> <p>Supportive/Preventive Programs</p> <p>Supportive/Preventive Programs</p>	<p>Young Parent Support Community-based supportive, preventive, and educational services to strengthen teen family functioning; promote parenting competency, ensure the safe and healthy growth and development of child(ren); offered as a continuum of services including outreach, home visiting, case management, core support/topical services, mentoring, and tracking services.</p> <p>Supervised Visitation Service conducted by a trained professional, affording child visitation with the non-custodial parent, in a safe, hospitable environment. This services may be accessed by DCF to support visitation requirements, by battered women when there are safety concerns, or as a court-ordered neutral environment for parties involved.</p> <p>Interpreter Short-term, closed referral service for bilingual, bicultural, hearing and visually impaired individuals and families during the absence of linguistically competent social work staff.</p> <p>Recreation/Camp</p>	<p>FBSS</p> <p>FBSS</p> <p>FBSS</p> <p>FBSS</p>	

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Supportive/Preventive Programs	Seasonal, day or residential camping/recreation service offered to children by qualified contracted providers; to encourage and stimulate the healthy emotional, social, and physical development of children. Hotline/Parental Stress Line A 24-hour confidential hotline designed to reduce stress, and the risk of child abuse and neglect; operating daily to provide information and referral, telephone crisis counseling to parents and other caregivers.	FBSS	
	Supportive/Preventive Programs	Coalition Supported Services Community-based coalitions of residents, health and human service providers, schools, businesses and religious and public safety organizations and policy makers whose goal is to facilitate the development of comprehensive family support systems.	FBSS	
	Supportive/Preventive Programs	Comprehensive Integrated or blended set of services, and delivered to consumers sequentially or simultaneously, which draws upon more than one model and/or external service elements.	FBSS	
	Supportive/Preventive Programs	Other Services which do not readily fall into previous model definitions. These should be defined by the DCF manager most familiar with the services being offered.	FBSS	
Family-based	Adolescent Day Program	Alternative Schools Programs designed for learning and improving practical skills such as reading, writing, and basic math, with emphasis on building self-esteem, social, and academic skills.	FBSN	
Contracted Support Services Services that may closely resemble internal Department mission or activities that are performed through purchase of services contracts.	Protective Services or activities designed to avoid or prevent incidence or continuation of child abuse or neglect.	Child Abuse Hotline 24 hour, 7 day a week telephone line dedicated to screening reports from the public and professionals concerning the abuse and/or neglect of children.	CSSH	
	Protective	Case Management This model currently covers two types of services. First, "conflict of interest" in which the provider investigates and manages cases that involve DCF employees and their immediate families. Second, a provider delivers a full range of case management services to refugee minors who are in state custody.	CSSI	
	Protective	Comprehensive Emergency Services	CSSE	22

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
	Protective	A coordinated system for providing immediate and effective supportive response on a 24 hour basis to individuals, families or children. Although these are crisis situations, they are not protective in nature. Investigations (Conflict of Interest) The provider conducts investigations of reports of child abuse and neglect that involve DCF employees and their immediate relatives.	CSSI	22
	Protective	Partnership Agency Services The PAS program is focused on serving cultural/linguistic minority populations. It includes the following mix of components: parent/kinship mentor services; visiting resource services; intensive adolescent services; family/group care reintegration services; foster home/kinship recruitment and support; and foster home management.	CSSP	22
	Protective	Unaccompanied Minors Arrange foster care placements for "unaccompanied refugee minors" placed with licensed and trained foster families through 25 affiliated child welfare programs. The program provides foster care and related services to youths, who lack a caregiver, from all around the globe.	CSSU	
	Service Management	PATCH A community-based partnership of public agency direct service staff, community groups, and residents to provide comprehensive direct services to families.	CSSS	
	Community Education & Training	Community Education & Training An array of activities aimed at the prevention or reduction of specific social problems through raising community awareness of the problem. Activities may include public speaking, publication of brochures, interagency networking, advertising, etc.	CSSC	
	Community Education & Training	Other Services which do not readily fall into previous model definitions. These should be defined by the DCF manager most familiar with the services being offered.	CSSS	
Administrative	Miscellaneous Payment	Emergency Payments Lump Sum Payment Child Care AIDS Network Foster Care Review Family Residence Service Insurance Coverage Preparing Adolescents for Young Adulthood (PAYA)		

Department of Children and Families Taxonomy

Category	Program	Model	Activity Code	Index Number
		Foster Parent Respite Exchange		
	Miscellaneous Administrative	Travel		

Commonwealth of Massachusetts

Department of Children & Families

Massachusetts Child Welfare Trafficking Grant Report

Massachusetts Child Welfare Anti-Trafficking Grant

Grant Number 90CA1829

Semi-Annual Grant Reporting

October 1, 2015 - March 31, 2016

The Massachusetts Child Welfare Trafficking Grant (MACWTG) has successfully achieved the goals and implementation activities outlined in the grant application implementation plan from October 1, 2015 through March 31, 2016. This semi-annual report describes the objectives, tasks, and accomplishments of this time period.

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Acronyms used within this report:

MACWTG – Massachusetts Child Welfare Anti-Trafficking Grant

DCF – MA Department of Children and Families

JRI – Justice Resource Institute, lead on grant

SEEN – Support to End Exploitation Now, a program of the Children's Advocacy Center of Suffolk County

HT – Human Trafficking

MDT – Multi-disciplinary team

CSEC – Commercial Sexual Exploitation of Children

MLMC – My Life My Choice, A Program of Justice Resource Institute

I. Project Implementation

A. Implementation Activities over the Past Six Months

Describe any accomplishments and progress toward each objective listed in the original grant application over the past six months. The following list corresponds to those items from the Grant Implementation Plan that were scheduled for or achieved in this reporting period.

Objective 1 / Statewide Partnerships

1. **Leadership Team Meetings:** The Leadership Team brings together the lead grant partners to focus on grant activities and related topics. It is comprised of: Lisa Goldblatt Grace (My Life My Choice, A Program of Justice Resource Institute), Susan Goldfarb (Children's Advocacy Center of Suffolk County /SEEN Coalition), Lori Ann Bertram (MA Department of Children and Families), Amy Farrell (Northeastern University), Evonne Meranus (Grant Coordinator), and Beth Bouchard on occasion (SEEN Case Coordinator).

Team meetings range from 1.5-2 hours and serve the purpose to plan implementation activities, develop materials collaboratively, assess progress and impact, and draw upon the technical assistance of MLMC and SEEN.

The dates of the Leadership Team Meetings in this reporting period are:

- **10/8/2015**, 10/29/2015, 11/10/2015, 12/17/2015, 1/19/2016, 2/11/2016, 3/17/2016

The 10/8/2015 meeting was an all-day Leadership Team Retreat to prepare for Year 2, review the two counties that received grant activities in year one, to determine the rollout plan for years 2-5. The following rollout plan and map (see next page) was developed at this retreat.

The Leadership Team also decided at the retreat to provide targeted training and technical assistance to one DCF-contracted service provider in each county to better support the development and expansion of the provider capacity across the state. My Life My Choice will begin to offer targeted technical assistance to a select provider in each county beginning in Year 2.

Hampden: Summer 2015 (YR1)
Bristol: Late Summer 2015 (YR1)
Cape & Islands: Late Fall 2015 (YR2)
Middlesex: Early Spring 2016 (YR2)
Essex: Late Spring 2016 (YR2)
Worcester: Fall 2016 (YR3)
Berkshire: Spring 2017 (YR3)
Plymouth: Fall 2017 (YR3)

1. Hampden: Summer 2015 (YR1)
2. Bristol: Late Summer 2015 (YR1)
3. Cape & Islands: Late Fall 2015 (YR2)
4. Middlesex: Early Spring 2016 (YR2)
5. Essex: Late Spring 2016 (YR2)
6. Worcester: Fall 2016 (YR3)
7. Berkshire: Spring 2017 (YR3)
8. Plymouth: Fall 2017 (YR3)
9. Norfolk: Spring 2018 (YR4)
10. Franklin/Hampshire: Fall 2018 (YR4)

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2. Quarterly Statewide Multi-disciplinary Child Trafficking Advisory Board:

The Leadership Advisory Board brings together top leaders of more than 20 state agencies involved with Human Trafficking, each of whom had submitted a Letter of Commitment along with the grant proposal.

In the recent reporting period, we convened 2 Leadership Advisory Board meetings with the following topics for discussion (in addition to a review of grant activities at each meeting):

- December 3, 2015 – Conversation about the MA Child Requiring Assistance (CRA) Law replacing CHINS (Child in Need of Services) Law
- March 3, 2016 – Discussion of the new DCF Protective Intake Policy

In addition to these meetings, this forum has fostered additional cross-agency leadership opportunities on issues that may involve human trafficking. For example, the representative of the Executive Office of Public Safety used the Leadership Advisory Board forum to solicit input on the Mass Gaming Problem Gambling Services Strategic Plan as new casinos are scheduled for development in several Massachusetts locations.

3. Input from the MLMC Leadership Corps

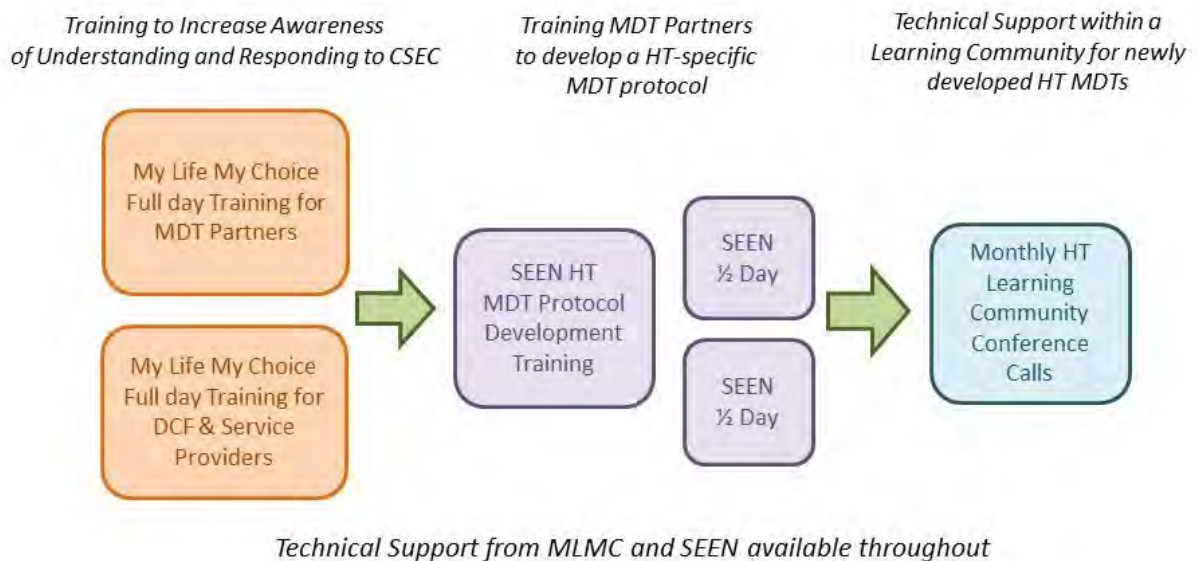
The MLMC Leadership Corp is comprised of youth victims of the commercial sex industry who have exited “the life” as survivors who are in the process of becoming leaders in the fight against exploitation. Leadership Corps members work on projects connected to raising awareness, pushing for systemic change, and supporting other girls.

