MASSACHUSETTS
Office of the Child Advocate

Family Resource Centers

RECOMMENDATIONS FOR INCREASING ACCESS AND IMPROVING SERVICE DELIVERY

APRIL 15, 2024
THE COMMONWEALTH OF MASSACHUSETTS
MARIA Z. MOSSAIDES, DIRECTOR

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About the Office of the Child Advocate

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

Acknowledgements

This report was produced by the Office of the Child Advocate and represents the views and perspectives of the Office. We are grateful to all who contributed information, ideas, analysis, and feedback on this report, while acknowledging that the OCA bears ultimate responsibility for the analysis and recommendations presented herein.

The following OCA staff members contributed to this report:

Melissa Threadgill, Senior Director of Policy and Implementation
Audrey Smolkin, Executive Director, Center on Child Wellbeing and Trauma
Kristi Polizzano, Senior Policy and Implementation Manager
Alix Rivière, Senior Policy and Research Analyst
Morgan Byrnes, Policy and Research Analyst
Jessica Seabrook, Data Analyst
Arianna Turner, Project and External Affairs Coordinator

The OCA also acknowledges the work of the following individuals who served as consultants to the OCA on this report:

Mary Kay Leonard, Senior Consultant
Jinna Halperin, DMA Health Strategies
Talia Hahn, DMA Health Strategies
Cara McKinney, DMA Health Strategies
Dan Burdo, DMA Health Strategies

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Guide to Acronyms

Acronym	Definition
ASO	Administrative Service Organization
BSAS	Bureau of Substance Addiction Services
CBHCs	Community Behavioral Health Centers
CBHI	Children's Behavioral Health Initiative
CCC	Community Connections Coalition
CRA	Child Requiring Assistance
DCF	Department of Children and Families
DDS	Department of Developmental Services
DESE	Department of Elementary and Secondary Education
DMH	Department of Mental Health
DPH	Department of Public Health
DTA	Department of Transitional Assistance
DYS	Department of Youth Services
EEC	Department of Early Education and Care
EOE	Executive Office of Education
EOHHS	Executive Office of Health & Human Services
EOHLC	Executive Office of Housing and Livable Communities
FACRA	Families and Children Requiring Assistance Advisory Board
FRCs	Family Resource Centers
JJPAD	Juvenile Justice Policy and Data Board
MHAP for Kids	Mental Health Advocacy Program for Kids
MOU	Memorandum of Understanding
PMPDs	FRC Program Managers and Program Directors

Executive Summary

The Massachusetts Family Resource Centers (FRCs), overseen by the Department of Children and Families (DCF), are community-based centers that provide a wide array of family support services. In FY24, there were 32 FRCs across the state, funded through a $33.8 million appropriation in the state budget.

The Massachusetts Legislature directed the Executive Office of Health and Human Services (EOHHS) to create the statewide network of FRCs to serve "families with children requiring assistance" as part of M.G.L. Chapter 240 of the Acts of 2012. In doing so, EOHHS and DCF built upon a prior network of federal grant-funded programs that had recently been established to increase the availability of services designed to support families and help them avoid entry into the child protective services system. As currently implemented, FRCs are open to all families in the Commonwealth and are directed to support family members with any human services issue through services on-site or through referrals.

This report was developed in response to a directive in the FY24 state budget that the Office of the Child Advocate (OCA) conduct a review of FRCs and make recommendations for improvements.

The OCA's findings and recommendations in this report are based on information gathered from interviews and focus groups with a wide variety of executive branch, legislative, and judicial stakeholders, community and advocacy organizations, FRC staff, and FRC consumers as well as analysis of a large amount of data on FRC operations and data on children involved in other state systems, including the child protective services (DCF) and Child Requiring Assistance systems.

Findings

Every day, **FRC staff provide real, concrete value to a diverse array of families**, many of whom face significant challenges and have substantial need for support.

Over time, the **mission and focus of FRCs has expanded considerably** beyond the initial focus on helping prevent involvement with the child protective services and Child Requiring Assistance systems. The reasons for this expansion are understandable; FRCs have responded, over and over, to the pressing needs of families in their communities even as those needs have shifted and expanded over time. At the same time, because **this expansion has not been accompanied by substantial increases in resources for individual FRCs** or other forms of support**, FRCs have become stretched too thin** – and **implementation of the original core FRC services has varied in consistency across the network** as a result.

Even as the number of FRCs has expanded over the years, **there are tens of thousands more families each year who could benefit from their services,** including those at risk of entry to the child protective services or CRA systems. **Preventing involvement in these systems by**

connecting families to services and support earlier and more effectively is beneficial for everyone – and given the significant per-person costs of those systems, likely much more cost effective as well.

Since FRCs were first procured, there have been **substantial changes in the human services landscape,** resulting in the potential **duplication of services and/or lack of alignment** in key areas. Improving FRCs' ability to reach families most at-risk, and to provide the most effective services possible, will require **increased alignment with and support from other state and local entities**, including schools, family serving state agencies, and the Juvenile Court system.

Recommendations

This report makes three primary recommendations to enhance the reach and impact of FRCs:

- **Recommendation 1: Focus FRCs on a priority goal of preventing entry (or re-entry) to the child protective services and Child Requiring Assistance systems:** Focusing on a specific mission and target population can help the Commonwealth improve FRC service design, enhance consistency across FRCs, and allow for more targeted marketing and outreach efforts.

  This does not mean that FRCs should establish eligibility criteria or restrict access to families, nor should we retreat from the goal of having FRCs serve as a central hub for their communities. Instead, focusing on a priority goal and population provides direction for inevitable decisions about strategy and prioritization of limited resources. We recommend building an updated FRC model around this goal and priority population, while allowing for community-specific innovation and additions *so long as it does not divert resources and focus from the core priorities.* Specific recommendations include:

  - **Recommendation 1A:** There should be a coordinated state effort to direct at-risk families to FRCs.
  - **Recommendation 1B:** The FRC Service Model should be redesigned to focus on this primary goal and population.
  - **Recommendation 1C**: Some current FRC functions should be eliminated, de-prioritized, made optional, or offered only in partnership with other state agencies.

  These recommendations to reduce redundancies and increase the level of focus on certain key priorities would be important at any point in time, but they become all the more important in times when state resources are more limited, as they may be in FY25 and beyond.

- **Recommendation 2: Expand funding for FRCs, which should be funneled toward expanding the number of sites and increasing staff at existing sites:** Prioritization can only

go so far. To reach more families, as we propose in this report, *and* more effectively support families most at risk, funding to support more staff and more offices is needed. Specific recommendations include:

  - **Recommendation 2A:** Open more FRC sites to improve access for families who are most in need of services.

  - **Recommendation 2B:** Expand funding available to each FRC through a more flexible contract model in the next procurement.

  - **Recommendation 2C:** The state should explore whether all available federal funding – especially Medicaid funding – is being secured to support FRC budgets.

- **Recommendation 3: Enhance support from, and integration with, other state systems and services:** While FRCs can and should serve as a central community hub, they cannot do this work alone. They need enhanced connections to, and support from, state agencies to both *reach* more families in the target populations and to better meet these families' needs. Specific recommendations include:

  - **Recommendation 3A:** FRCs should be operated by a state agency (or division of a state agency) with a strong focus on family support.

  - **Recommendation 3B:** DCF (with support from EOHHS as needed) should negotiate formal partnerships at the state or regional level to expand the expertise available to families at FRCs and to ensure consistent referral options for FRC families.

  - **Recommendation 3C**: The State should enhance EOHHS's ability to plan and oversee the management of a family support system that meets the needs of the Commonwealth's families.

  - **Recommendation 3D:** The advisory structure for the FRCs should be revised.

It has been nearly twelve years since the passage of *An Act Regarding Families and Children Engaged in Services* and the first procurement of the Family Resource Centers. It took time to implement FRCs across the state, establish and fine tune the original model, and collect sufficient data to understand how FRCs are working and what impact they are having. In this period, there have also been substantial changes in the behavioral health and human services landscape in Massachusetts.

After approximately a decade of implementation, and with all of the learnings and new information we have, **this is the right moment to revisit the original vision and plans for the FRC network and forge a plan for the future utilizing this new information.**

Introduction

The Massachusetts Family Resource Centers (FRCs), overseen by the Department of Children and Families (DCF), are community-based centers that provide a wide array of family support services. FRCs connect families to needed resources and supports, facilitate access to basic needs, offer parent education classes and support groups, provide school-related educational support, and offer recreational and other activities. FRCs work to strengthen relationships between children and their families so that both can thrive.[1]

This report was developed in response to a directive in the FY24 state budget that the Office of the Child Advocate (OCA) conduct a review of Family Resource Centers: [2]

> provided further, that not less than $200,000 shall be expended for the office to review the current capacity of family resource centers including, but not limited to: (i) catchment area penetration; (ii) the programmatic activities and partnerships of each family resources center; (iii) statewide and regional analysis of the needs of families and children seeking the support of a family resource center; and (iv) family resource center service gaps across the commonwealth; provided further, that the review shall be conducted in collaboration with the Families and Children Requiring Assistance Advisory Board established in section 34 of chapter 240 of the acts of 2012 and the department of children and families; provided further, that the office shall engage with consumers and family resource centers during its review; provided further, that the department of children and families shall provide the office with direct access to any de-identified data, management reports, evaluation studies or other documents held by the department or by any external vendor the department contracts with that the office deems relevant to its review to aid the office in its efforts to collect or analyze data and information related to family resource centers, including contracted family resource center providers and the ForHealth Consulting division of the University of Massachusetts Medical School; provided further, that not later than April 15, 2024, the office shall submit a report to the joint committee on children, families and persons with disabilities, the joint committee on the judiciary and the house and senate committees on ways and means on the review including, but not limited to: (a) findings and recommendations regarding improvements for core services, key community partnerships and system navigation services; and (b) recommendations for closing access gaps to family resource centers.

The OCA submits this report in response to this directive. In recognition of our broader statutory mandate to "examine, on a system-wide basis, the care and services that executive agencies provide children," "examine systemwide responses to child abuse and neglect," "advise the public and those at the highest levels of state government about how the Commonwealth

[1] UMass Chan Medical School. (2022). Massachusetts Family Resource Center Network: 2021 Program Evaluation Report. https://www.mass.gov/doc/massachusetts-family-resource-center-network-program-evaluation-report-march-2022
[2] Commonwealth of Massachusetts. (n.d.) FY 2024 Final Budget. https://malegislature.gov/Budget/FY2024/FinalBudget

may improve its services to and for children and their families," and "examine systemic issues related to the provision of services to children and provide recommendations to improve the quality of those services in order to give each child the opportunity to live a full and productive life," the OCA has also provided broader findings and recommendations beyond the scope of the legislative directive but in keeping with our organizational mission.[3]

Methodology

The research process for this report was led by the OCA. The OCA contracted with a team of consultants, listed on page three, to conduct interviews and focus groups with identified stakeholders; review, analyze, and summarize qualitative and quantitative data; develop and administer a survey; and develop data charts and visualizations.

