

**Response to the Commonwealth of Massachusetts Department of Children and Families
Support and Stabilization Services RFI
(Bid: BD-22-1034-0009-DSS09-67937)**

Responses to Section 3 of the RFI: Diversity, Equity, and Inclusion

Section 3.1: Cultural and Linguistic Competency

1. What strategies can be used to meet the diverse language needs of families to ensure that language access is provided to families in a timely manner?

On April 6, 2021, Commissioner Spears testified before a Joint Hearing of the House and Senate Committees on Ways & Means. In [this testimony](#), Commissioner Spears spoke about DCF's concerted effort to recruit and hire bilingual and bicultural staff, continue use of a telephonic interpretation service, and utilize FY22 funding for staff diversity training.

When recruiting and hiring, the state should be mindful of appropriate compensation benchmarks. Multilingual ability, in addition to lived experience, is a unique skillset that is integral to a high-functioning child welfare system and attracting and retaining staff with this skillset is fundamentally tied to compensation. That said, multilingualism is not the same skill as professional interpretation. Multilingual staff skills can be bolstered with professional interpreting training.

In addition, while Commissioner Spears' testimony noted that 30% of DCF staff are bilingual (the data was silent on whether staff possessed professional interpreting certifications), this data point alone is not sufficient to confirm that consumers – who according to [MA DCF Annual Report FY 2021](#) use at least 13 languages – are actually accessing language-aligned staff. The next chapter of continuous quality improvement and evaluation at DCF should prioritize data relating to whether consumers were actually offered, and whether they actually accessed, culturally- and linguistically-aligned DCF services.

Finally, demographic data tracking/analysis methods should be revised to more accurately represent the linguistic communities served. For instance, in the [MA DCF Annual Report FY 2021](#), data on the primary language of all consumers (Fig. 9) merged the two categories of “English” and “Unspecified.” This merger is a form of data “aggregation” rather than “disaggregation.” Disaggregation of data relating to race, ethnicity, language, and other features of inclusion/exclusion is well-understood to be a critical lever for equity advancement ([Racial Equity Will Not be Achieved Without Investing in Data Disaggregation, Health Affairs 2021](#)).

2. What are the barriers, if any, for families with diverse language needs to receive services? What are suggestions for overcoming those barriers?

Some families speak “enough” English to get by conversationally. However, in MLPB's long experience partnering with communities of care across the Commonwealth, care team colleagues often observe that these speakers of ‘some English’ have difficulty navigating

systems like DCF due to jargon-heavy processes. Speaking some English should not be treated by DCF as establishing English proficiency or fluency; rather, DCF should systematically invite families to identify the languages (oral and written) they are most comfortable communicating in.

Families who identify as non-native English speakers should be asked if they would like an oral interpreter, and then be provided with oral interpretation services at the investigation stage and during every subsequent interaction with a DCF employee. Considering the sensitivity of a DCF investigation and the high stakes for family (dis)unity, families should never be asked to rely on anyone outside of the system (e.g., their children, their neighbors) for interpretation or translation services.

Once families have identified their languages of fluency, interpreting and translation services should extend not merely to court-related activities but also to family stabilization efforts. Families should only receive referrals to services that are accessible in their language(s) of comfort.

3. What strategies can be used to serve families from diverse cultures, including different racial, ethnic, and religious backgrounds?

DCF should use relationship-based practice and reflective-practice as the gold standard for partnering with children and families. These methods are utilized in social work practice and many other settings to aid in rapport-building, center care around a family unit, and avoid compassionate fatigue ([Relationship-Based Practice and Reflective Practice, Child & Family Social Work 2015](#)). Mindful of our zones of experience and expertise in offering this comment, MLPB shares this specific recommendation in part due to our long experience operating within interdisciplinary teams that explicitly engage in person-centered reflective practice.

Whenever possible, families should be assigned a caseworker who is fluent in their primary language and has lived experience in their community. All DCF policy should also take into consideration the need for robust confidentiality training for caseworkers operating in shared, small communities.

DCF should also provide implicit bias and strengths-based communication trainings to caseworkers so that they can be supported to interact with families – and colleagues – in respectful and effective ways. These professional development investments can mitigate the well-documented risk that caseworkers will substitute their (often Western and/or American culture-driven) judgments about family norms and priorities over a parent's/caregiver's distinctive judgment.