The goal of the grant project has been to include the voice of the MLMC Leadership Corp in all facets of our work. While the grant team has sought to invite members of the MLMC Leadership Corp to the grant Leadership Team meetings as well as to the Leadership Advisory Board meetings, the timing of these meetings (during school and business hours) has thus far prohibited the youth from attending.

In the recent reporting period, the Leadership Corps created a video to share with the Leadership Advisory Board which will be used in the next reporting period and also in other training opportunities.

Objective 2 / Infrastructure Development through Regional Child Trafficking Multidisciplinary Teams (MDTs)

The primary work of the Infrastructure Development objective is comprised of a series of five trainings followed by on-going technical assistance in each county. These trainings provide the foundation of the work that each county then continues independently as it develops its own Human Trafficking Response Protocol. The grant provides additional technical support over the full award period. To further deepen the capacity to respond to victims in each county, additional training provided by the grant and grant partners includes: targeted technical assistance to a human trafficking service provider in each county, law enforcement training offered by the DA's office, and the MLMC CSEC Prevention Curriculum training.



4. Provide Full-Day MLMC Training to MDT Partners in 2 Counties

To begin the work of developing an MDT in each county, the first step is to build awareness of the issue locally and nationally. To do this, we provide the MDT partner community with a full-day MLMC training entitled "*Understanding and Responding to Victims of Commercial Sexual Exploitation*" which addresses the national picture of human trafficking, risk and vulnerability, recruitment, impact of exploitation on the mind, body, and soul; screening and identification; worker response; and referrals and resources.

In this reporting period, this training was delivered to two counties:

- Cape & Islands (Barnstable & Dukes Counties): November 16, 2015
- Middlesex County: February 24, 2016

Participants for each training by discipline was as follows:

Training	Total	DCF	Juvenile Justice	Legal Comm.	Education	Law Enforc.	Service Provider	Health Care	Other
Cape MDT	54	8	8	3	1	15	9	4	6
Middlesex MDT	69	35	8	2	0	17	2	1	1

These trainings involve pre-training and post-training assessment surveys for the grant evaluation. (For evaluation analysis of these trainings, see the first appendix.)

5. Provide Full-Day SEEN MDT Protocol Development Training to MDT Partners in 2 Counties

Building on the county's enhanced ability to understand and respond to victims of commercial sexual exploitation following the full-day MLMC training, SEEN works with the leadership of the MDT partner agencies to help develop each county's MDT Protocol for human trafficking. This full-day training was delivered in Year 2 as follows:

- Cape & Islands (Barnstable & Dukes Counties): November 24, 2015
- Middlesex County: February 25, 2016

	Total	Child Welfare	Juvenile Justice	Legal Community	Education	Law Enforce.	Service Provider	Health Care	Other
Cape MDT	41	7	4	1	1	11	9	3	5
Middlesex MDT	33	6	4	3	0	9	3	4	4

These trainings involved a subset of the community partners who attended the MLMC training, namely the decision makers or leaders within the partner agencies.

The focus of this training is to develop a draft of a Human Trafficking Protocol for each county. Partners collaboratively develop a shared mission, core principles, and detailed elements of a human trafficking protocol for their county. The process of developing the protocol builds new cross-partner relationships and reinforces existing ones. The product of this training day is a draft protocol which is then revisited and revised in the subsequent half day trainings. Furthermore, a steering

committee may be assigned to address additional topics such as screening tools, community outreach, or additional training needs.

These trainings involve pre-training and post-training assessment surveys for the grant evaluation. (For evaluation analysis of these trainings, see the second appendix.)

6. Provide Two Additional Half-Day SEEN MDT Protocol Development Trainings

The work in each county to continue developing the MDT Protocol for human trafficking takes place over several weeks and months as each county continues the work as a team of multi-disciplinary partners. Attendance for this training is the same group as the full day Human Trafficking Protocol Development, schedules permitting. The draft protocol is revisited and revised, often with a discussion of a recent human trafficking case (when possible) to examine the effectiveness of the coordinated response using the protocol. Counties report that familiarity and comfort with a new protocol to respond to human trafficking takes time.

The following are the subsequent meeting dates in the respective counties for the recent reporting period:

- Cape & Islands (Barnstable & Dukes Counties): January 21, 2016, April 14, 2016
- Middlesex County: 3/28/2016, TBD

7. Provide SEEN Technical Assistance: On-going

SEEN Technical Assistance provides on-going support to the counties engaged in MDT Protocol Development work. Support from SEEN includes technical assistance on building the MDT partner community, coaching on leadership development for the MDT, communication, and providing additional resources and tools to support each county.

SEEN Technical Assistance is also provided to partners on the grant, MLMC and DCF, as the grant work impacts the work done in both of those organizations.

In addition, SEEN provides monthly technical assistance conference calls with the counties trained to date. As new counties are trained, they join this “Learning Collaborative” to receive support from SEEN and share experiences, learnings, and questions with one another. The content of these calls includes: review of current human trafficking case coordination, communication challenges, tools and data collection procedures, and general support of case coordination.

Dates of SEEN Technical Assistance Calls in this reporting period: 12/29/2015, 1/25/2016, 2/29/2016, 3/28/2016

Objective 3 / Training and Tools

8. Provide MLMC Training to DCF and DCF-Contracted Providers: On-going

This training continues to expand the knowledge, awareness, and ability for DCF and service providers statewide to better respond to human trafficking.

In the recent reporting period, MLMC delivered the full-day “*Understanding and Responding to Victims of Commercial Sexual Exploitation*” to DCF and DCF-contracted providers in two counties:

- Cape & Islands (Barnstable & Dukes Counties): November 23, 2015
 - Serving the Cape & Islands Area Office and Southern Regional Team
- Middlesex County: March 4, 2016
 - Serving Arlington, Cambridge, Lowell, Malden, Framingham Area Offices and Northern Regional Team

	Total	DCF	Juvenile Justice	Education	Service Provider	Health Care	Other
Cape DCF	72	55	0	3	6	1	3
Middlesex DCF	33	28	1	1	2	1	0

(Note: When MDT partners are unable to attend the MDT MLMC training, they are invited to participate in the DCF MLMC training as an alternative date.)

9. Provide the MLMC Prevention Curriculum Training for DCF and DCF Contracted Providers

The MLMC provides training on its CSEC Prevention Curriculum Training to 6-10 people per county under the grant. The Prevention Curriculum is designed for providers and programs interested in delivering a 10-week group prevention program to at-risk girls. The group may be appropriate for Residential Schools, Group Homes, schools, DCF offices, and other programs.

Enrollment in the MLMC Prevention Curriculum through the Grant in recent reporting period: 9 individuals

10. Provide MLMC Technical Assistance: On-going

MLMC technical assistance continues in Year 2 to support the grant partners and the service providers statewide. One example of technical support offered is working to help hire survivor mentors in communities in the western part of Massachusetts so that the capacity for the mentorship/interpersonal support model can grow statewide. MLMC continues to work closely with DCF on case specific concerns, placement issues, policy development and implementation. MLMC works closely with the service provider community to improve the effectiveness of programming for victims of HT in placement.

11. Develop Online DCF Trafficking Toolkits: On-going

Working with grant partners, Roxbury Youthworks Inc (RYI) and Julie Dahlstrom (Clinical Instructor, Human Trafficking Clinic at Boston University School of Law, previously with Ascentria, formerly known as Lutheran Social Services), DCF Toolkits are being drafted to provide workers with resources and to specifically address the topics of transition-age youth (aging-out of care), dually involved youth, and labor trafficking.

Drafts of all three toolkits are under development. The Labor Trafficking Toolkit will be the first to be released, towards the end of Year 2. The Transition Age Youth toolkit and the Dually Involved toolkits are planned for release in years 3-4.

12. Develop Administrative Data Collection Procedures: On-going

DCF has implemented a new version of its case management information system, i-Family Net, to reflect the recent changes in DCF policy. With new allegations of human trafficking for commercial sexual exploitation and labor trafficking as reportable conditions for child abuse thus requiring by law mandated reporting to DCF, data on commercial sexual exploitation and labor trafficking is now being tracked and analyzed to help with policy implementation, quality assurance, and to support the Federal reporting requirements. The data will also serve the grant team to show how effectively increased awareness through training and newly established MDT responses serve the trafficked youth over time. The DCF data on human trafficking will be analyzed and shared with the leadership team, the Leadership Advisory Board, and will become part of the project evaluation.

Additional on-going administrative data collection procedures include: meeting tracking, training attendance tracking, pre/post training assessment data collection, etc.