Unless otherwise noted, data for this report was provided to the OCA by ForHealth Consulting at the UMass Chan Medical School, which serves as the Administrative Service Organization (ASO) for the FRC Network and, in that role, administers the FRC CRM (Customer Relationship Management) database. Data provided by the UMass ASO and analyzed by the research team for this report includes data on populations served (including totals and demographics), FRC usage by zip code, services provided to families by FRCs, referrals sources, and staff vacancy data. Other quantitative data sources referenced in this report include data from the U.S. Census Bureau, the Department of Elementary and Secondary Education student enrollment and indicators data, data on caseloads from the Department of Transitional Assistance, data from the Department of Children and Families related to the child protective services process, and data from the Juvenile Court on the Child Requiring Assistance system.

This report uses the most up-to-date, full year data available to us. In some cases, the data was available through the end of CY23, while in other cases the most recent available data was through CY22. Expanded data charts, including full "ns" and percentages where relevant, are included in Appendix A.

The research team conducted interviews with 46 stakeholders for this report, including state agency and legislative leaders and staff, staff at DCF who work with FRCs, members of the FACRA board, community organization leaders, and FRC Program Managers and Program Directors (referred to in this report as FRC PMPDs). The team conducted 9 focus groups with 134 participants among FRC staff, two focus groups with DMH Directors of Family Driven Practice as well as with DMH Juvenile Court Clinicians, 13 focus groups with a total of 112 FRC consumers (in English, Spanish and Haitian Creole), and two focus groups with consumer advisory groups run by DMH and DCF. The team also conducted an online survey, which was made available to all FRC PMPDs. The team received 22 responses to the survey, representing 20 out of 32 FRCs. In total, the team heard from 328 unique individuals.

The team also reviewed individual FRC 2023 workplans to identify planned support groups and activities as well as 2023 available monthly reports by FRC to determine how FRC staff language

[3] M.G.L. c. 18C

capacity aligned with service population languages. Other documents reviewed included FRC Annual and Mid-Year Reports, and reports issued by the FACRA Board.

Where relevant, the OCA also relied on research previously conducted for other reports, most notably the 2022 Juvenile Justice Policy and Data Board's report on the Child Requiring Assistance systems.[4]

The OCA presented an overview of the intended research process to the FACRA board in the fall of 2023 and solicited feedback at that time; updated FACRA board members on progress at FACRA meetings; and presented initial findings to the FACRA Board in March 2024. Given the FACRA meeting schedule and the short timeframe for completing this report, the OCA was not able to present draft recommendations to the full FACRA board but did present recommendations to the FACRA Board chairs and solicited feedback. The OCA also provided DCF and EOHHS an opportunity to review a draft of this report and provide feedback. The OCA is grateful to all who contributed feedback on this report, while acknowledging that the OCA bears ultimate responsibility for the analysis and recommendations presented herein.

This report is **not** an evaluation of individual FRCs. For this reason, although we refer to data on individual FRCs for this report, we have chosen not to include information on which specific FRC we are referring to in discussion of that data. The data on individual FRCs is presented to illustrate our arguments regarding variation in the network, not to praise or critique the services of an individual FRC. We do, however, occasionally mention specific FRCs when highlighting promising practices.

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

The FRC Model

In this section, we describe how the FRC model was developed, discuss how it evolved over time, and provide basic information on how FRCs currently function.

History of the FRCs

In 2012, the Massachusetts Legislature statutorily authorized the creation of a statewide network of FRCs as part of legislation (M.G.L. Chapter 240 of the Acts of 2012: Families and Children Engaged in Services) designed to reform the prior "Children in Need of Services," or CHINS, system.[5] The goal of this reform legislation was to connect the child and their family with services that can address behavioral issues and any underlying causes (e.g., mental health, trauma, ineffective educational supports) that, in theory, could help prevent court involvement.

The 2012 legislation defined which community-based and school services should be utilized to support families before the CRA court process is initiated. It also defined the factors that would indicate a child "required assistance." The statute specifically charged the Secretary of Health and Human Services with responsibility for establishing a "network of child and family service programs and family resource centers throughout the Commonwealth to provide the community-based services needed by families with "children requiring assistance."

When the CRA legislation passed, DCF had already established twelve FRCs. Those first FRCs were funded at $3M annually and built on a network of Community Connections Coalitions funded by federal grants to involve residents in planning for services that would meet their needs. The program's design as an entry point to a network of community-based services was meant to enhance family engagement and the coordination of family services within communities. The first FRCs served families with children primarily under age 12, providing a mix of individual and group-based family support services and social activities. DCF had started building out FRCs as part of a broader effort to increase the availability of services designed to support families and help them avoid entry into the child protective services system.[6]

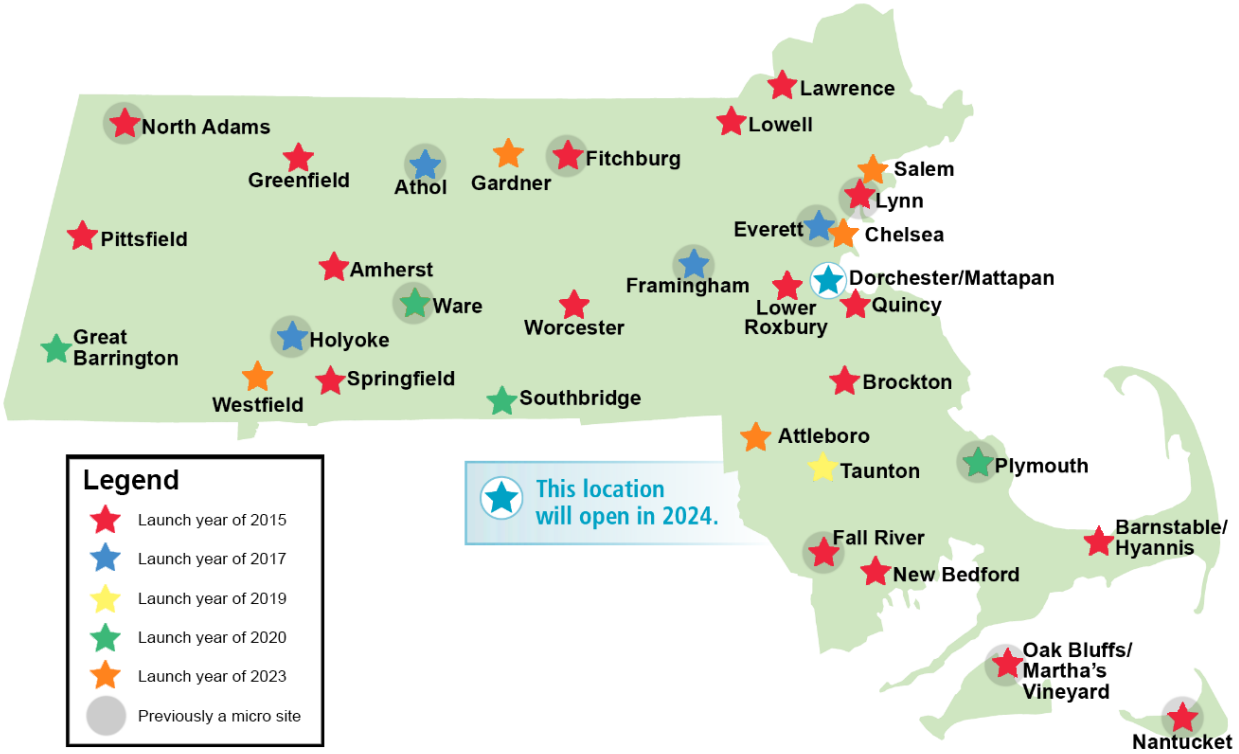
To implement Chapter 240, EOHHS and DCF built on this initial DCF FRC network, expanding its mandate to include the families and services required by the Families and Children Engaged in Services legislation.[7] In 2014, EOHHS, in partnership with DCF, issued a Request for Responses (RFR) to fund an expanded vision for FRCs—a single point of entry for families with children

[5] M.G.L Chapter 240 of the Acts of 2012: https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter240
[6] For more information, see DCF's 2022 RFR for FRC expansion: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1034-0009-DSS09-75411&external=true&parentUrl=close
[7] This was through a new competitive procurement process. All previous contracts were sunset. Nine of the 12 original agencies operating an FRC were awarded a new contract.

ages birth to 18 to access family support services and help them avoid entry into the child protective services and CRA systems.[8]

EOHHS and DCF initially funded 18 FRCs, with at least one in each county. Over time, the number of FRCs has grown to 32 sites across the state, with one more currently planned for the Dorchester/Mattapan section of Boston. Twelve FRC "full service" sites started as micro sites, which had a smaller staff and budget, as shown in Figure 1, below. These were subsequently expanded to full service centers.

Figure 1:
Map of FRC Locations



State appropriation for FRCs has expanded over the years, from $850,000 in FY14 to $5.2M in FY15, reaching $33.8M in FY24. (See Table 1 below). This includes a $4.8M earmark in FY24 for flexible funding grants to "support current activities and services that are beyond contractual requirements for a family resource center and are necessary to meet needs, including emergency needs, to stabilize families in family resource center catchment areas" as well as a $3M earmark for MHAP for Kids.

Accounting for inflation, this increase in funding has primarily supported expansion in the *number* of FRCs and in converting micro sites to full-service sites by doubling the required direct

[8] More FRCs were added to the network over the years in subsequent procurements, but all were based on the original RFR contract model.

service minimum staffing rather than expansion of budget and staffing for existing full service FRCs.[9]

Table 1: FRC Appropriated and Expended Funds (FY14-FY24)								
FY	**# of FRCs**	**Allocated (GAA)**				**Expended**		
		4800-0200	**MHAP earmark**	**4000-0051**	**Total**	**4800-0200**	**4000-0051**	**Total**
2024	**32**	$33.8 mil*	$3 mil	$500K	$34.3 mil	N/A	N/A	N/A
2023	**32**	$28.3 mil	$2.3 mil	$500K	$28.8 mil	24,157,385	$67,769	$24,225,154
2022	**27**	$25 mil	$1.5 mil	$500K	$25.5 mil	$19,787,821	$0	$19,787,821
2021	**27**	$17.45 mil	$950K	$500K	$17.95 mil	$17,316,046	$35,000	$17,351,046
2020	**27**	$16.5 mil	$500K	$500K	$17 mil	$14,561,903	$10,000	$14,571,903
2019	**24**	$15.05 mil	$50K	$500K	$15.5 mil	$10,739,592	$0	$10,739,592
2018	**22**	$9,731,116	$50K	$500K	$10,231,116	9,656,845	$266,430	$9,923,275
	22	$9,978,898	N/A	$500K	$10,478,898	$8,971,700	$0	$8,971,700
2016	**18**	$7,398,054	N/A	$2.5 mil	$9,898,054	$7,395,111	$1,939,234	$9,334,345
2015	**14**	$5,227,963	N/A	$2.5 mil	$7,727,963	$4,917,000	$2,313,000	$7,230,000
2014	**0**	N/A	N/A	$850K	$850,000	^	^	^

Notes:
**Funding included an earmark of $4,800,000 funding for "flexible funding grants to support current activities and services that are beyond contractual requirements for a family resource center and are necessary to meet needs, including emergency needs"*
^Data unavailable

The legislation that led to the creation of the FRCs (Chapter 240) also established a Families and Children Requiring Assistance Advisory Board (FACRA). The Advisory Board is chaired by appointees from the Governor and the Chief Justice of the Juvenile Court and includes representatives of state agencies, the Juvenile Court, the Legislature, advocacy organizations, non-profits, and parents. The Advisory Board's duties include advising EOHHS, collecting and reporting data, monitoring implementation of the legislation, and issuing an annual report.