4. What are the barriers, if any, to serving families from diverse cultures, including different racial, ethnic, and religious backgrounds? How can those service delivery barriers be overcome? For example, how can barriers to initial and on-going training, or barriers to hiring staff that mirror the communities being served, be overcome?

See our responses to Questions 1, 2, and 3 above.

Due to the disparate impact of DCF policies and practices on communities of color and families with mixed immigration status, when tackling system-wide diversity and inclusion goals, DCF should prioritize building trust with communities of color and immigrant communities from which it seeks to attract and retain workforce talent. To hire and retain support staff with lived experience, DCF should establish a field-based experiential learning program that includes trauma-informed principles and cultural competencies not just for new hires, but for veteran workforce as well.

DCF can also provide families with “cheat sheets” in their preferred language so that families can understand what DCF is, what DCF involvement means exactly, and what the stakes of that involvement are for the family. These resources can include graphics and be geared to grade school vocabulary for caregivers who may not have high school level literacy.

Section 3.3: Additional Comments

Do you have any additional comments that are not addressed in the questions included in this section?

In many cases, families are asked to participate in services that are (a) duplicative, (b) unsupported by clinical or medical staff, (c) not evidence-based, (d) do not fit their particular needs, and/or (e) are generally inaccessible. The existing [Family Assessment and Action Plan Policy](#) requires Action Plans to reflect the particular circumstances of the case and the particular needs of the caregiver – but too often this level of tailoring appears absent.

In fact, we hear frequently from care team colleagues that services required in a caregiver’s Action Plan are duplicative of services that they already receive. For instance, a caregiver who is enrolled in a program that has home visiting services like [Smart from the Start](#) may be required to obtain a home visitor through a different program like [Healthy Families MA](#). DCF could consider creating a more general Action Plan that identifies the prioritized service type, while allowing the family to select the ultimate provider or identify that they already are connected to an aligned resource.

A more general Action Plan would also help to acknowledge the expertise of clinicians and medical providers. Consider the following scenario: a caregiver undergoes a psychosocial evaluation and is advised by their medical team to undergo biweekly therapy. The Action Plan requires weekly therapy. If the caregiver follows their doctor’s recommendation, they would be considered out of compliance with DCF. Not only is this counterintuitive and counterproductive in meeting the caregiver’s health goals, but it can have serious financial effects on the caregiver as health insurance often refuses to cover services that are not supported by the medical record.

In addition, a more general plan would also help sub-populations of families find services that fit their specific needs. Unfortunately, many programs currently available to families are structured as “one-size-fits-all.” This approach does not take into consideration the unique needs of families who are experiencing intergenerational poverty, survivors of intimate partner violence, members

of the LGBTQIA+ community, or non-birthing parents. Increasing access to a wide variety of supports and allowing caregivers to select their service providers, would promote inclusion and belonging within DCF culture and operations on a large and impressive scale.

Finally, families often report a desire to participate in services, but lack of reliable transportation is a barrier to participation. Whenever a family with limited resources is required to participate in a specific service, they should be offered transportation resources. This may include direct transportation by a caseworker, a taxi voucher, or (if available and reliable in the area) a public transportation pass. Families should not be penalized for living in rural areas, or not having access to affordable, reliable transportation. DCF and other state agencies should work closely with MassHealth to determine what reimbursable options may exist for families who require transportation not only to their medical appointments, but to their social health appointments, such as those often connected to DCF Action Plans.

Section 4 of the RFI: Life Cycle of a Case

Section 4.1: Intact Families Caring for Children at Home

6. Internal research revealed the impression that most S&S services assist families with accessing concrete services. What are ideas for how to incorporate delivery of concrete resources to children and families in future S&S services? Which concrete resources are most needed?