13. Conduct Interviews of MDT Members and MDT observations: On-going

Dr. Amy Farrell, the grant project evaluator, continues to conduct interviews of the MDT members as towards the second half of the MDT Protocol Development Training. The following is a summary of the interviews conducted to date (conforming to IRB restrictions for sharing the information on human subjects):

1. County 4 – Local law enforcement – November 17, 2015
2. County 4 – DCF – November 17, 2015
3. County 4 – Federal law enforcement – November 30, 2015
4. County 4 – Federal law enforcement – December 10, 2015
5. County 4 – Victim service agency – December 16, 2015
6. County 4 – Victim service agency – January 28, 2016

7. County 2 – DCF -- March 29. 2016
8. County 2 – Local law enforcement-- March 29, 2016
9. County 2 – Prosecution 1 -- March 29, 2016
10. County 2 – Prosecution 2-- March 29, 2016
11. County 2 – Victim Service Agency-- March 29, 2016
12. County 2 – Victim Service Agency-- March 29, 2016

The insights gained from the interviews are shared with the Leadership team to help inform the work of the grant and to support the on-going MDT development in each county.

Objective 4 / Policy and System Development

14. Integrate Child Trafficking into DCF Policies (Protective Intake, Assessment & Action Planning, Policy Regarding Missing or Absent Children from Departmental Care or Custody, and DA Referral Policy and others throughout Grant Period): On-going

The role of the grant to help inform policy changes at DCF continues to be an important and significant aspect of the grant work. At the start of the grant, DCF Protective Intake policy included a caretaker requirement in order to be screened in for a response. One goal of the grant team was to help shape DCF policy to reflect the Massachusetts Safe Harbor provision of the 2011 MA Human Trafficking law which defines commercial sexual exploitation as child abuse, thereby requiring DCF to investigate and if applicable, provide services to the victims.

This goal has been achieved earlier than anticipated, as DCF was directed by the Governor to revise its Protective Intake policy which took effect February 29, 2016.

DCF policy now requires any youth with an allegation of human trafficking to be screened in. Grant work on practice tips, supporting resources, and clarification relative to human trafficking in these allegations has commenced and will continue.

15. DCF Grant Manager to Update DCF Commissioner/ Senior Staff on Grant

Activities: On-going

The DCF Grant Manager continues to work closely with senior DCF staff members, providing regular updates. The communication and coordination of information around grant activities has increased in Year 2 due to focus on human trafficking and the change in the DCF Intake Policy. Training of DCF staff on human trafficking and the two new human trafficking allegations that are mandated by law to be reported to DCF have elevated the importance of the grant work statewide to help build the infrastructure through regional MDTs that will work in concert with the DCF staff in response to all cases of trafficking or suspected trafficking of youth in Massachusetts.

Communication between the DCF grant partner and senior leadership within DCF has increased significantly with the new policy. Formal updates on grant activities to the DCF Commissioner and senior staff continue bi-annually. Additionally, the DCF Commissioner attends the Leadership Advisory Board quarterly.

B. Challenges/Barriers

In the second reporting period of the grant, the challenges faced by the MACWTG include:

- **HT Taxonomy:** The nomenclature related to human trafficking has become confusing. Clear definitions of the terms sexual exploitation, commercial sexual exploitation of children (CSEC), human trafficking, labor trafficking, and other related issues such as pornography, sexting, statutory rape, and sexual abuse are needed. The advent of the new DCF Protective Intake policy shed light on the need to provide clarity related to the two new allegations for suspected abuse: Human Trafficking – Sexually Exploited Child and Human Trafficking – Labor. In early review of data from March of 2016 on human trafficking allegations, it is clear that confusion exists at intake. In order to collect accurate and reliable data on trafficking, clear and consistent definitions for the range of possibilities child welfare may encounter are critical and will require guidance and additional training.
- **Turnover within CACs:** An inevitable aspect of the work in human service agencies is turnover. The grant has witnessed several CACs lose staff and

management involved in the work. New staff take time to learn the complexities of human trafficking case coordination, and may require additional training.

- **Differentiating a HT MDT Protocol from other MDT Protocols:** In counties that have not previously experienced many human trafficking cases, the tendency to confuse the MDT Protocol for human trafficking with that of other MDTs, such as SAIN MDTs for sexual abuse, is high. The complexity of trafficking cases is different from sexual abuse and requires a different approach, specifically addressing the stages of change model that in which youth may or may not identify as victims and in which relapse is a frequent occurrence. The grant strives to impart the difference of HT cases and the need for a different level of case coordination and communication across partners.

C. Changes (Additions and Deletions) from Original Application or Implementation Plan

- **Training Extension:** Based on our experience in Hampden and Bristol counties, the grant team identified the need for deeper training to support service providers in each community. MLMC will add two additional training offerings:
 - Grant-sponsored scholarships for service providers involved in the grant for the MLMC Prevention Curriculum Training
 - Targeted technical assistance training for a DCF-selected provider in each community.

This change in offerings from MLMC deepens the capacity for services in each community more than originally planned. This is made possible by consolidating the MLMC *“Understanding and Responding to Victims of CSEC”* trainings for DCF staff and DCF-contracted providers into a single training. Another benefit of this consolidation is the opportunity for DCF and providers to build or strengthen relationships.

- **Contractor Substitution:** One change we made to our original application / implementation plan. For the Labor Trafficking Toolkit, we switched the subcontractor from Ascentria (formerly Lutheran Social Services) to Julie Dahlstrom, an independent contractor. At the start of the grant, Julie was an employee of Ascentria, and that has since changed. The work was always intended to be done by Julie, so the change is simply from her former employer to her independently.
- **Toolkit Completion Extension:** Due to the complexity of policy change within DCF, the work on the Toolkits will continue beyond Year One of the grant.

Additional work involved in the toolkit development will include focus groups and DCF vetting.

D. Contextual Events or Community Changes

The change in DCF policy for Protective Intake was the biggest contextual event impacting the grant in the recent reporting period. This change in policy removed a barrier for serving the youth victims of human trafficking – sexually exploited or human trafficking – labor within the state child welfare agency.

The impact of this change on DCF, partner agencies, and on the development of HT MDTs statewide has yet to be fully identified at this nascent stage of the new policy's implementation. Protocols for response to HT developed before this policy change require review and updates to clarify roles and responsibilities for cases that are now screened in for response by DCF. Case coordination for human trafficking requires a new level of communication and cross-agency collaboration to ensure a coordinated and effective response.

E. Lessons Learned

Some of the key lessons learned in the grant work to date include:

- **Relationships matter:** In each county, the trainings facilitate a transfer of knowledge, but also an opportunity for people to meet and get to know one another. The work of the grant is difficult and the time invested in the trainings helps facilitate collaboration explicitly and tacitly.
- **Values matter:** In HT MDT Protocol Development training, a challenging topic continues to be arrest policy. Because local police are constrained by the MA Child Requiring Assistance (CRA) Law, much conversation in the HT MDT Protocol Development training revolves around the options available for law enforcement in lieu of arrest when responding to at-risk or youth victims of trafficking. With aspirations to create a *victim-centered* and *trauma-informed* response, difficult conversations on the topic of arrest continue in most counties as they develop their protocols.
- **Planning matters:** The coordination of the trainings in each county has varied significantly (allowing for local leadership to play a central role). We have learned that the effectiveness of a training depends significantly on the space: specifically, an adequately sized room, with good acoustics and A/V support. The grant trainers have experienced a wide range of spaces for trainings, and

we have learned what works well and what doesn't. We hope that lesson will be able to inform the subsequent trainings in the remaining eight counties over the next four years.

- **Leadership Matters: The Importance of a “three-legged stool”:** The grant has identified an important formula for success in implementing the HT MDT Protocol in each county: a three-way leadership partnership between DCF, the CAC, and the DA's office. In the counties where the leadership of these three partners is strong and “bought in” to the HT MDT Protocol, trafficking cases have more successfully received a coordinated response. In counties where these partners are not as strong, the coordinated response has not been as successful. Identifying the leadership and fostering the partnership across these three agencies has become an important component of the HT MDT Protocol development work.

F. Activities Planned for the Next Reporting Period

Implementation Activities
Objective 1: Statewide Partnership
1. Convene Monthly Leadership Team Meetings (JRI, DCF, SEEN, HT Coordinator, Evaluator and others, as needed)
2. Convene Quarterly Statewide Multidisciplinary Child Trafficking Leadership Advisory Board (LAB)
3. Share input and feedback from the MLMC Leadership Corp to the Leadership Team and to the LAB
Objective 2: Infrastructure Development Through Regional Child Trafficking Multidisciplinary Teams (MDTs)
4. Provide (1) Full-Day MLMC Training to MDT Stakeholders in 2 additional counties (Essex & Worcester)
5. Provide (1) Full-Day Child Trafficking MDT Protocol Development Training in 3 additional counties (Essex & Worcester)
6. Provide (2) 1/2 Day Follow Up Child Trafficking Protocol Development Trainings in 3 additional counties (Essex & Worcester)
7. Conduct Pre and Post MLMC and MDT Training Assessments in each county
8. Provide SEEN Technical Assistance (Policy, Data, Implementation, Other)

Objective 3: Training and Tools
9. Provide MLMC Training to DCF Social Workers and Supervisors in Each Region
10. Provide MLMC Training to DCF-Contracted Providers including Foster Parents, Group Homes, Residential
11. Provide MLMC Prevention Curriculum Training for DCF-Contracted Providers
12. Provide MLMC Technical Assistance
13. Continue to Develop Online DCF Trafficking Toolkits
14. Collection of Administrative Data from DCF and MDTs
15. Conduct Interviews of MDT Members and MDT Observations
Objective 4: Policy and System Development
16. Integrate Human Trafficking into DCF Policies (Protective Intake, Assessment & Action Planning, Policy Regarding Missing or Absent Children from Departmental Care or Custody, DA Referral Policy, and others throughout the Grant Period)
17. DCF Statewide Manager of Trafficking to Update DCF Commissioner and Senior Staff re Grant Activities (Bi-Annually)
18. Develop Measures to Monitor Efficacy of MDT Protocols and Accountability Measures
19. Conduct Annual Project Assessment
Other
20. Attend Annual Grant Meeting in Washington DC
21. Report Data to Leadership Team (Quarterly)
22. Report Data to Advisory board (Annually)
23. Grant Reporting, as Required

II. Process Evaluation

This section describes the process evaluation activities the project engaged in over the past six months, focusing on the key interventions/activities delineated in the project's logic model as well as the recommended Cluster-Level Logic Model (see Appendices II and III for both):

- Training (MACWTG Logic Model Program Measure #2; Cluster-level Logic Model #3.3, PM-OTOOL measure #9)
 - MLMC CSEC Trainings for DCF and DCF Employees: 2 full days
 - MLMC CSEC Trainings for MDT Community Partners: 2 full days
- Development or enhancement of multidisciplinary partnerships (MACWTG Logic Model Program Measure #4; Cluster-level Logic Model #3.1)
 - Ongoing meetings and communication of the Statewide Leadership Advisory Board: 2 quarterly meetings
 - Successful establishment of local county-based HT MDTs: 2 (Cape & Islands and Middlesex Counties)
 - SEEN HT MDT Protocol Development Trainings: 2 full days, 3 half days
- Policy development (MACWTG Logic Model Program Measure #5; Cluster-level Logic Model #3.2)
 - Continued support / development of DCF Policies: Protective Intake Policy

A. Intervention/Activity No. 1: Staff Training

- **DCF Training of DCF and partner agencies**
- Outputs (e.g., # of trainings, # of hours of training received, # of recipients): To date = 2
- Challenges/Barriers regarding Activity No.1: Timing and availability, willingness to participate, availability of training spaces
- Lessons Learned: DCF is highly receptive and engaged in understanding and responding to human trafficking. Training has already led to an increase in identification and coordinated response in the counties where training has been delivered. Additional non-grant sponsored trainings on human trafficking (also provided by MLMC) have in some cases reduced the number of DCF staff attending grant-sponsored training, but overall increased the number of DCF staff trained. The additional training has provided more options for DCF staff to attend and receive the training.