National Context

Family Resource Centers were first established in neighborhoods across the United States in the 1980s as part of a broader movement toward family support. Although there is no federal funding specifically designated for FRCs, there are over 3,000 nationwide in 39 states and the District of Columbia.[10] These centers most often provide parenting support, access to resources

[9] The rate paid to providers to operate a full-service site has increased over the years, from $546,000 in FY15 to $736K in FY24. Accounting for inflation, $550K in 2015 is equivalent to $720K in 2024. See: https://www.bls.gov/data/inflation_calculator.htm
[10] National Family Support Network. (n.d.) What is a Family Resource Center?. https://www.nationalfamilysupportnetwork.org/_files/ugd/ec0538_9c82d343310a497ba1a4ef0c9d1a5d82.pdf

to help families meet basic needs, child development activities, and parent leadership development.

While there are many variations on the FRC model across the country, research on different FRCs demonstrates that they produce positive outcomes, including:

- **Decreased use of the child welfare system**: One study found that the preventative services provided by FRCs in Allegheny County Pennsylvania contributed to a decrease of 26% in community-level child abuse and neglect investigations.[11]

- **Increased capacity in families and communities**: An evaluation of Colorado's FRC system found that families served reported improvements in income, cash savings, debt management, housing, employment, food security, childcare, children's education, mental and physical health, and transportation after utilizing the services provided by an FRC.[12] Specifically, the evaluation found that:
    - Families accessing services had a lower median income ($16,872) compared to the state median ($80,184) but demonstrated statistically significant gains in economic security and access to concrete support in times of need.
    - While receiving services, families were most likely to make improvements in the areas of housing, employment, and debt management.

- **Positive cost-benefit analysis:** In an investment analysis, Alabama calculated that for every dollar invested in the state's FRC network, the state received $4.70 of immediate and long-term financial benefits.[13] Another study conducted in Teller County Colorado found that every dollar invested in FRCs resulted in a $3.65 savings for the county's child welfare system.[14]

Massachusetts FRCs' emphasis on providing support before a CRA petition in Juvenile Court distinguishes our statewide model from others in the U.S. While the Massachusetts model offers many of the same services as FRCs nationally, the primary impetus for statutorily creating the statewide FRC network was specifically to support families with a child requiring assistance,

[11] Wulczyn, F., & Lery, B. (2018). Do Family Support Centers Reduce Maltreatment Investigations? Evidence from Allegheny County. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2019/03/FSC-Allegheny-County-_Dec2018.pdf

[12] CFRCA. (2020). Colorado Family Resource Center Association 2022-2023 Evaluation Report. https://www.cofamilycenters.org/wp-content/uploads/2023/12/Family-Resource-Center-Association-2022-2023-Annual-Evaluation-Report.pdf

[13] Community Services Analysis. (2014). Alabama Network of Family Resource Centers: Social Return on Investment Analysis. http://www.csaco.org/files/103503730.pdf

[14] OMNI Institute (2021). Return on Investment of a Family Resource Center to the Child Welfare System: Community Partnership Family Resource Center, Teller County, CO. Submitted to National Family Support Network, Washington, D.C. https://www.texprotects.org/wp-content/uploads/2021/12/186a7-communitypartnershipfamilyresourcecenterchildwelfarereturnoninvestmenttechnicalappendix_oct2021.pdf

with an emphasis on providing that support *before* a CRA petition is filed and, hopefully, diverting the child from the Juvenile Court altogether.[15]

FRC Operations

DCF contracts with 24 community-based agencies to operate FRCs in 32 locations. (Six agencies oversee more than one FRC.) These community-based agencies provide an array of services. Most (72%) provide behavioral health services, including operating one or more Community Behavioral Health Clinics (CBHC) or a Licensed Mental Health Clinic (LMHC). Many also operate a variety of programs in addition to the FRCs, often holding contracts with DCF, DMH, DDS, DYS, and/or other state agencies for other services as well.

The FRC contracts are rate-based, and DCF pays each FRC the same rate – $61,373/month or just over $736k annually in FY24 – regardless of the location, population density of the surrounding area, or number of family members served.

DCF also contracts with ForHealth Consulting at UMass Chan Medical School to serve as the Administrative Service Organization (ASO) for the FRCs, providing a range of program support activities, including data collection and reporting, marketing and communication support, evaluation, training, and technical assistance to the FRCs and DCF.

Who do FRCs serve?

FRCs have no eligibility criteria; they are expected to serve any family member who requests support, regardless of where they live.[16] However, FRCs are procured by DCF for a specific geographic area and tend to serve individuals in their own communities; the vast majority of families served by each FRC come from a relatively small number of zip codes near the FRC.[17]

In CY23, FRCs served 19,333 families (for a total of 30,612 family members served), an average of 604 families per FRC. The number of families and individuals served by the FRC network has grown over time, with a 77% increase in the number of families served since 2019. While the number of families served from one FRC to the next can vary greatly, as demonstrated by the grey lines in Figure 2, the average number of families served statewide remained fairly steady for several years until 2022, when the average number of families served by FRC increased by 22%.

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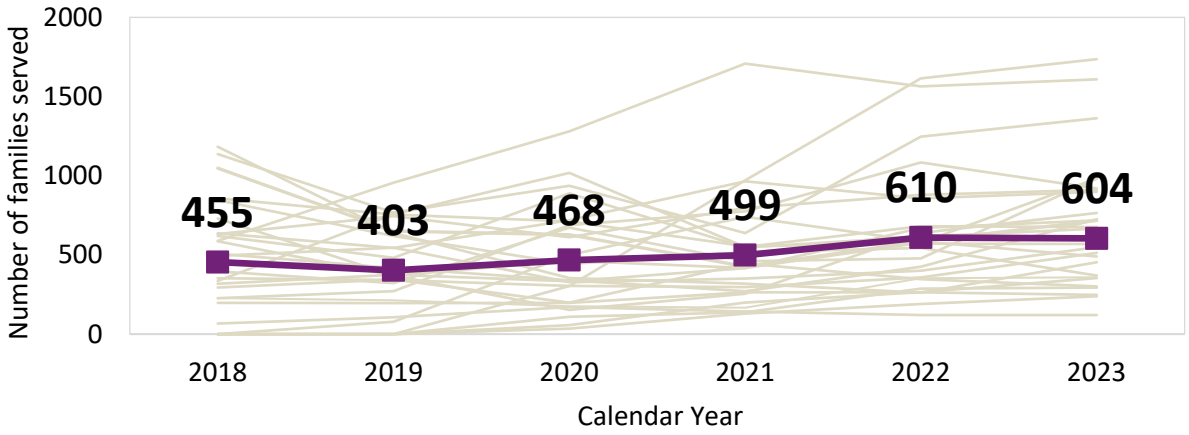
[15] "Subject to appropriation or third party reimbursement, the secretary shall: (1) establish a network of child and family service programs and family resource centers throughout the commonwealth to provide community-based services to families with children requiring assistance under subsection (c);"…"The network of community-based services and family resource centers shall: (i) assist families so that, whenever possible, children may continue residing with their families in their home communities; (ii) assist families to enable children to continue as students in their community schools; (iv) strengthen the relationships between children and their families; and (iv) provide coordinated, comprehensive, community-based services for children at risk of dropping out of school, committing delinquent acts or engaging in behaviors which impede the likelihood of leading healthy, productive lives." M.G.L Chapter 240 of the Acts of 2012: https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter240

[16] However, FRCs do not serve individual adults who are not caregivers to a child. For more information, see DCF's 2014 RFR establishing FRCs: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS01-00000001071&external=true&parentUrl=close

[17] See Figure 17 on page 53.

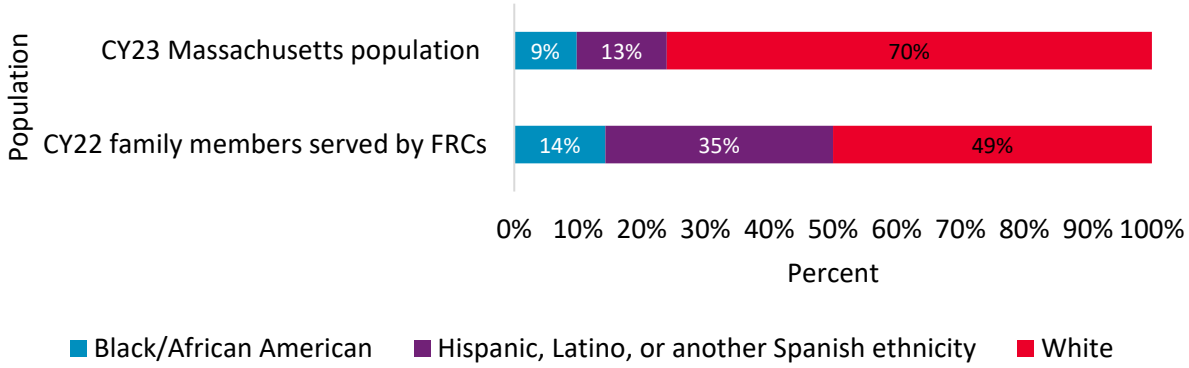
Figure 2:
Average Number of Families Served per FRC



Each gray line on the above chart represents an FRC and the number of families it served each year.