This is a broad and important question and responding comprehensively is a tall order in the context of a word-limited RFI. Regardless of the scarce, health-promoting resources in question – housing, food, utility service, employment, health insurance, etc. – the organizations and staff partnering with families to support them in flourishing are navigating complex systems in which these scarce resources are often “locked up.” MLPB was instrumental in making the case for [Legal Partnering for Child & Family Health](#) and would be happy to brief DCF on the growing evidence base for expanding the interdisciplinary assets that can help promote successful, family-centered stabilization and support. This approach has animated our strong partnership with [The Children’s Trust](#) for more than 5 years, and is animating a Massachusetts innovation – DULCE – that now operates in 9 states through the [DULCE Learning Network](#) convened by the Center for the Study of Social Policy.

7. What are barriers to providing children and families with the right kinds of concrete resources that they need? How can those barriers be overcome?

This again is a broad and important question, difficult to answer fully and meaningfully in this setting alone. At a high level, we encourage DCF to (re)prioritize allocation of its scarce resources to supporting children in their homes with their caregivers. The [MA DCF Annual Report FY2021](#) indicates that service expenditures increased by merely 3% in the last fiscal year. Most of these increases went toward supporting children in out-of-home placements (e.g., foster care, residential schools, adoptive homes). In addition, once children are removed from the home, DCF immediately reverts all funding to support the child in their placement, making

it near-impossible for a family lacking concrete resources or discretionary income to make the necessary changes to reach DCF goals.

Channeling DCF resources in ways that are more upstream and midstream, as opposed to downstream, represents progress on family-centeredness. Facilitating family access to concrete supports prior to removal would allow many caregivers to adequately provide for their child, averting the need for removal and continued DCF intervention. By shifting the focus to proactive family support, DCF could instead spend that money to help families meet basic needs within the home and retain unity/move toward reunification.

8. When there are no longer protective concerns in a family, DCF closes a case. How can linkages to other sources for concrete resources be ensured so that when a DCF case closes, a family remains stable, and children remain safe? (This question is asked in another way in Section 6.3 Bridge Services, Section 6 Response Sheet. Feel free to respond in both locations.)

Currently, DCF has the discretion to extend childcare vouchers to caregivers for up to one year after a case is closed. This program should not be discretionary as that policy, caseworker-tied distribution of this scarce and valuable resource, fosters inequity. Universal offering of childcare vouchers on this basis should become a formal DCF protocol.

Section 4.2: Foster Care Settings and Families with Children in Foster Care

10. DCF is using the term “Family Time” to replace the former label “Supervised Visitation.” The fundamental change is a transition from observing and assessing parent-child interactions to a focus on training and supporting skill-based improvements in parenting that result in enhanced parent-child attachments and relationships. What are other ways to describe the desired changes that will transition this service into the desired (Family Time) model?

We applaud this shift from a framing that invoked surveillance to a framing that centers families and family unity. This change in label must be accompanied by additional shifts within the DCF approach to these interactions. Under the “Supervised Visitation” framework, visits are an opportunity for DCF to scrutinize the caregiver’s parenting skills. This is done at a particularly disruptive time in the lives of both caregivers and children. For instance, it has come to our attention that instead of providing diapers and toys for children to use during visitation, DCF has used this as an opportunity to analyze whether the family came “prepared.” At times, this means that a family member who only sees their child weekly is given a demerit for not knowing that their child grew into a new sized diaper.

Ideally, Family Time is an opportunity to reinforce positive parenting strategies. DCF should provide the resources necessary to make the visit successful and focus on supporting a strong relationship between the caregiver and child. This could be accomplished by training DCF staff in an evidence-based practice such as [Brazelton Touchpoints](#), which has been found to increase caregiver knowledge about child development, enhance relationships between the child and the caregiver, and even improve relationships between the caregiver and the

provider ([Touchpoints Role in Optimizing Child Development, Strengthening Families, and Building Communities, Brazelton Touchpoint Center 2008](#)). Using an evidence-based, relational, developmental aligned communication strategy would help foster positive relationships between caregivers and children during Family Time – and enhance trust with the DCF staff facilitating Family Time

11. What barriers (if any) exist for transitioning from a supervised visitation model to a Family Time model?

See our answer to Question 10, above. The foundation of Family Time must be strengths-based and not punitive. It may be worth including in any staff training role-played depictions of the kinds of interactions that reflect “Supervised Visitation” – what DCF wishes to retire – and the kinds of interactions that reflect the intended values of “Family Time” (e.g., training that makes clear “Yes, Do This!” vs. “No, Don’t Do That!”).