B. Intervention/Activity No. 2: MDT Development

- **Statewide partnerships/policy and system development**
- Outputs:
 - a. Statewide MDT Partnership Meetings= 2 Leadership Advisory Board Meetings
 - b. Local county based MDT Meetings: 5 (SEEN Trainings establishing the HT MDT in Cape & Islands and Middlesex Counties)
- Challenges/Barriers regarding Activity No.2: Timing and availability of participants to attend
- Lessons Learned:
 - a. Positive engagement of the leadership at the highest levels of the Leadership Advisory Board partner agencies, an exemplary model of MDT for local county level to emulate.
 - b. Positive Local engagement of MDT teams in the counties where the grant has delivered training leading to ongoing, independent meetings of the HT MDT Steering Committees/Advisory Boards,
 - c. Data analysis of the pre and post training survey of the MDT Protocol Development trainings (See Appendix).

C. Intervention/Activity No. 3: Policy Impact

- **Policy Impact**
- Outputs (# policies reviewed, # policy meetings attended): To date: 2 policies reviewed and recommendations made.
- Challenges/Barriers regarding Activity No.3: Ability to weigh in on policy as an outsider
- Lessons Learned: DCF consultation with outside experts is not always possible or timely for policy development.

III. Outcome Evaluation

This section should describe the evaluation activities that the project engaged in over the past six months, focusing on the key activities delineated in the project's logic model that are related to the following outcomes (as applicable to each project):

Stakeholder awareness of trafficking: Measured in pre- and post- training evaluations. (See attached appendix for a summary report).

Stakeholder collaboration: Assessed through baseline interviews with MDT principals in Hampden and Bristol counties and observations of MDT meetings.

A. Outcome No. 1 (MACWTG Logic Model Outcome #3; Cluster-level Logic Model #4.2)

- **Stakeholder Awareness of Trafficking**
- Methods of data collection: Readiness Assessment, Pre-Post-Training Surveys, MDT Interviews and Observations of MDTs
- Sources of information: MDT participants, Training recipients
- Timeframe for collecting information: Beginning Q3 and on-going throughout grant
- Methods for analyzing the information to determine whether the outcome was attained: Data analysis (i.e., tabulation of frequencies, assessment of relationships between or among variables using statistical tests); qualitative analysis of interview data and observation notes.
- Challenges/Barriers regarding Outcome No.1.: Survey response rates/coordination of pre/posttest surveys. Note: response rates and coordination of pre/posttest surveys has been resolved through the use of a paper-pencil version of the survey given immediately prior and immediately following the trainings. Created additional challenge of data entry for pencil and paper surveys.
- Findings: (See Appendix for results from trainings that occurred during this reporting period)
- Interpretation of findings: (See Appendix for interpretation of findings)

B. Outcome No. 2 (Cluster-level Logic Model #4.1): Collaboration

- **Stakeholder Collaboration**
- Methods of data collection: Wilder Assessment used as pre- and post- training survey instrument given during the last reporting period. This period we have utilized interviews with MDT principals in Hampden and Bristol counties to assess their baseline levels of collaboration.
- Sources of information: MDT participants, Leadership Advisory Board Participants
- Timeframe for collecting information: Beginning Q3 and on-going throughout grant
- Methods for analyzing the information to determine whether the outcome was attained: Data analysis (i.e., tabulation of frequencies, assessment of relationships between or among variables using statistical tests), qualitative analysis of interviews and observation notes.
- Challenges/Barriers regarding Outcome No.2.: Scheduling interviews was difficult but we have completed all principal MDT members' interviews in both counties either through in-person or telephone interviews.
- Findings:
 - a. See Appendix for results from trainings that occurred during the reporting period)
 - b. Interviews of MDT partners in the first two MDT sites (Hampden and Bristol counties) were completed during this reporting period. All key stakeholders in the MDT were interviewed within the first three months following the training and technical assistance to establish the MDT process in two counties. Although interview data have recently been

transcribed and systematic analysis of findings across interviewees will be conducted next reporting period, there are some preliminary findings of interest.

- i. Some MDT principals had previous collaborative relationships on other issues involving crimes against children but universally principals in both counties did not have a history of recognizing HT, but others had poor histories and antagonistic relationships.
- ii. Prior to the MDT development there was little working knowledge about how to respond to a HT case when it was recognized.
- iii. The development of protocols to guide identification and response is perceived as critical to the MDT process because few local norms or policies exist to guide identification and response to HT.
- iv. The MDT principals universally recognize a need for increased community and provider training.
- v. In each of county studied thus far there are principals in the MDT who are less active and whose participation will continue to be a challenge.
- vi. A particular challenge is identifying and supporting providers who will appropriately house and serve CSE youth once they are identified.

- Interpretation of findings: (See Appendix for interpretation of findings related to MDT training for Cape and Island and Middlesex County)

C. Outcome No. 1 (MACWTG Logic Model Outcome #1; Cluster-level Logic Model #4.5/5.2): Trafficking Referrals

- **Trafficking Referrals**
- Methods of data collection: Filing of 51As
- Sources of information: DCF Data
- Timeframe for collecting information: Beginning Q4 and on-going throughout grant
- Methods for analyzing the information to determine whether the outcome was attained: Data analysis (i.e., tabulation of frequencies)
- Challenges/Barriers regarding Outcome No.1.: Data systems currently undergoing changes and development. New Human Trafficking allegations have been added to the 51A report of suspected abuse. Definitions of what constitutes human trafficking as Human Trafficking – Sexually Exploited Child or Labor are needed for data accuracy.
- Findings: Not yet available
- Interpretation of findings: Not yet available

D. Other Evaluation Activities

Dr. Amy Farrell has also been part of a CJA grant working on the data collection and reporting of HT data for CACs. The data collection and reporting project received supplemental funding from the Commonwealth of Massachusetts. These funds were utilized to develop the conceptual model for a data collection system that would be utilized by each county MDT to report information on child trafficking victims. A pilot of the data collection system was designed in RedCap and rolled out to three pilot MDT sites (Suffolk County, Bristol County and Hampden County). Results from the pilot data collection process and next steps regarding the build of the complete data collection portal will be discussed in the next reporting period.

The grant team continues to speak in conferences and other forums statewide and nationally about the work of each agency to address human trafficking, as well as to share information about the collaboration, activities, and impact of the grant in Massachusetts.

E. Technical Assistance Needs

None for this reporting period.

F. Activities Planned for Next Reporting Period

Evaluation activities for the next six months include: continuation of pre- and post- training survey data collection, MDT partner interviews, and observations of the on-going technical assistance Learning Collaborative calls among the newly established HT MDTs.

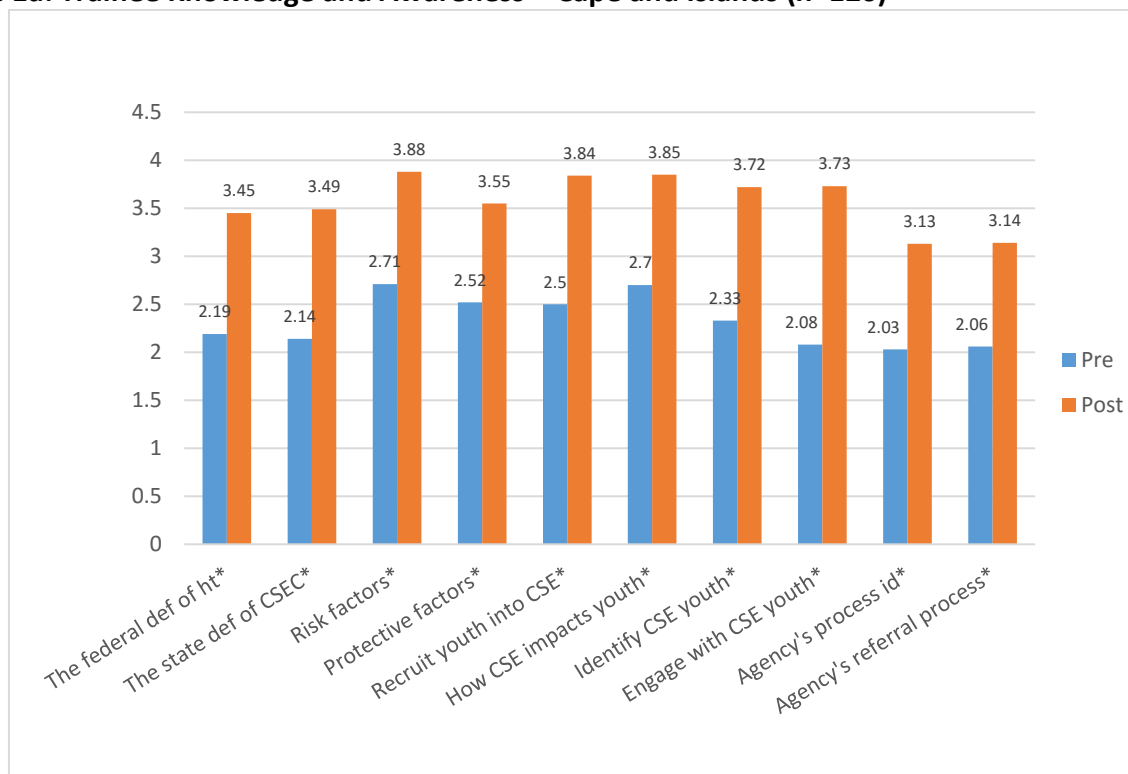
Appendix: MACWTG Evaluation

Understanding and Responding to Victims of CSEC/Human Trafficking Training Bristol and Hampden Counties Combined

During this reporting period, we conducted pre/post training analyses for MLMC CSEC trainings of DCF Employees and MDT Community Partners in the second two MDT sites (Cape and the Islands and Middlesex County). A total of 228 participants completed the pre/post training survey in the two sites (126 in the Cape and Islands and 102 in Middlesex County). Respondents represented many different agencies and community partners including Department of Children and Family (DCF) employees and child welfare specialists (55%), law enforcement (14%), service providers (8%), juvenile justice practitioners (8%), legal advocates (2%), health care providers (3%), school administrators and staff (2%), and other community partners (8%). The following analyses examine the changes in participant awareness, belief and readiness to respond to human trafficking/CSEC as a result of the MLMC CSEC training.