In CY22,[18] 35% of FRC family members were reported to identify as Hispanic, Latino, or another Spanish ethnicity, 14% were reported to identify as Black/African American, and 49% were reported to identify as white.[19] In comparison, 13% of Massachusetts residents identify as Hispanic/Latino, 9% identify as Black/African American, and 70% identify as white.[20]

Figure 3:
Race/Ethnicity of Family Members Served by FRCs



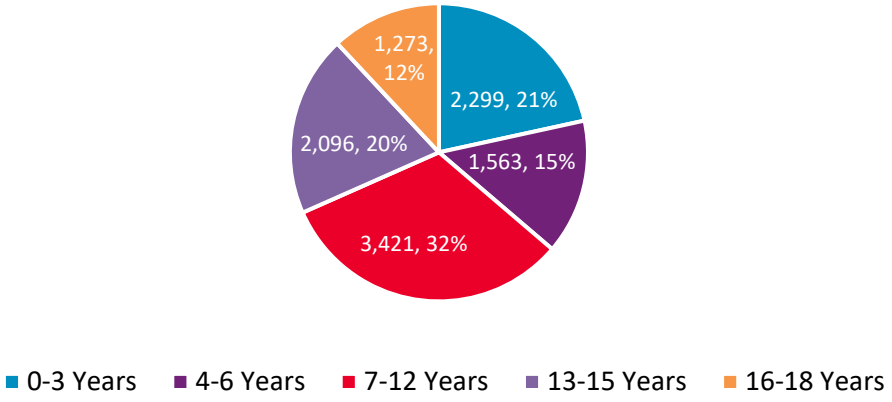
In CY22, 17% of family members reported Spanish as their primary language, 1% Haitian Creole, 3% Portuguese (including Brazilian Portuguese), 1% Cape Verdean Creole, and 1% some other

[18] FRCs served 28,047 individual family members from 16,464 families in CY22.
[19] Family members served by FRCs are not required to provide race and ethnicity information. Totals do not add to 100% because family members can select multiple categories for race and ethnicity, though not all demographic data is self-reported. In CY22, at least 19% of family members left Race blank or chose not to answer, and at least 16% left Ethnicity blank or chose not to answer.
[20] United States Census. (n.d.) Quick Facts Massachusetts: Population estimates, July 1, 2023. https://www.census.gov/quickfacts/fact/table/MA/PST045223

language. In total, 23% of FRC consumers listed a language other than English as their primary language.[21]

Sixty-five percent of family members served identified as female, 30% as male.[22] Of the children served in CY22 (n=10,652), almost a third (32%, n=3,421) fell between the ages of 7-12.

Figure 4:
Age Distribution of Children Served by FRCs (CY22)



According to a March 2023 FRC Program Evaluation Report, most (69%) families served by the FRCs in CY22 were single-parent households. The report also noted that among new families served in 2022, about 14% were homeless (sheltered and unsheltered).[23]

Families seek help from the FRCs for a variety of reasons. As indicated in Table 2 below, the top reasons families visited the FRC (beyond "Other") were for family hardship/financial reasons, health/mental health concerns, and issues with housing/rent. An analysis of write-in responses found that many families were coming to the FRC for material goods, such as diapers and clothing, as well as for activities and events.[24]

Table 2: Reason for Visit (Average 2019-2023)	
Category	**Percent of all reasons**
Family Hardship / Financial Issues	11%
Health / Mental Health Concerns	11%
Housing / Rent	11%

[21] Seventeen percent of respondents did not answer, which means the percent speaking another language may be higher. See Appendix A for a full list of languages spoken.
[22] The remainder were non-binary (.3%), prefer not to answer, or unknown.
[23] Swan, H., et. Al. (2023, March). "Massachusetts Family Resource Center 2022 Program Evaluation Report". ForHealth Consulting at the UMass Chan Medical School. https://malegislature.gov/Reports/17075/(2)%20FRC%20Legislative%20Report%20CY2022_Final.pdf
[24] Swan, H., et. Al. (2023, October). "Massachusetts Family Resource Center 2023 Mid-Year Evaluation Report". ForHealth Consulting at UMass Chan Medical School. https://www.mass.gov/doc/massachusetts-family-resource-center-network-program-evaluation-report-march-2022/download

School Issue / School Info	10%
Food/Nutrition	8%
Seeking Information on Parenting / Parenting Education	7%
Teen/Young Adult Activities	4%
DCF Involvement / Support	5%
All other combined (includes 16% marked "Other" plus other reasons making up 2% or less of total)	33%

In CY23, 28% of families served (n=5,465) had at least one child aged 6-17 years old, making them age-eligible for a CRA petition. Of those 5,465 families, 33% (1,796) had at least one age-eligible child who was deemed either at risk for a CRA (approximately two thirds of these families) or had already been the subject of a CRA (approximately one third).[25]

FRCs follow a common process for identifying a child as being "at risk" of a CRA petition. Risk factors include a child (between the ages of 6 and 17) missing a significant number of days of school, running away from home, having a difficult time following rules at school or at home, or if a child was referred by a school, court, probation, or law enforcement for "CRA-related" issues. These factors match the statutory definition of a "child requiring assistance" under M.G.L. Chapter 240.

FRC Services

FRCs provide on-site services as well as referrals to other community-based programs. The contract with DCF specifies a certain number of "Basic Services." Per contract, all of these services must be delivered on site, but the delivery can be by either the FRC or another agency.

The contract also requires each FRC to develop a network of community-based services to which it can refer families. It lists 23 treatment and support services to be included in this network, including employment, eligibility determinations for financial assistance and housing programs, and health and mental health services.

The services FRCs currently provide directly to families can be grouped into the following seven categories:[26]

- **Group Parenting Support**: These include a variety of evidence-based and evidence-informed parenting classes, as well as workshops and parent/caregiver mutual support groups. FRCs are required by contract to provide a minimum of two evidence-based parenting programs per quarter, as well as at least one peer-to-peer support group for youth and adults per week, and one grandparent support group that meets twice monthly.

[25] In CY23, 583 families were served that had at least one child who had been the subject of a CRA petition, and 1,224 had a family with at least one child who met the "at-risk" guideline.
[26] These categories were developed by the OCA for the purposes of this report. FRCs report data to DCF at a more granular level.

- **Individual and Family Supports:** These include family strengths and needs screenings and assessments; service planning; individualized referrals to other services, such as child care and pre-school programs, early intervention and developmental screening, child development information, and domestic violence supports; system navigation support; and other individualized assistance with information, advice, and resources to help support child and family wellbeing.

- **CRA Prevention and Support**: This category includes individualized assessments and service planning for families with a child at-risk of involvement with the CRA system or currently involved with that system; support to families and youth with school attendance issues and those needing to access special education (IEPs, 504s) services and other educational supports; and referrals to mentors and youth programming.

- **Basic Needs Support:** This category includes operation of food banks and distribution of other material goods, such as car seats, diapers, gift cards, and personal hygiene and cleaning supplies; helping families find, apply for, and access financial assistance programs, housing, fuel and utility assistance, and transportation; and holiday and back-to-school events offering gifts, school supplies, clothing, and food.

- **Access to Health and Behavioral Health Services:** These include screening/assessments to identify behavioral health needs; service planning related to health/behavioral health needs; provision of short-term/bridge therapy and support groups; and referrals to health care, substance use disorder treatment, recovery support, and behavioral health services for both adults and youth.

- **Recreational Activities and Events:** These include family fun events, such as potlucks, cookouts, family outings and holiday parties, senior activities, baby showers, and other community events. These are often coupled with basic needs support (e.g., back-to-school events) and education about the FRC and other community services.

- **Education:** This category includes life skills classes and workshops for adults and youth on topics such as financial literacy, household management, computer literacy, GED and adult basic education, and English language classes. FRCs are required to hold life skills workshops at least once per month, and an onsite educational program at least once per quarter.

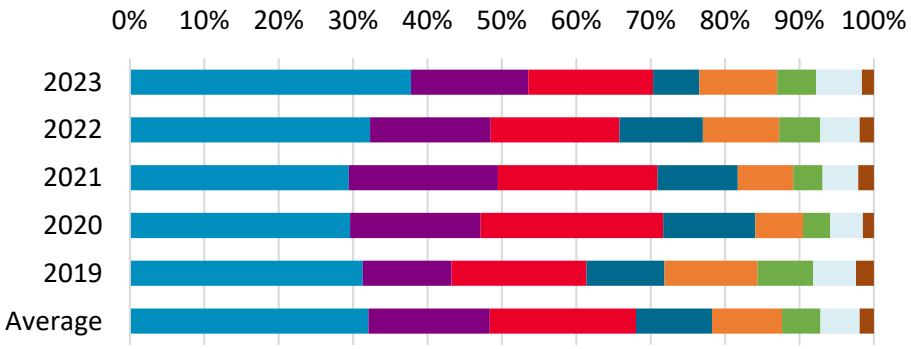
In addition to the above seven categories, FRCs have regularly been called upon to provide **crisis support**, including the provision of tangible supports in response to specific emergencies such as the influx of evacuees following Hurricane Maria, the Merrimack Valley gas explosion, providing community support (food drives, support with vaccine outreach, etc.) during the COVID-19 pandemic, and responding to the needs of the current influx of migrants. This is

similar to and often overlaps with basic needs supports, but these needs are often more intense, urgent, and community-wide and are the result of unexpected events.

The chart below shows percentages of total reported services delivered to families, grouped into the seven categories, during the period of 2019-2023. [27] (Available data is not categorized in such a way as to allow for disaggregation of crisis support work across years, but qualitative interviews and focus groups, as well as service data in specific years, make clear this has, at times, made up significant portions of FRCs' work with families.)

Basic Needs Support is the most frequently delivered service, followed by Individual and Family Supports, and Group Parenting Support. Of note, CRA Prevention and Support services make up only 9% of services delivered, on average.

Figure 5:
Services Provided as a Percentage of All Services Delivered (2019-2023)



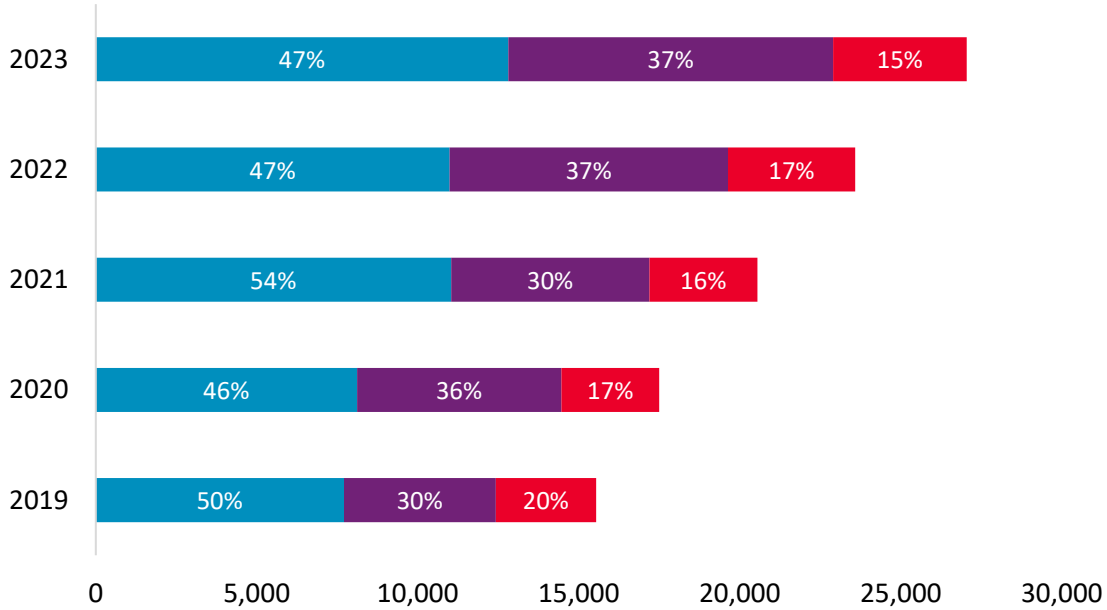
	Average	2019	2020	2021	2022	2023
Basic Needs Support	32%	31%	30%	29%	32%	38%
Group Parenting Support	16%	12%	18%	20%	16%	16%
Individual and Family Supports	20%	18%	25%	21%	17%	17%
Other	10%	10%	12%	11%	11%	6%
CRA Prevention and Support	9%	12%	6%	7%	10%	10%
Access to Health & Behavioral Health Services	5%	7%	4%	4%	6%	5%
Recreational	5%	6%	4%	5%	5%	6%
Education	2%	2%	1%	2%	2%	2%

FRCs document the number of unique days they work with a family member. While there is substantial variation *across* FRCs, on average**,** the unique days of service ratio remained consistent between 2019 and 2023, with about half of the family members receiving one day of service, a third receiving 2-5 days of service, and 15-20% of family members receiving 6 or more

[27] Note that one family may receive more than one service, and so data is presented by "services delivered" rather than "families receiving a given service".

days of service.[28] It is worth noting, however, that as the overall number of family members being served by each FRC has increased over time, the numbers of family members receiving more intensive (2-5 days and 6 or more days) service has also increased – even as the proportion of family members in each category has remained relatively consistent (see Figure 6, below).