12. What would be needed to overcome these barriers?

See our answers to Questions 10 and 11, above. DCF should provide carefully designed training to all staff on this important change in policy. DCF should also enforce the new policy consistently throughout the state. In other words, all staff should be subject to reprimand for using Family Time as an opportunity to punish families and should be rewarded for their effort to use the time to teach healthy parenting skills and maintain caregiver/child bonds.

Section 6 of the RFI: Service Delivery Issues

Section 6.4: Service Facilitation

12. What logistical or systemic barriers, if any, do families experience that interfere with their ability to take full advantage of the services and resources available to them?

See all of our answers above. DCF should also consider the intersection between its internal policies and the policies of other state agencies on which many caregivers rely to access concrete supports (like SNAP, housing subsidies, MassHealth, unemployment insurance, and Emergency Assistance Shelter, to name a few). For instance, in the context of Emergency Assistance (EA) shelter, the Department of Housing & Community Development (DHCD) affirmatively excludes caregivers from EA Shelter eligibility if their child is not in their custody. Thus, a DCF removal results not only in the traumatic separation of the caregiver and their child, but also in prompt eviction from shelter. Although DHCD has a limited exception, which allows caregivers to remain in shelter for up to sixty days after a removal, it typically takes much longer than sixty days for DCF to reunite separated families even in favorable circumstances. In addition, caregivers who receive nutritional support (i.e., SNAP) and financial assistance (i.e., TAFDC) for their child also experience a significant drop in public benefits when their child is removed from the home. This consequence severely hampers a caregiver’s ability to achieve stability and regain custody. When evaluating policies at the intersection of DCF services/interventions and concrete supports, DCF must look beyond their

internal policies and evaluate the ripple effects of DCF action on a caregiver's eligibility for housing through DHCD, nutritional support through the Department of Transitional Assistance (DTA), and financial support through DTA and the Social Security Administration.

Section 6.5: Use of Telecommunication Technology

Focus group responses: What worked well when services were delivered virtually?	Focus group responses: What did not work well when services were delivered virtually?
<ul style="list-style-type: none"> • Increase in family participation: virtual services removed barriers like scheduling, transportation, wariness regarding a provider entering the home • Families and children engaged more deeply with providers: more frequent meetings and more in-depth conversations • More families served: providers reduced their own travel time, leading to an increase in families served • Allowed families to stay connected with service providers: maintaining contact, even in a limited way, is helpful 	<ul style="list-style-type: none"> • Services for younger children: difficult to keep younger children engaged on screen • High-risk families: greater latitude to hide concerning issues, reduced transparency around safety and risk. • Building relationships: decreased retention for mentorship programs, which should build skills in community living and are based on relationships best developed in person • Parent aide support services: being in the family's home allows providers to see much more of how a family is doing • Technology barriers to communication: for example, lack of technology access, connectivity issues
<p><i>Bullet points above reflect the responses of the focus group members and are not necessarily the opinion of the Department.</i></p>	

16. Is there anything you would add to or remove from the table above regarding the benefits or disadvantages of using telecommunication technology for service delivery?

We strongly recommend adding the following to the chart:

- ***Telecommunication does not work for non-verbal children.*** *A nonverbal child could include infants and/or children with disabilities. In addition to difficulty with successfully engaging children virtually, telecommunication is inappropriate for visitations between a nonverbal child and their caregiver – a phenomenon we learned about from care team colleagues in the course of our work.*
- ***Telecommunication does not promote developmentally appropriate attachment between caregiver and child.*** *Critical and well-established early childhood development practices require the caregiver to be in-person with their child (e.g., skin-to-skin contact for caregivers and their infants to foster newborn bonding). The chart should explicitly recognize that when telecommunication is deployed, these best practices for child development cannot be achieved.*

- ***Telecommunications do not provide the appropriate safeguards for removal or placement decisions.*** *We understand that hybrid approaches are being piloted in many systems due to pandemic conditions. However, if DCF believes that there is a serious threat to the safety of a child, then DCF should visit that child in person, period. Children should not be removed from the home without an in-person visit and DCF should not be able to maintain physical custody without having conducted an in-person evaluation of the child's placement.*