Respondents in both sites self-reported having significantly more knowledge about human trafficking definitions after the training (Tables 1a and 1b).

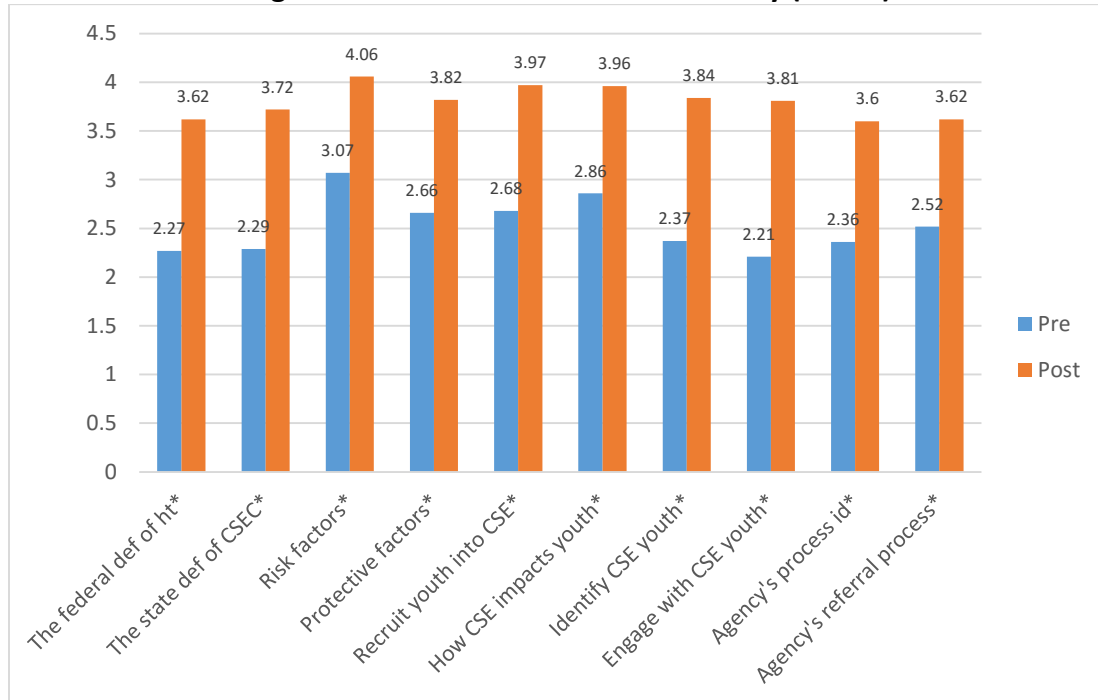
Table 1a: Trainee Knowledge and Awareness – Cape and Islands (n=126)



* p<.05 denoting statistically significant differences between the pre and post training groups

Question asks about trainee knowledge on scale from 1 “No Knowledge” to 5 “Expert/Complete Knowledge”

Table 1b: Trainee Knowledge and Awareness – Middlesex County (n=102)



* $p < .05$ denoting statistically significant differences between the pre and post training groups

Question asks about trainee knowledge on scale from 1 “No Knowledge” to 5 “Expert/Complete Knowledge”

Prior to the training respondents reported only slightly more than “a little knowledge” of federal human trafficking and MA CSEC laws. Following the training, on average respondents reported being “knowledgeable” about federal and state laws (means of 3.5 and 3.6 for federal laws in Cape and Islands and Middlesex respectively and 3.5 and 3.7 for state laws in Cape and Island and Middlesex). Respondents in both sites also report having significantly more knowledge about how CSEC and human trafficking affect youth and more knowledge about the strategies needed to respond following the MLMC training.

The survey also assesses change in respondent beliefs about human trafficking/CSEC. Prior to the training, respondents expressed strong beliefs that CSEC victims were not to blame for their own victimization and exploited youth do not have the choice/ability to stop being victimized at any time (Tables 2a and 2b). These scores did not change meaningfully following the training, but that is likely due to the fact that respondents came in with beliefs about CSEC in line with what they learned in the training. Similarly, respondents did not agree that CSEC victims should be detained (means of 2.3 in Cape and Islands and 2.1 in Middlesex) and those responses did not change significantly following the training. Respondent knowledge of and beliefs about the existence of

services available to youth and youth participation in those services increased significantly as a result of the training in both sites.

Table 2a: Trainee Beliefs about Human Trafficking/CSEC Cape and Islands (n=126)

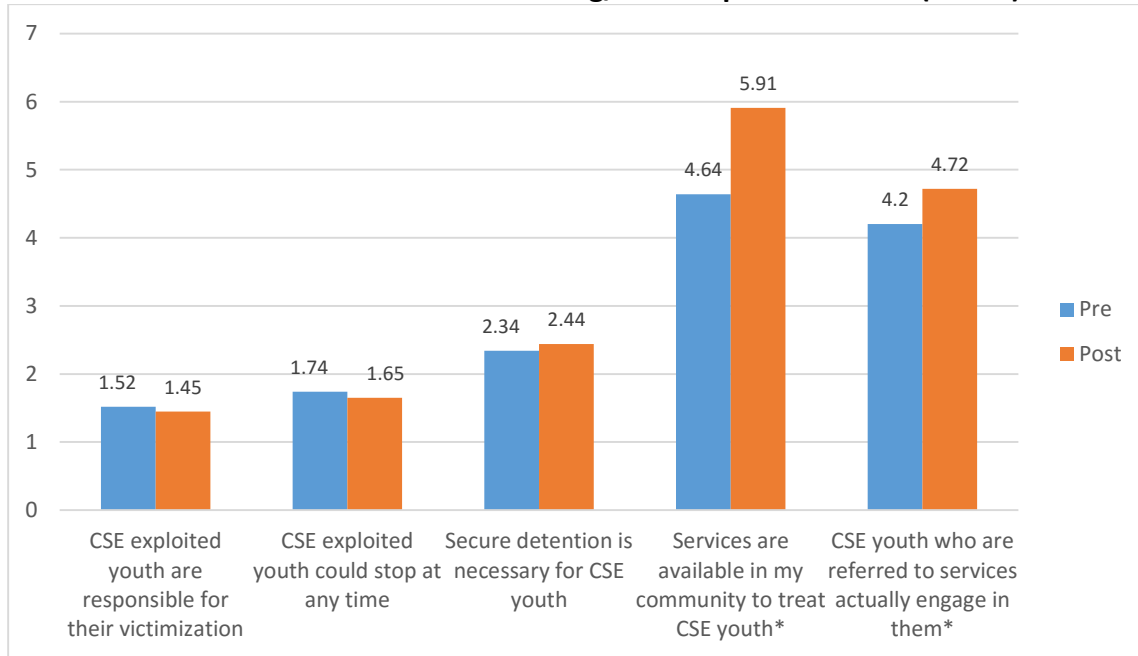
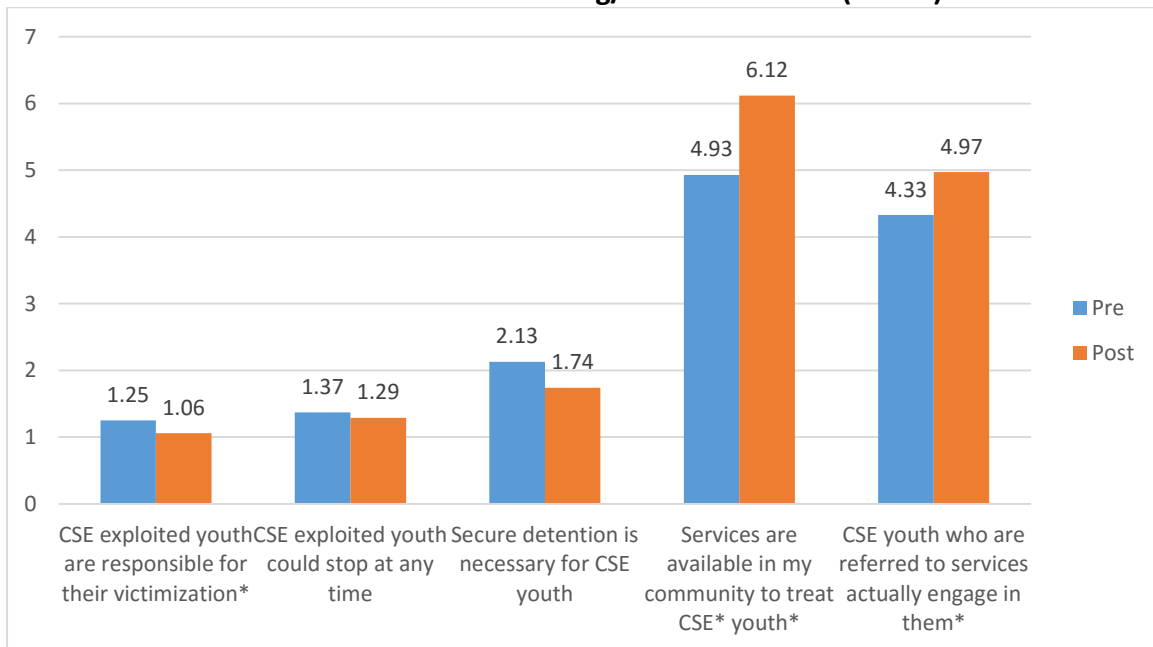