Figure 6:
Unique Days of Service per Family Member, All FRCs (CY19-CY23)



	2019	2020	2021	2022	2023
1 Day	7,707	8,113	11,036	10,989	12,808
2 to 5 Days	4,715	6,347	6,157	8,645	10,091
6 or more Days	3,116	3,038	3,353	3,947	4,146

How Do Families Find the FRCs?

FRCs are expected to develop community engagement plans, which includes engagement with court and school personnel, police, child and family service agencies, and health and behavioral health facilities. Most FRCs have instituted large community events that pair access to tangible goods (such as holiday gifts or back-to-school supplies) with information about FRC and

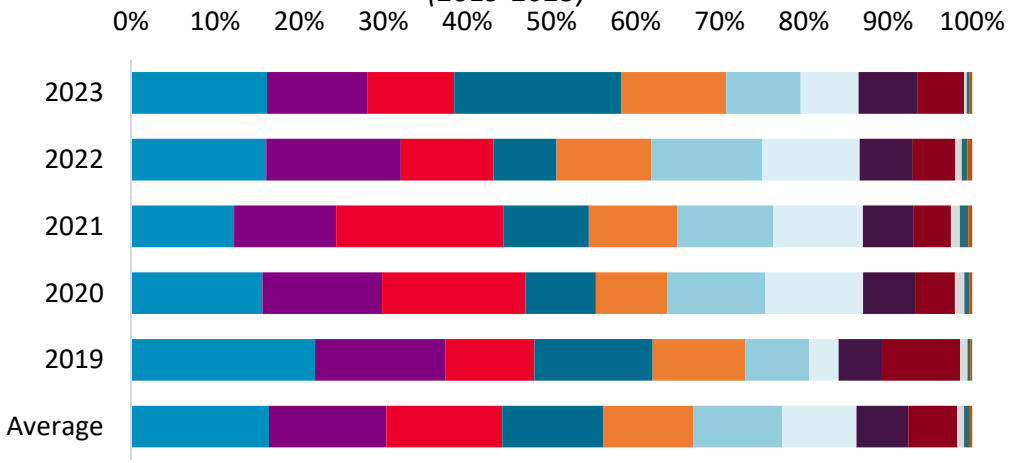
[28] Unique days of service is only counted for family members who have a listed "service date" and may not capture all family members who attended an event, including food/clothing/holiday drives. One day of service means they received services on just one day in the calendar year. Attendance at an event is not tied to an individual family member and would not necessarily be counted in their service dates or service provisions.

community resources. These events provide both a needed service and make families aware of FRCs and their services as well as other community services.

The chart below shows the reported referral sources to FRCs for new families as a percentage of all reported referrals each year between CY19 and CY23. In CY23, 38% reportedly came from an institutional source (state agency, school, or court), while 16% came from a friend or family.[29]

Figure 7:

Referral Sources for New Families, Percentage of All Referrals, All FRCs (2019-2023)



	Average	2019	2020	2021	2022	2023
Friend or familiy	16%	22%	16%	12%	16%	16%
Other State Agency	14%	16%	14%	12%	16%	12%
Other	14%	11%	17%	20%	11%	10%
Self	12%	14%	8%	10%	8%	20%
School	11%	11%	8%	11%	11%	12%
DCF	11%	8%	12%	11%	13%	9%
Social or print media	9%	3%	12%	11%	12%	7%
Mental Health/ Health provider	6%	5%	6%	6%	6%	7%
Court	6%	9%	5%	4%	5%	5%
Faith-based org	1%	1%	1%	1%	1%	0%
Mass 211	1%	0%	1%	1%	1%	0%
Community agency	0%	0%	0%	0%	1%	0%

[29] This data should be interpreted with caution for a variety of reasons. First, families may not always choose to share who they were referred by, particularly if that referral came from a source that could be perceived as negative, such as the court. Second, referral source data is incomplete for some FRCs. Note also that FRCs can check more than one referral source.

How are FRCs staffed?

The FRC contract requires all FRCs to have a minimum staffing level of five direct service full time equivalent (FTE) staff[30], which includes:

- Two **family support workers**, who provide information, educational resources, and referrals to families. They also host/support parent and youth support groups.

- One **clinician**, who conducts the intakes, screenings, and assessments for all family members experiencing "CRA-related issues." The clinician oversees the development of the Family Support Plan, supervises the family partner, and provides clinical support to other staff.

- One **family partner,** an individual from the community with "lived experience" or familiarity with CRA-related issues, who works with the clinician to complete assessments, develop family support plans, and oversee the implementation of the plan, with support from other FRC staff. While the family partner (and clinician) may work with any FRC family, families experiencing CRA-related issues are expected to be prioritized.

- One **school liaison**, who works with school districts to help families navigate education and school-related concerns and identifies families who may need family support services.

The clinician and the family partner are hired by a Licensed Mental Health Center through a contract with the FRC. This center provides clinical supervision for these two employees, and the FRC provides administrative supervision.

The FRC contract also requires another 1.5-2 FTE management positions:

- One **program manager**, who is responsible for the day-to-day supervision and management of FRC operations, coordination with the network of service providers, managing community relations, and monitoring community needs.

- One-half FTE **program director**, who is responsible for managing the FRC's contracts, relationship with the ASO, EOHHS and DCF, compliance with contract and other requirements, and supervision of the program manager. The program director often works part-time in the parent agency for the FRC.

In practice, FRCs employ between 7 and 10 staff. [31] Those that have additional staff have chosen to add other positions. Examples include an administrative assistant (25 FRCs), youth support worker (2 FRCs), and group facilitator (2 FRCs).

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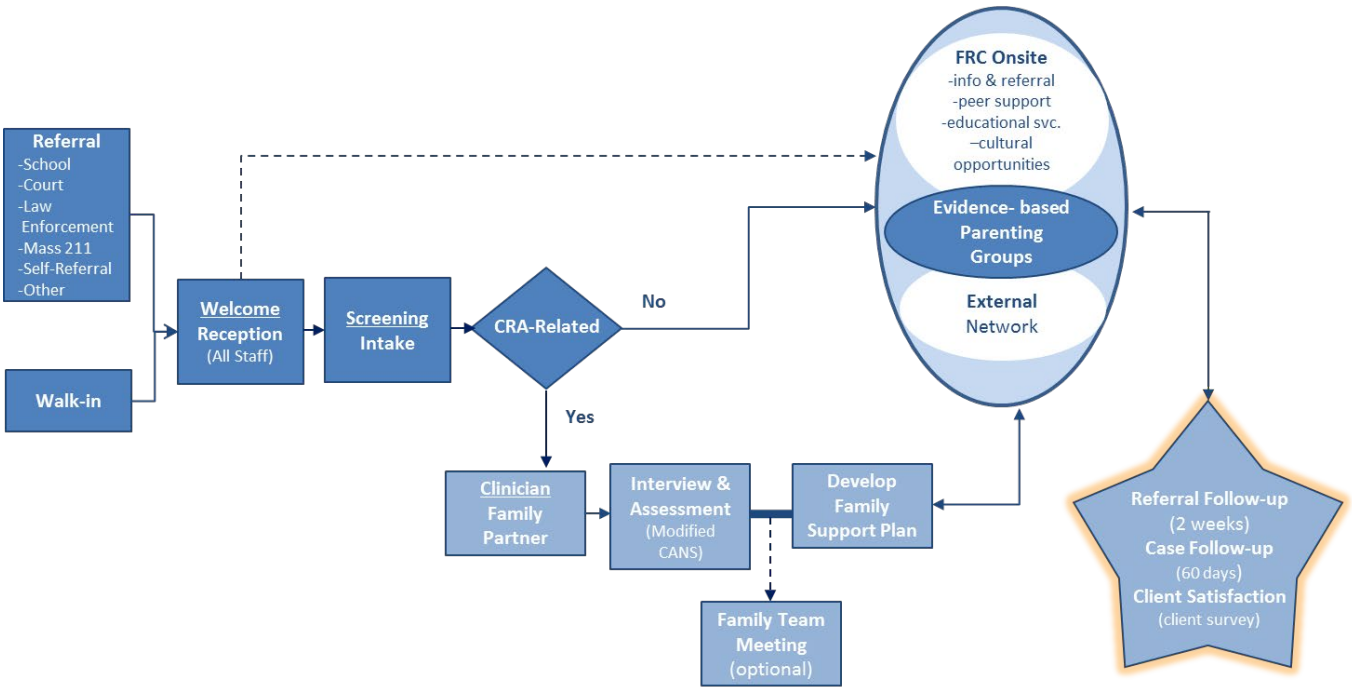
[30] The responsibilities for each position are defined in contract. For more information, see DCF's 2014 RFR establishing FRCs: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS01-00000001071&external=true&parentUrl=close

[31] FRCs that employ additional staff report covering this through "support from the parent agency," private fundraising, or "braiding" funds with other contracts.

How do FRCs support families?

When a family contacts an FRC for help, there is a standard intake process which the FRC follows. This process is described in the flow chart below.[32]

Figure 8:
FRC Standard Intake Process



While all families go through a screening and intake, if a family has a child with an open CRA case or a child who is at risk of a CRA filing,[33] there are additional steps. The clinician, with the family's permission, completes an interview and the Family Strengths and Needs Assessment (FSNA) to determine the child and family's needs.[34] Based on the assessment results, and with the family's permission, the clinician and family partner work with the family to develop a family support plan, which they then help to implement.

By contract, FRC staff are expected to follow up on referrals and CRA cases; however, data on the extent to which follow-up happens, and when, is not available.

[32] For more information, see DCF's 2014 RFR establishing FRCs: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS01-00000001071&external=true&parentUrl=close

[33] For brevity, these families will be referred to as "CRA/CRA at risk" for the remainder of this report. See page 18 for a description of how a child is identified as being "at risk" for a CRA.