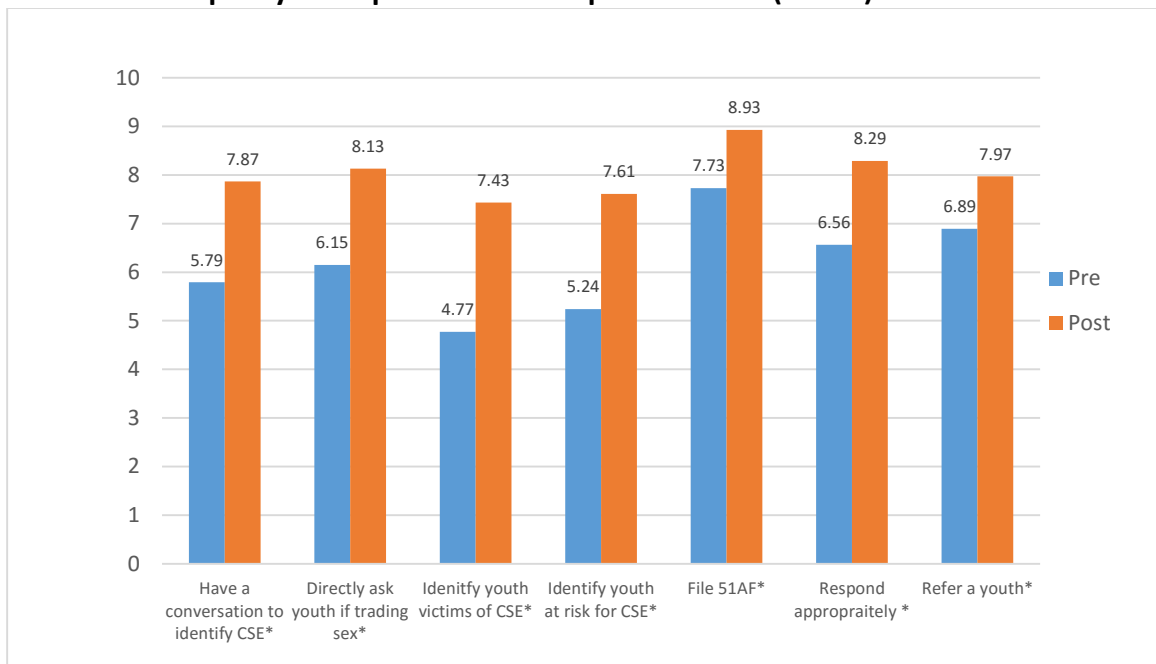
Table 2b: Trainee Beliefs about Human Trafficking/CSEC Middlesex (n=102)



* p<.05 denoting statistically significant differences between the pre and post training groups
Question asks about trainee knowledge on scale from 1 "Completely Disagree" to 10 "Completely Agree"

Finally, the survey assessed growth in trainee capacity to respond to human trafficking/CSEC. This was one of the most promising areas of growth in both sites trained this reporting period. As a result of the training, respondents self-reported feeling significantly more comfortable having a conversation with a youth to identify CSEC, asking a youth if they are trading sex, identifying both victims of CSEC and youth at risk for CSEC, filing a report on behalf of an at risk or commercially sexually exploited youth with DCF, and responding to and referring youth appropriately. The largest area of growth following the training for all respondents was in their comfort identifying victims of CSEC (a 2.66 point increase in the Cape and Island and a 2.56 point increase in Middlesex County between pre and post training tests) and identifying youth at risk for CSEC (a 2.37 point increase in the Cape and Islands and a 2.32 point increase in Middlesex County between pre and post training tests) (See Tables 3a and 3b). The increase in both counties is promising, particularly considering that Middlesex County participants expressed higher levels of comfort with CSEC responses prior to the training compared to participants in the Cape and Islands, but both groups experienced significant growth in comfort with CSEC response as a result of the trainings.

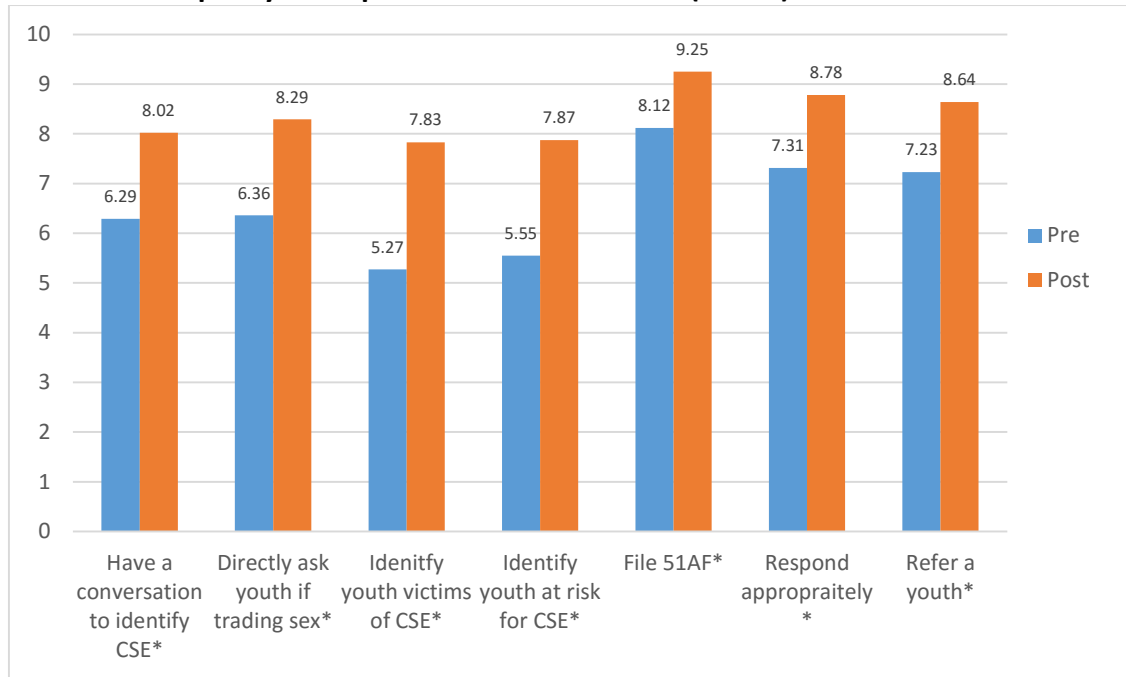
Table 3a: Trainee capacity to respond to CSEC Cape and Island (n=126)



* p<.05 denoting statistically significant differences between the pre and post training groups

Question asks about trainee knowledge on scale from 1 “Not at all Comfortable” to 10 “Completely Comfortable”

Table 3b: Trainee capacity to respond to CSEC Middlesex (n=102)



* p<.05 denoting statistically significant differences between the pre and post training groups
 Question asks about trainee knowledge on scale from 1 "Not at all Comfortable" to 10 "Completely Comfortable"

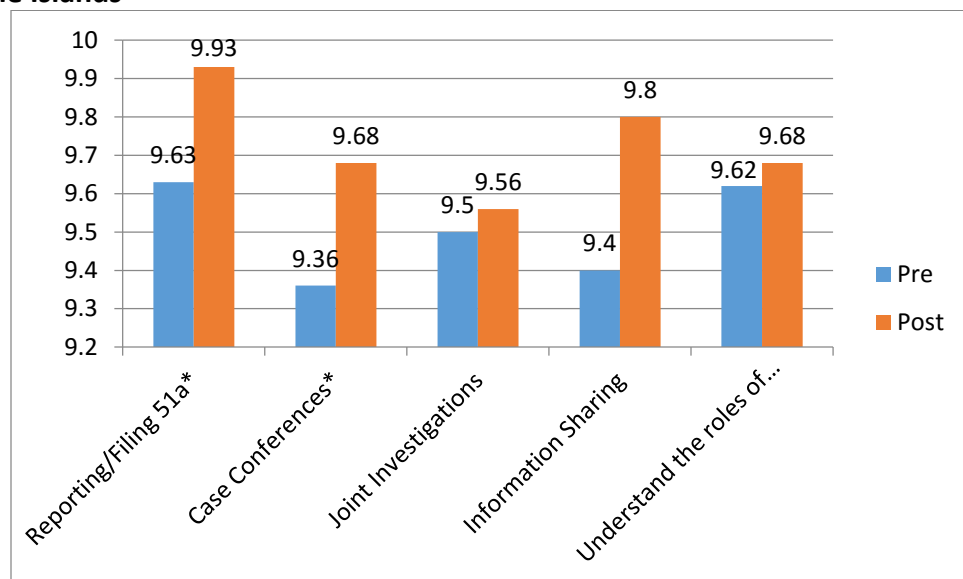
Appendix: MACWTG Evaluation of Multi-Disciplinary Team (MDT) Protocol Development Training Counties of the Cape and Island and Middlesex County

During this reporting period we conducted pre/post training analyses for the two additional MDT Protocol Development trainings for the stakeholders who will be participating in the MDTs in the counties of the Cape and the Islands and Middlesex County.

A total of 75 individuals completed the pre/post training surveys (44 in the counties of the Cape and the Island and 33 in Middlesex county). Respondents represented a cross-section of the agencies and community partners who will participate in the MDTs including Department of Children and Family (DCF) employees and child welfare specialists (18%), law enforcement (27%), service providers (16%), juvenile justice practitioners (11%), legal advocates (5%), health care providers (10%), school administrators and staff (4%), and other community partners (9%) The following analyses examine the changes in participant beliefs about collaboration and human trafficking/CSEC response as a result of the MDT Protocol Development training.