[34] The Family Strength and Needs Assessment is a comprehensive tool which looks at many factors, including financial status, food security, transportation, residential status, parenting and life functioning skills, knowledge of and involvement with service options, parent/caregiver and child health and well-being, and child developmental and education needs.

Partnership with MHAP for Kids

Across the state, FRCs partner with the Mental Health Advocacy Program for Kids (MHAP for Kids),[35] which provides legal assistance to youth and their families with unmet mental health needs who are court involved or at risk of court involvement.

MHAP for Kids currently has 17 staff attorneys and 5 paralegals serving families statewide out of 15 Family Resource Centers. These highly trained staff advocate (based on the family's identified need) to:

- Begin or improve special education services
- Secure and/or coordinate community-based mental health services
- Increase access to state services by collaborating with DCF, DMH, and DDS
- Advocate for general education accommodations
- Assist with health insurance coverage

In addition to supporting families, MHAP for Kids attorneys also provide training to FRC staff and families on key issues. The MHAP for Kids attorneys are available to FRC staff for consultation on cases even for families that do not become MHAP for Kids clients.

MHAP for Kids began in 2017 as a pilot in two counties, Essex and Middlesex. MHAP for Kids has since expanded and as of 2023 serves families statewide through attorneys based in 15 FRCs in Boston (Roxbury), Brockton, Everett, Fitchburg, Holyoke, Hyannis, Lawrence, Lowell, Lynn, Pittsfield, New Bedford, Quincy, Salem, Springfield, and Worcester. From 2017 to 2023, the program served 1,757 youth and families.

Research demonstrates that MHAP for Kids improves outcomes for youth and their families. A 2017-2022 study conducted by the Boston University School of Public Health found that after receiving services through MHAP for Kids, families experienced: [36]

- **Improved family functioning.** The report found statistically significant improvements to the overall mental health of youth, the overall mental health of their caregivers, caregiver-youth conflict, and overall youth total difficulties.
- **A decreased need for emergency mental health services.** This includes a reduction in need for youth inpatient hospitalization, emergency room visits, in-home mobile crisis team services and youth stays in residential facilities.
- **Reduced court involvement.** MHAP staff attorneys advocated to avoid or shorten delinquency court involvement as well as CRA involvement.

[35] MHAP for Kids is a program of Health Law Advocates (HLA), a non-profit public interest law firm whose mission is to improve access to health care for Massachusetts residents. Health Law Advocates. (n.d.). Mental Health Advocacy Program for Kids. https://www.healthlawadvocates.org/initiatives/mhapforkids

[36] Elliot, P., Stransky, M., & Feinberg, E. (2023). Mental Health Advocacy Program for Kids. https://www.healthlawadvocates.org/pdfs/BUSPH-Evaluation-MHAP-Report-3-2017-to-6-2022-2023-1-24-Final.pdf

Demand for the program is high. Starting in 2020, coinciding with the COVID-19 pandemic, the program began maintaining a waitlist for referred clients. MHAP for Kids has received funding in the state budget to support the program, beginning with a $50,000 earmark in FY2018. In FY24, the earmark grew to $3,000,000.

Finding 1: FRCs provide valuable support to families across the Commonwealth

In interviews and focus groups with FRC stakeholders, there was near unanimous agreement that FRCs provide much-needed services within their communities. FRCs use a strength-based, family-focused, and nonjudgmental approach and work to develop trusting relationships with families. Indications of high satisfaction include:

- **A 2020 program evaluation**[37] found that over 87% of survey respondents reported that the FRC was very or somewhat helpful in 5 of the 6 need areas.[38] The only area where there was less satisfaction was in helping families meet their housing needs—and even in that category, 72% found the FRC very or somewhat helpful.

- In **focus groups** conducted for this report, FRC consumers were overwhelmingly positive about the support they received from the FRCs. (See Figure 9 for direct quotations from consumer focus groups.)

- In **interviews with organizations which either refer to or work with FRCs**, we heard strong support for their work, particularly in building relationships with community organizations, providing tangible supports/basic needs, and responding to community crises.

[37] UMass Chan Medical School. (2022). Massachusetts Family Resource Center Network: 2021 Program Evaluation Report. https://www.mass.gov/doc/massachusetts-family-resource-center-network-program-evaluation-report-march-2022

[38] UMass surveyed over 1,900 randomly selected family members who sought help from FRCs in one of six areas—housing, mental health counseling, parenting support, children's schooling, children's behavior, and being a parent (for DCF involved parents).

Figure 9: FRC Consumers Describe Impact of FRCs on their Lives

- *"I've received so much support. We have each other's trust. I could say whatever I wanted to the people here… What happens here stays here. We're always together. If [Leader] left, we would cry. If FRC closed, we would be very sad."*
- *"My grandkid was kicked off a bus and kept having issues. The FRC got him onto a van pool when the school refused to help."*
- *"The FRC has helped me a lot… I've been having problems with my marriage with my youngest daughter who is very hyper… I came to the FRC through a friend and I started to take the parents class… The mentors and their advice really helped me. I learned to speak on behalf of my child and understand my child better… They've helped my self esteem and to find myself. They helped me learn that I need to take time for myself… [and] take care of myself. This class was, oh my god, like a therapy for me… The FRC has been a huge help for me and other parents."*
- *"The FRC has been able to guide us and offer suggestions when one thing we try doesn't work… The resource center has been extremely helpful."*
- *"My child has special needs and the center has been so helpful (starts crying). It is a very beautiful place. It's super good."*
- *"I've been coming to the center for 6 years. I first came when my child was 9 months old, and they gave us playdoh. They helped my kid learn to read. I've been to a lot of groups. They tell us 'you are important'… It's been a big help."*
- *"I was in a domestic violence situation, and the FRC helped me a lot. They've made a big impact on me and my children. I'm very grateful."*
- *"When first had grandson, on spectrum, issues of PTSD and separation anxiety, often couldn't leave house… but nothing bothered him at FRC… Will be 14 in April, now so comfortable… Used to be able to take free books. He loved book day. Now reading more advanced books, attribute that to book day."*

FRCs demonstrate a number of strengths in how they serve families that distinguish them, in the eyes of some FRC consumers and other stakeholders, from other state services. These include:

- **Building trust with families and making families feel welcomed and heard.** Consumers described FRC staff as caring and respectful, and they appreciated being treated "like a human." They also reported that staff go above and beyond to provide support. Many

consumers spoke of finding a "second family" at the FRC or regarding the FRC and its staff as family, who are "amazing," and bring them food after surgery or illness. (See Figure 10 for more direct quotations from consumer focus groups about their experiences with staff.) Many staff in FRCs live in the communities they serve and experience some of the same challenges their families face, which helps in establishing rapport and building trust.

Figure 10: Consumers Report High Levels of Satisfaction with their FRC Experiences

- *"I feel very welcome here. They give a good orientation for different topics… [Staff] have given me a lot of information quickly and that's been great."*
- "*Resonate with calling it a safe space… It feels good to walk in here. Not a lot of places where you can just be. When you do engage with others, you know ground rules, feel safe… warms heart to see familiar spaces."*
- *"Since I came here, I started going to the FRC and learned a lot of things here that I didn't know before. The people are very nice. Sometimes you feel a little lonely and very sad, now they help me with my family."*
- *"They care about you. Feels like red carpet is set out for me… Gentle way of offering support, not pushing it on you. Respect your comfort zone… Positive use of the word family. Safety net. Consistent feeling over years of staff."*
- *"FRC has way of making you feel at home…, embraced with warmth, not alone… Always come out with smile on face. Ask how you are doing. They know a lot even dietary restrictions. They take time to know what can benefit you."*
- *"No one is judging you here about needing help, or the past, present, or future. They're just here and are all around kind people."*
- *"They go over and beyond, do more than they need to do. Helpful, nice, genuinely care, and not just because it's their job… Won't say no based on geography. Want to give back to them, because they give so much for us."*
- *"They have been such a great help… always so kind and welcoming and encouraging, which makes all the difference as a first-time mom. They are great at reaching out to see if I am interested in the programs they are offering."*

- **Establishing partnerships across their communities and acting as a community "hub."** As described in *The FRC Model*, above, FRCs are expected to develop partnerships and referral relationships with a wide variety of service providers across their community.

Although FRCs face some challenges in doing this, as further described later in this report, they are by and large very successful at knowing what services exist in their community, establishing relationships with other service providers, bringing a variety of community services to the FRCs to support families, and otherwise helping families navigate the wider service system. In interviews with DCF staff and agencies that collaborate with FRCs, the provision of basic needs supports (e.g., food, clothing, equipment, school supplies) was mentioned as a particular strength of all FRCs.

As one DCF staff member put it, *"They really are a staple in their communities…[they] provide a lot of support to a lot of families."* As one state agency manager summed it up, "*FRCs uniformly have become a valued community partner. [They] provide a lot of services and supports around social determinants of health. FRCs have become the "go to" for crises emerging in communities, i.e., natural disasters, accidents, and influx of immigrants. [They] Provide concrete support and resources, and a safe place when having trouble*."

- **Serving the needs of the *whole* family across a variety of need areas.** Many human services focus on the needs of the adult or the child, but not necessarily both. Other programs may focus only on younger children or older children, but not both. In contrast, FRCs are set up to look at the needs of the entire family: the caregivers (including grandparents when they are serving as primary caregivers) as well as children of all ages.

  For many families, FRCs serve as a warm and welcoming "front door" to a variety of services, including financial supports, SNAP benefits, housing support, MassHealth enrollment, access to behavioral health services, and much more. As FRC staff and the family get to know each other, their work together can branch into other need areas. For example, while many consumers first visit an FRC for basic needs, like food, diapers, clothing, and assistance paying utility bills, many also then return to the FRC for other supports, like peer support groups and parenting classes. Several appreciated that FRCs work with the whole family and provide ongoing support, including afterschool activities, exercise classes, and homework clubs.

  For example, as one FRC consumer explained it, *"I needed clothing for my children. They also have helped with groceries. Honestly whatever supports I'm looking for, I tend to get. I just started a weekly parenting group… The Family Resource Center is a lot of help to my family."* Another described, *"I was referred to Grandparents Group and then it snowballed. Everyone welcomes you. I was told about so many other groups. They have a family play area... Kids have anger issues and the staff have been so helpful with the kids and court situations, housing*."

- **Attracting and working with families for whom English is not a primary language as well as families who are immigrants.** As described in *The FRC Model*, above, 23% of 2022 consumers were reported to speak a language other than English. Although data on the immigration status of FRC consumers is not available, based on the multitude of languages spoken by FRC consumers and anecdotal evidence provided in interviews and focus groups, it seems clear that FRCs have established a reputation as being a safe and supportive place for immigrant families and those for whom English is not a primary language to seek help. In focus groups, consumers largely reported that **FRCs are respectful of their language and culture.** (See Figure 11 for direct quotations from consumer focus groups.)

  FRCs also strive to hire multi-lingual staff who speak the languages most common in their communities—and these staff will often "go the extra mile" to translate documents from other state agencies or participate as a translator for families with other agencies. As one FRC Program manager noted, "[Our] s*taff resemble [our] community a lot: Ninety-five percent speak Spanish/English [and] some other languages… [This is] key to being able to serve [our] community."*

  > *"We serve a large Latino population. As you can imagine for our Latino population, housing, immigration and gainful employment are barriers. We have two Family Support Workers that are bilingual and understand the unique challenges our immigrant families face. Language is a barrier for the rest of us who are not bilingual. Even with language being a barrier, we are able to communicate in simple ways with these families and serve them. A smile goes a long way. Simple acts of kindness such as being able to offer a drink or snack while they wait."* – FRC Manager

Based on January through September 2023 monthly reports available from 29 FRCs, 75% of FRCs had staff that spoke the most common languages (comprising 5% or more) of total clients served, 17% had minor language concordance issues for either certain months or languages, and 6% did not have staff that spoke at least one language comprising 5% or more of clients served in 2023.[39]

[39] Of the five FRCs that opened in 2023, three did not have monthly reports for January through September and two started providing monthly reports in April 2023.

Figure 11: A Safe and Supportive Place for Immigrant Families

Quotes from FRC Consumers

- *"All the staff are so warm. It doesn't matter what nationality or immigration status..."*
- *"Latino support group... Many nationalities. We've always been quiet… stuck in darkness. Group is good for getting help and helping others."*
- *"It's been very positive. I come from [the Dominican Republic]… In the DR, kids live their childhood differently than here… This type of freedom isn't ok here… Helped me see a new way of childhood development… I learned how to help my kid have a more productive childhood, more educational, what you learn in childhood stays with you forever. Every game and toy is important. They explained childhood differently here and helped me learned how to support my children more."*
- *"We did a therapy group for four weeks. Sometimes there are uncomfortable things in my relationship. This group helped us to communicate. I'm very grateful… My partner has a lot of problems speaking with other people. This group helped us. I've learned a lot. There isn't this type of support in the DR."*
- *"The group is in Spanish. It's very empathetic. We feel very comfortable, like we're at home. It's like a family. You can trust anyone. We help each other."*
- *"It's a group where they respect our culture and language, and you feel good because you feel supported in every way."*
- *"If I see someone in community or friend/family, I know I can refer them to FRC. Make them feel welcome, even if English isn't first language."*

Finding 2: There is considerable variation from FRC to FRC – which can be positive, but can also create challenges

All FRCs have the same funding level from DCF and required staffing pattern, and all are required by contract to provide the same set of "basic" services.[40] Despite that, there is wide variation in what FRCs offer across the state: how many families they serve a year, what services they offer on-site, and even how they work with individual families and over what period of time.

In this section, we highlight three key types of variation among FRCs:

- Variations in services offered and areas of focus
- Variations in the size of the population served
- Variations in approach: breadth vs depth

This variation is at least in part by design. In any given community, the needs of families and the services available from other, non-FRC sources can vary. In interviews, it was frequently mentioned that FRCs know their community's resources, and many participate in multi-agency committees to identify and help address gaps in community needs.

Some of the variation is also driven by what individual resources specific FRCs may have to draw on. For example, some community-based agencies that run FRCs also provide behavioral health services and as such may have increased capacity to connect families to behavioral health services. Other FRCs are run by an agency that also operates a Community Connection Coalition (CCC), which the FRC might leverage to enhance outreach to parents and referral opportunities. Another agency that runs an FRC also runs housing programs and provides support as needed. Variation may also be due to differences in the skills, capacity, and interests of FRC staff themselves.

There is much value to this locally driven approach, but it also poses challenges. While it is beneficial that community-based agencies can draw upon their own internal resources to benefit FRC consumers, this can lead to inequities and gaps in situations where some provider agencies may have fewer internal resources to draw on than other provider agencies.

There is also no actual way of determining, **at the state level, if each local FRC is correctly identifying and responding to the local community needs, missing critical gaps or patterns, and prioritizing the events and services that would be *most* impactful.**

This approach can also **make it more challenging to align local and state efforts**. If every FRC is different, it can be difficult for entities at the state level to communicate what FRCs are and what they do to potential state level partners (e.g., for DESE to communicate about FRCs to

[40] This refers to funding provided by DCF to operate the FRC. Some FRCs report securing additional funds through grants and other mechanisms, which in some cases is used to support additional staff.

schools or the Administrative Office of the Juvenile Court to communicate to local judges and clerks). Indeed, as further described in Finding 5, below, there is considerable confusion among stakeholders across state government about what FRCs are and what they do.

Similarly, it can be challenging to ensure that state-level priorities are implemented equally across the state; for example, while the provision of services that can help prevent a CRA filing for youth at significant risk (for example, those who are chronically absent for school) was a clear priority for the Massachusetts State Legislature, which ultimately funds FRCs, the extent to which individual FRCs have prioritized this population in their services and planning is highly varied. We also note that our review has identified many excellent and impactful practices developed by individual FRCs, but those practices in many cases have not spread across the larger network.

There are significant variations in services FRCs offer and areas of focus

As described in *The FRC Model*, FRCs are required by contract to offer a set of "basic services" on site and to develop a network of community resources across 23 required categories to which they can refer families.

By design, FRCs have latitude in what they deliver themselves on site versus when they partner with other community organizations to do so. For example, one FRC offers an on-site food pantry which serves 300-400 families daily through a collaboration with multiple local agencies. Another FRC utilizes parenting group facilitators from other agencies to provide some of the required parenting classes on-site.

The FRC contract model allows for some amount of variation based on community need, and some ability to provide different/additional services to fill community gaps. At the same time, looking at the basic services FRCs are required to provide, there is substantial variation across FRCs in what they offer within each of these core categories and the percentage of families that participate in them – both overall and over time.[41] While some amount of variation is to be expected, data on services provided by individual FRCs suggests that in some cases, certain services may not be prioritized at the level envisioned in the original model.

For example:

- **Group Parenting Support:** For some FRCs, this is a focus; for one FRC in 2023, 41% of services provided to families were parenting related. In contrast, for a different FRC, only 2% of services provided were parenting related that same year. On average, Group Parenting Support made up 16% of services provided by FRCs in 2023.

[41] The reported data does not capture the extent to which individuals supported by the FRC are being provided a direct service by an FRC versus services that may be provided via referral, nor does the data capture whether families access services to which they are referred. It is also important to note that one family can receive multiple services.

- **CRA Prevention & Support Services:** On average, services specifically labeled as "CRA Services"[42] make up only about 4% of all services provided across FRCs. In 2023, at the high end, for one FRC it made up 12% of services provided, while in another FRC it made up less than 1% of all services provided. (In 2022, this was as high as 23% for one FRC.) When we include additional categories of services that could be considered CRA prevention, such as adolescent services and school related services, the average climbs to 10%.

- **Access to Health & Mental Health Services:** On average, 4-6% of services provided by FRCs are related to health/mental health, a rate that has remained relatively consistent over time. But in some years, at some FRCs, health/mental health services have made up 15-20% of services provided, while other FRCs document that health/mental health services are 0-2% of services provided. In 2023, 50% of all health/mental health services provided came from four FRCs.

FRCs also host a variety of events, including family recreational activities as well as food/clothing drives, back-to-school events, and holiday gift drives. Data on attendance at events is reported separately from data on service provision.[43, 44]

- **Family Recreational Activities:** In 2022, the average number of annual attendees at recreational activities for an FRC was 855 – but some FRCs reported far fewer, with six FRCs reporting fewer than 100 annual attendees at events in 2022.

- **Food/Clothing/Holidays Drives:** Some FRCs put significant resources into managing food and clothing drives or holiday gift programs, while others do not run these at all. In CY22 for example, one FRC had over 16,000 attendees at their drives (annual total, not per event), while at least three FRCs had zero families attend one (presumably because they were not offered by the FRC.)[45] The average number of attendees per FRC at these drives was 1,195 in CY22.

- **Other Youth Services:** There is also variation with regards to the number and type of youth-focused programming, and the extent to which this is a focus. "Teen & Youth Support" attendees make up an average of 5% of all attendees at events or workshops

[42] CRA services, as categorized in data reported by UMass, include CRA Assessments, CRA related referrals to a LMHC, CRA service plans, and CSEC services.
[43] Due to inconsistencies in data reporting, we suspect, but cannot confirm, that there is some overlap, at least for some FRCs, between attendance at events and service provision data. For example, a family attending a food bank may also be listed as having received food/nutrition support in service data – but given that reported attendance at events such as food drives is much higher than the number of families reported as receiving food/nutrition support, there may be underreporting in the food/nutrition support category.
[44] One individual may attend more than one event and thus be counted twice in the data.
[45] It is also possible that an FRC reporting zero attendees listed these as "recreational activities" and so the data is being counted in the first category.

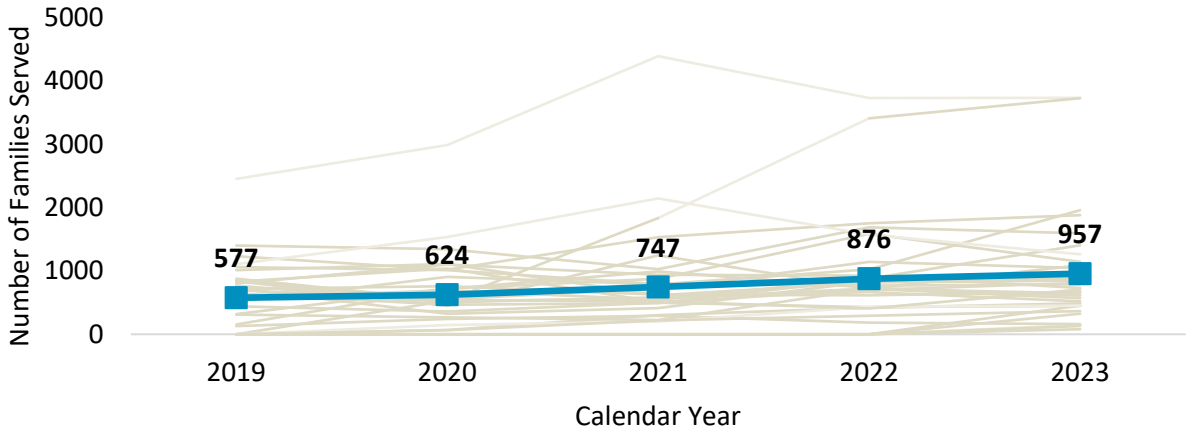
provided across FRCs in 2022, ranging from as low as 0% to as high as 41%. Many stakeholders interviewed for this report, as well as consumer focus groups, noted this as an area where they would like to see FRCs do more: more teen-focused training and programs, homework clubs, or stipends for youth staff/interns. Two FRCs have specific "youth support workers" on staff, but this practice is not widespread (or required by contract).

Although there are definitions provided to FRCs for data reporting purposes, it seems possible that at least some of this variation is due to differences in how data is recorded rather than differences in what services are provided. At the same time, the level of variation between FRCs and how it manifests with regards to delivery of services was also a common theme in interviews and focus groups. It was also evident in reviewing annual work plans developed by individual FRCs.