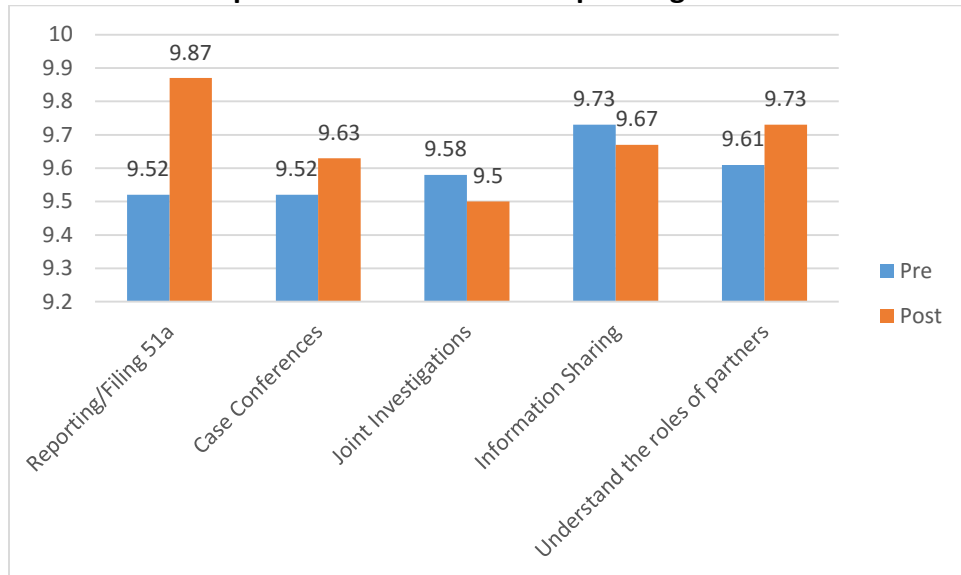
Respondents came into the training believing that many factors emphasized in the MDT Protocol Development training are important for an effective human trafficking/CSEC response (Table 1a and b). The only areas where training significantly increased respondent belief in the importance of factors in CSEC response was increased belief in the importance of filing a 51a to report suspected child exploitation to the Department of Children and Families and the importance of case conferences. *Note increases in Middlesex county were not statistically significant likely due to the smaller number of respondents.*

Table 1a: Trainee Belief in Importance of Factors in Responding to CSEC in the Counties of the Cape and the Islands



* $p < .05$ denoting statistically significant differences between the pre and post training groups
Question asks about trainee knowledge on scale from 1 "Not at all important" to 10 "Critical"

Table 1b: Trainee Belief in Importance of Factors in Responding to CSEC in Middlesex County



* $p < .05$ denoting statistically significant differences between the pre and post training groups
 Question asks about trainee knowledge on scale from 1 "Not at all important" to 10 "Critical"

The second question on the MDT Protocol Development training survey asks respondents whether they agree or disagree about some basic principles of collaboration in response to human trafficking/CSEC. Across the board, respondents came into the training with relatively high levels of agreement that collaboration was important. Although belief in collaboration rose slightly following the training, none of the changes were statistically significant (Table 2).

Compared to responses from the Hampden County MDT survey (mean of 4.43 reported last period), respondents in both the Cape and the Islands and Middlesex were less likely to report a history of agencies working together to solve common problems (mean in Cape and Islands 3.63 and Middlesex 3.61) prior to the training. These findings continue to support a belief that not all counties will have the same type of history of collaboration upon which to build in the MDT process. It is promising to note that MDT principals in both the Cape and Islands and Middlesex strongly believed that it would be difficult to accomplish the goals of combatting CSEC without collaboration.

Table 2a: Respondent Belief in Collaboration in Response to CSEC in the Cape and Island

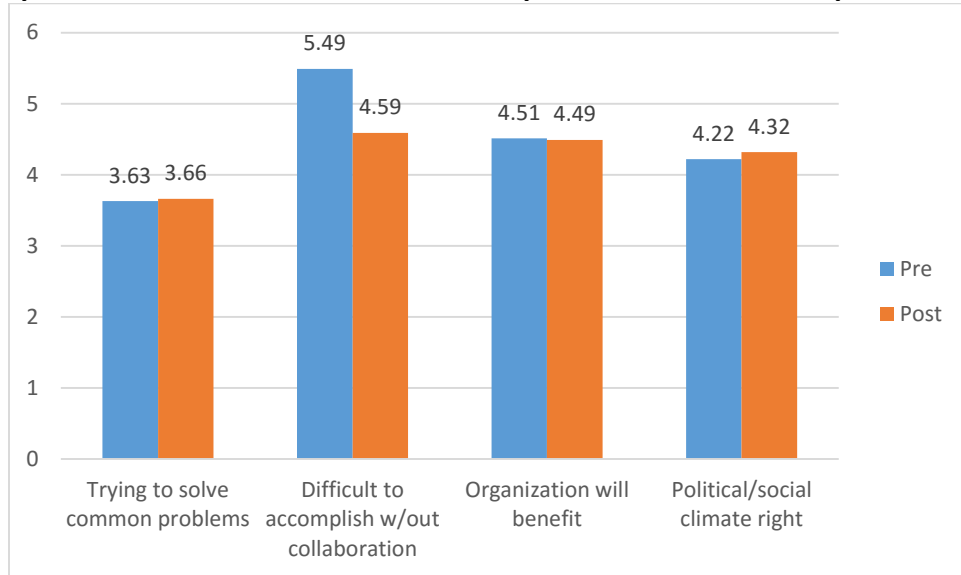
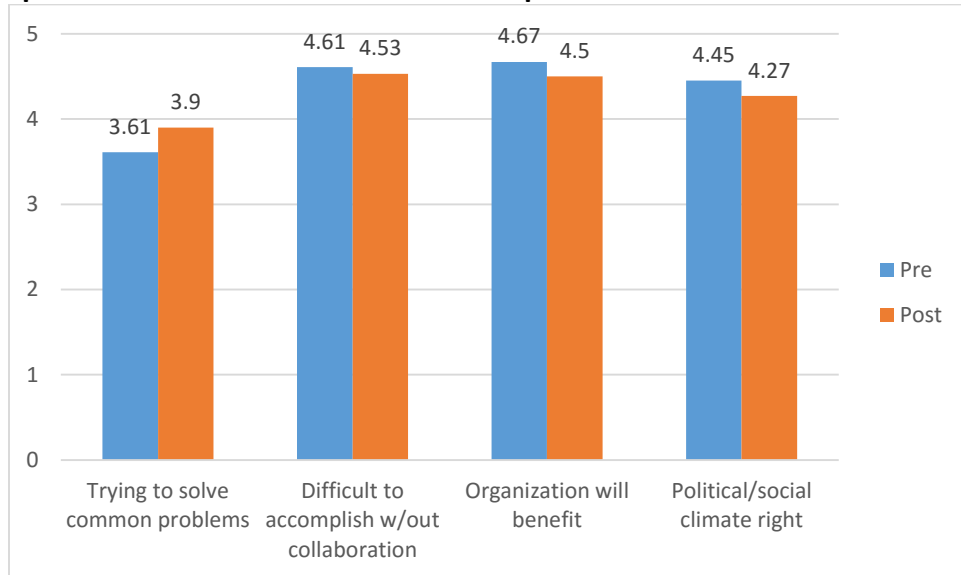


Table 2b: Respondent Belief in Collaboration in Response to CSEC in Middlesex County

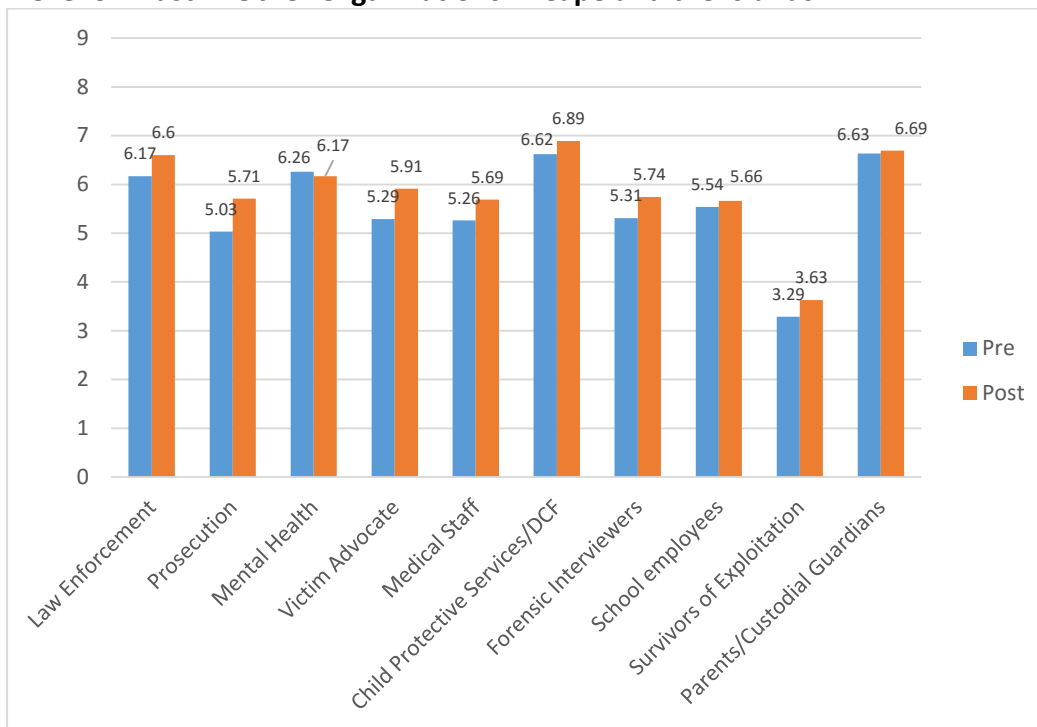


* $p < .05$ denoting statistically significant differences between the pre and post training groups
 Question asks whether respondents “Strongly Disagree” (1) to “Strongly Agree” (5) with each statement about collaboration.

The survey asks respondent to indicate their level of trust for a variety of organizations who will likely participate at MDT partners. Trust across groups generally increased following the training, though not statistically significantly. Bridging the trust gaps between law enforcement and social service and health agencies is an important challenge in the development of effective MDTs. There are some noticeable differences between the respondents from the two MDT trainings. MDT principals in Middlesex had much higher levels of trust in DCF than those in the Cape and Islands

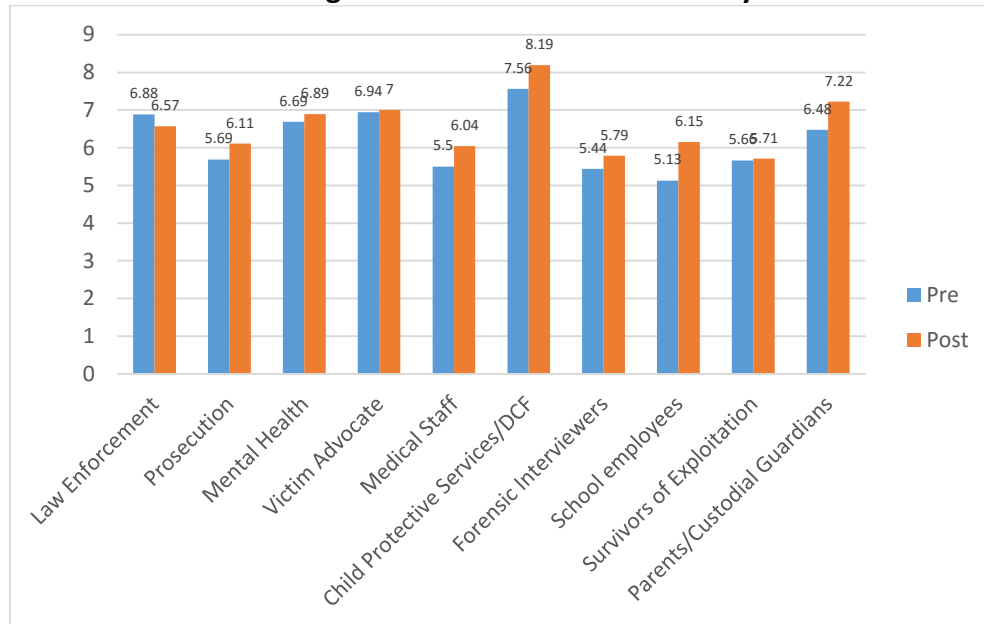
both before and after the training (6.62 pre and 6.89 post in Cape and Island and 7.56 pre and 8.19 post in Middlesex). Similarly, principals in the Cape and the Islands had very lost trust in survivors of CSEC both before and after the training (mean of 3.29 pre and 3.63 post) compared to the respondents from Middlesex county (mean of 5.66 pre and 5.71 post). This different may signal different histories across the counties working and being familiar with CSE youth.

Table 3a: Level of Trust in Other Organizations in Cape and the Islands



* $p < .05$ denoting statistically significant differences between the pre and post training groups
 Question asks whether respondents trust other organizations on a scale from 1 "Do Not Trust" to 10 "Completely Trust".

Table 3b: Level of Trust in Other Organizations in Middlesex County



* $p < .05$ denoting statistically significant differences between the pre and post training groups
 Question asks whether respondents trust other organizations on a scale from 1 “Do Not Trust” to 10 “Completely Trust”.

Finally, respondents were asked to rate how important each organization was to an effective CSEC response in their community. Prior to the training respondents as a group agreed that law enforcement, DCF (though rated as less important in Middlesex County), victim advocates, and forensics interviewers were very important to an effective CSEC response. In both counties respondents through that school employees, survivors, and parents were less important for an effective CSEC response. There were no statistically significant increases in the belief in the importance of any group following the training (Tables 4a and 4b).

Table 4a: Importance of Other Organizations to CSEC Response in Cape and Islands

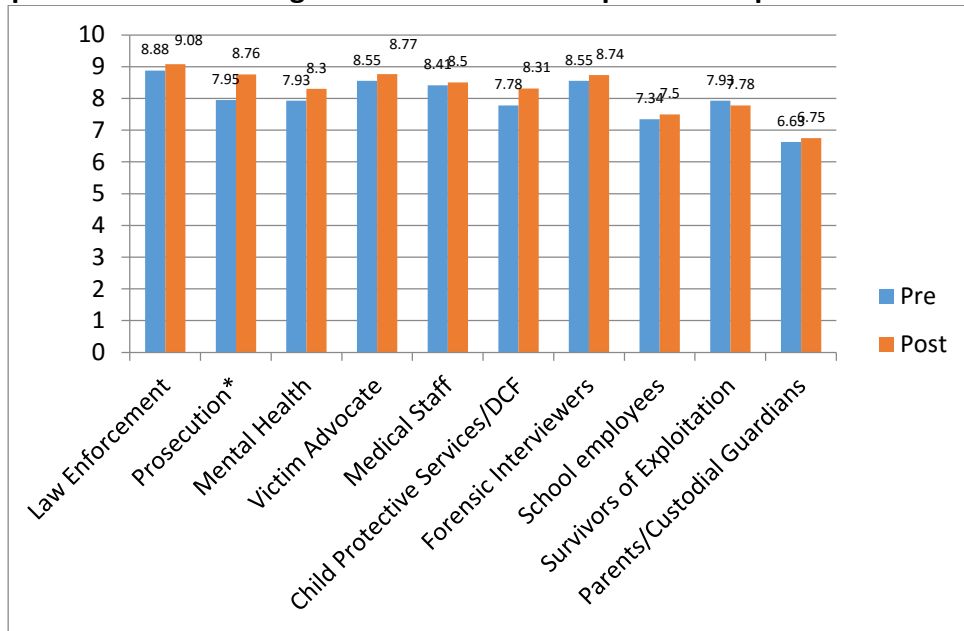
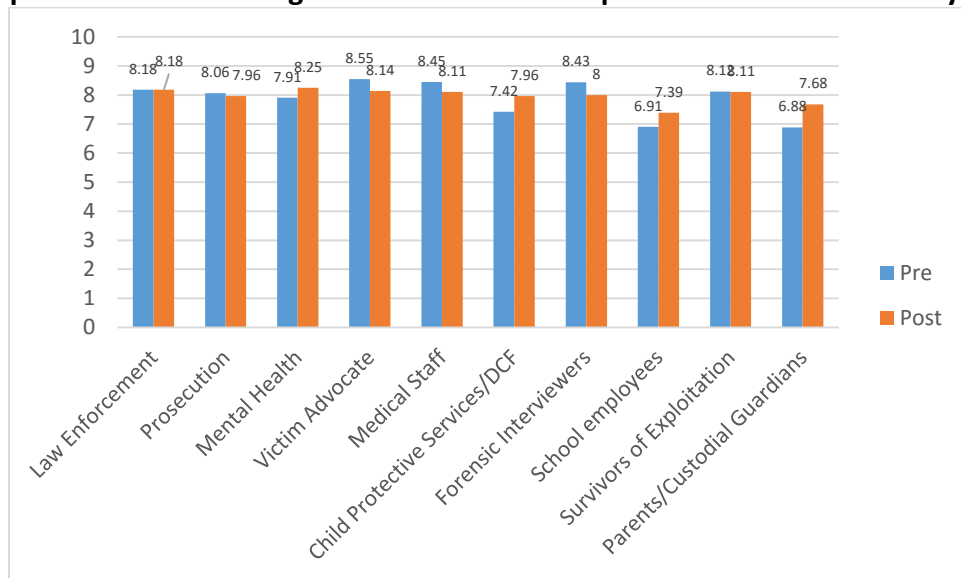


Table 4b: Importance of Other Organizations to CSEC Response in Middlesex County



* $p < .05$ denoting statistically significant differences between the pre and post training groups

Question asks the degree to which respondents believe other organizations are important for an effective CSEC response on a scale from 1 "Not Important" to 10 "Critical".

Commonwealth of Massachusetts

Department of Children & Families

CAPTA Data – Social Worker Demographics

Workforce Summary Report for DSS, 2016 Q 3

SEO Job Category Description	Summary Total Workforce	Male	Male %	Female	Female %	Minorities	Minorities %	Veterans	Veterans %	Disabled	Disabled %
Officials and Administrators	249	55	22.1	194	77.9	55	22.1	2	0.8	4	1.8
Professionals	3142	617	19.7	2524	80.3	1089	34.6	14	0.4	42	1.3
Technicians	37	8	21.7	29	78.3	12	31.2	0	0.0	3	8.1
Protective Service:Non-Sworn	6	1	17.2	5	82.8	1	17.2	0	0.0	1	17.2
Office/Clerical	179	15	8.4	164	91.6	79	44.1	1	0.6	8	4.3
Skilled Craft	1	1	100.0	0	0.0	1	100.0	0	0.0	0	0.0
Service Maintenance	4	0	0.0	4	100.0	2	50.0	0	0.0	0	0.0
Grand Total	3617	697	19.3	2919	80.7	1238	34.2	17	0.5	58	1.6

Workforce Summary Breakdown by Males

	Grand Total	White	Black	Hispanic	Asian	American Indian	Unknown
Officials and Administrators	Male	55	43	10	1	1	
	%	22.1	17.3	4.0	0.4	0.4	
Professionals	Male	617	423	106	70	16	2
	%	19.7	13.5	3.4	2.2	0.5	0.1
Technicians	Male	8	7		1		
	%	21.7	19.0		2.7		
Protective Service:Non-Sworn	Male	1	1				
	%	17.2	20.8				
Office/Clerical	Male	15	11	1	3		
	%	8.4	6.2	0.6	1.7		
Skilled Craft	Male	1			1		
	%	100.0			100.0		
Service Maintenance	Male	0					
	%	0.0					
Male		697	485	117	76	17	2
Male %		19.3	13.4	3.2	2.1	0.5	0.1

Workforce Summary Breakdown by Females

	Grand Total	White	Black	Hispanic	Asian	American Indian	Unknown
Officials and Administrators	Female	194	151	21	17	5	
	%	77.9	60.6	8.4	6.8	2.0	
Professionals	Female	2524	1630	430	396	58	7
	%	80.3	51.9	13.7	12.6	1.8	0.2
Technicians	Female	29	18	6	4		
	%	78.3	49.8	16.3	12.2		
Protective Service:Non-Sworn	Female	5	4	1			
	%	82.8	79.2	20.8			
Office/Clerical	Female	164	89	36	35	3	1
	%	91.6	49.8	20.0	19.6	1.7	0.6
Skilled Craft	Female	0					
	%	0.0					
Service Maintenance	Female	4	2		1	1	
	%	100.0	50.0		25.0	25.0	
Female		2919	1893	493	454	67	8
Female %		80.7	52.4	13.7	12.6	1.9	0.2