The population served by each FRC differs in size significantly

The number of family members served by individual FRCs each year varies significantly. While the average number of family members served by each FRC in 2023 was 957, the number of family members served by each individual FRC that year ranged from 80 to 3,733.[46] The data does not follow a clear pattern based on location; while many of the FRCs that report a higher number of families served are in urban areas, there are also FRCs in other high poverty urban areas who report a lower number of families served, as well as FRCs in rural areas that report a higher number of families served.

Figure 12:
Average Number of Family Members Served Per FRC (2019-2023)



Each gray line on the above chart represents an FRC and the number of family members it served each year.

This data is not a perfect measure of FRC "output," because it does not differentiate by intensity of service. As further described below, one FRC may serve a smaller number of families in a

[46] 80 was for a new site; the lowest for an established site was 162.

given year, but on average those families may require more intensive support. In contrast, another FRC may serve a larger number of families but with a "lighter touch", such as through food banks or holiday events.

While not a perfect measure of output, the variation from FRC to FRC can still give some indication of different levels of demand in a community, other available services in a community, different FRC levels of success at attracting consumers, or some combination of the three.

Variations in approach: breadth vs depth

FRCs have taken different approaches as to how they use their staff resources to serve families. Some FRCs focus on breadth of reach (serving a large number of families, albeit at a lower intensity) while others focus more on depth (serving a smaller number of families, but serving each more intensively.) Many, of course, are somewhere in between those extremes. Measures of this variation include:

- **Unique Days of Service:** For example, data on "unique days of service" in 2023 show a range across FRCs, from 12% of family members at one FRC being "one-touch" to a high of 79% at a different FRC, with an average of 47% across all FRCs.[47]

  Data available for this report was not categorized in such a way as to determine what "one-touch" families are coming to FRCs for specifically. It's also worth highlighting that, due to the way data is collected, a "one-touch" family may still attend food drives or recreational events beyond that one initial service visit.[48]

  In general, FRCs that serve a higher total number of people tend to have a higher percentage of "one-touch" clients, although this is not universally true.

- **Individual and Family Support:** On average, in 2023, 16% of services provided by FRCs were related to individual and family support, but this varies widely on an FRC-by-FRC level. At the high end, in 2023, 56% of services provided by one FRC were related to individual and family support, and on the low end, it was 0-2% of services provided by three FRCs in 2023 (which is consistent over time for these FRCs).

While all FRCs provide some level of individualized support, in focus groups, FRC staff seemed to have varying approaches to how much "handholding" they might do with a family: for example, how much follow-up they do, the extent to which they "hand them a pamphlet" versus "make the call for them," and whether they give them an application or help them fill it out.

[47] 79% was for a new site; 68% was the highest for an established site.

[48] Data on number of "touches" comes from service provision data. As noted in footnote 43, above, data on attendance at events is reported separately by FRCs but may in some cases overlap with service provision data. In other words, it is possible that some families have "one touch" that is recorded in service data but have additionally attended a back-to-school drive, a food bank, or a recreational activity that was not counted in service provision data.

Many family support workers interviewed for this report described providing ongoing and frequent case management support to families. Some staff spoke of spending hours working with a family in a given week if they have an urgent need, with one saying they connect with *"every family once a month, but once a week for those with greater needs."*

However, FRC staff also expressed confusion over the extent to which they were *supposed* to be doing "case management" or not, and some FRC staff interviewed specifically felt they were discouraged from doing case management, even as they felt it was often necessary for the families they were working with. One FRC staff member put it, "*I know we are only supposed to [do] short-term case management, but we have clients who have stayed on longer..."*. In interviews, DCF staff recognize the need for more ongoing support/case management for some families, but since the current contract does not require this level of follow up, DCF believes they cannot require FRCs to do it.[49]

One example of how this variation in approach can be seen is in how FRCs report helping families navigate the often-challenging special education process. In focus groups with school liaisons, it was clear each FRC has a different approach to how much support, and what kinds of support, they should provide. Should they help families complete forms? Support families with self-advocacy? Attend meetings with families to help families and schools communicate around these difficult issues? Advocate and negotiate with schools on the families' behalf? The answers to these questions varied considerably across FRCs – and although the answers to these questions were strongly influenced by what the local school district would allow a school liaison to do,[50] part of the variation was clearly driven by decisions made by school liaisons (and potentially their managers) themselves about what kind of support they would provide or had the capacity to provide.

[49] As further described on page 83, the term case management can mean different things to different people, which in of itself may be adding to the confusion.

[50] According to school liaisons interviewed for this report, some schools would allow them to attend meetings with families and some would not.

Finding 3: Expansion of the role and scope of FRCs – without similar expansion in staffing or budget – has led to staff stress and less focus on the child protective services and CRA prevention work for which they were originally created

As described in *The FRC Model,* above, DCF originally created FRCs as part of a broader effort to increase the availability of services designed to support families and help them avoid entry into the child protective services system. The Legislature, with the 2012 CHINS legislation, then added a focus on helping prevent entry to the Child Requiring Assistance system.

The DCF contracts with FRCs state that "*The Contractor shall ensure that its FRC welcomes any Family Member with any human services related issue and provide assistance or services on-site or through referrals, as appropriate."* This is a broad contractual scope, and it has allowed for the role that FRCs play and the scope of services they regularly provide to gradually and persistently expand since the initial contracts were awarded, as further described in this finding. At the same time, as discussed in *The FRC Model*, the required staffing pattern has not been updated since the 2012 procurement and the budget per full-service FRC has grown only slightly, accounting for inflation.

The end result of the increased demands on FRC staff time is that there is less time for the CRA and child protective services prevention work for which they were originally created:

- As one FRC PMPD put it, *"I know FRCs were in place to address CRAs, but we have been pulled in so many directions that meeting that original directive has been very hard."*

- Or as another PMPD stated, *"Spending so much time in crisis mode, it's hard to shift gears to parent education classes and playgroups."*

- A state agency staff person said, "*FRCs are like dumping ground for every need a community comes up with…when shift to having them do everything, CRA needs get lost."*

- A community organization representative said, "*The FRC role in the community has expanded…. They were designed for parental and family support for specific child welfare types of cases, but now are integral in the community and people come to the FRCs for things they aren't designed to do*."

Expansion of FRC duties over time

FRC PMPDs interviewed for this report explained that, from their perspective, **FRCs have become the provider of first and last resort,** especially if other agencies do not provide families with the support they need.

Said one, "*Over time, FRC services have expanded beyond what was proposed in each RFR procurement. The continuous request to expand services beyond our role leads to confusion for families and the community.*" A state agency staff person said*, "I see a lot of basic needs and housing needs, including some mental health and community connections. What they're doing is needed and beyond their original scope."* A community agency staff person stated, "*There has been a bit of scope-creep, and some FRCs are covering larger areas with the same funding as others*."

Additional duties most or all FRCs have taken on over the years include:

- **Responding to humanitarian crises**. This includes responding to the Merrimack Valley gas explosion or the influx of evacuees after Hurricane Maria struck Puerto Rico, or most recently, FRCs being asked to be an entry point for services for migrant families moving into temporary shelter in their communities (in many cases before a designated provider of support services was assigned for families living in hotels and motels.)
- Supporting families trying to maintain their **housing** with applications for RAFT[51]
- Helping families complete **applications for financial assistance benefits**
- **Providing interim/bridge therapy** to families with behavioral health needs because waiting lists for treatment are long
- Providing diapers and other tangible supports during the **COVID-19 pandemic** and beyond
- Opening **food banks** in response to increased food insecurity
- **Translating documents** from other state agencies when the documents families are given are not in their primary language

DCF staff interviewed for this report acknowledge the expansion of FRC roles and that they now provide services beyond what is feasible given their staffing levels. As one DCF staff member put it, "*They saw the need and took on the responsibility, even though FRCs don't have a lot of staff capacity to stretch. I do believe that there are times that they are asked to do too much—certain things outside of the model*." Another DCF staff member said, "*We should look at why FRCs were created, and also look at what has happened since then with emergencies and new community needs from Hurricane Maria [and the] migrant crisis."*

FRC staff are clearly deeply committed to this work, and by and large embrace a "do whatever it takes" philosophy outlined in the procurement for this work.[52] In interviews with eight DCF central and Area Office staff, all noted that FRC staff are highly committed, with "can do" attitudes and a willingness to do whatever is needed to support families. As one DCF staff member said, "*The FRCs are going above and beyond anything they're asked to do. They do a lot*

[51] The Residential Assistance for Families in Transition (RAFT) program provides short-term emergency funding to help with eviction, foreclosure, loss of utilities, and other housing emergencies. See: https://www.mass.gov/how-to/apply-for-raft-emergency-help-for-housing-costs

[52] For more information, see DCF's 2022 RFR for FRC expansion: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1034-0009-DSS09-75411&external=true&parentUrl=close

of great work, but not to say they're not stressed or burdened. Just because they're getting it done doesn't mean it's easy." A judge who works with FRCs said, "*FRCs say no to nobody because of their can-do mantra, so [we] ask them to do too much."*

FRC PMPDs also noted that the level of financial need among clients has increased over time, with more clients needing support with housing, utilities, food, and other tangible goods.

Indeed, **it is clear that FRC staff are stretched too thin** by increasing/new demands on their time, increases in the number of families served by FRCs, increases in the acuity of needs of FRC consumers, as well as by staff vacancies, as further described below. **The idea that FRCs are expected to do too much, at least given the level of staffing they have, was raised in nearly every interview and FRC staff focus group conducted for this report**. It was also a common theme in interviews conducted by the OCA in support of the 2022 JJPAD report on the Child Requiring Assistance system.[53]

As one FRC PMPD put it, "*It's unrealistic that 6-7 people will be able to do the variety of groups and demands across the ages and needs."* The range of services and supports staff are expected to provide as well as the volume of service requests leave staff feeling like they are *"always putting out fires."*

FRC staff also question if they have the appropriate expertise to provide all of the additional services expected of them, particularly as it relates to responding to the most recent migrant crisis. A common theme in interviews and focus groups with FRC staff was that they do not have the expertise nor adequate training to manage the multiple issues migrants face—particularly housing, employment, and legal questions regarding immigration and what state and local services immigrants qualify for.[54] Although many stakeholders interviewed for this report noted the important work FRCs have done to support newcomers to their community with everything from delivery of diapers to hotels to help enrolling children in schools, this does not negate the fact that FRC staff do not have the expertise to handle many of the specific multifaceted needs of these families, nor do staff have adequate support in addressing the secondary trauma that some have experienced in providing this much needed support.

One FRC PMPD said, "*We can't go to hotels to be exposed to this trauma all day long*" and another offered, "*Significant trauma training is required, due to secondary vicarious trauma."*

Beyond concerns from FRC staff about capacity and expertise to address the needs of migrants, FRC staff also frequently noted a need for additional training, information, and support in

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

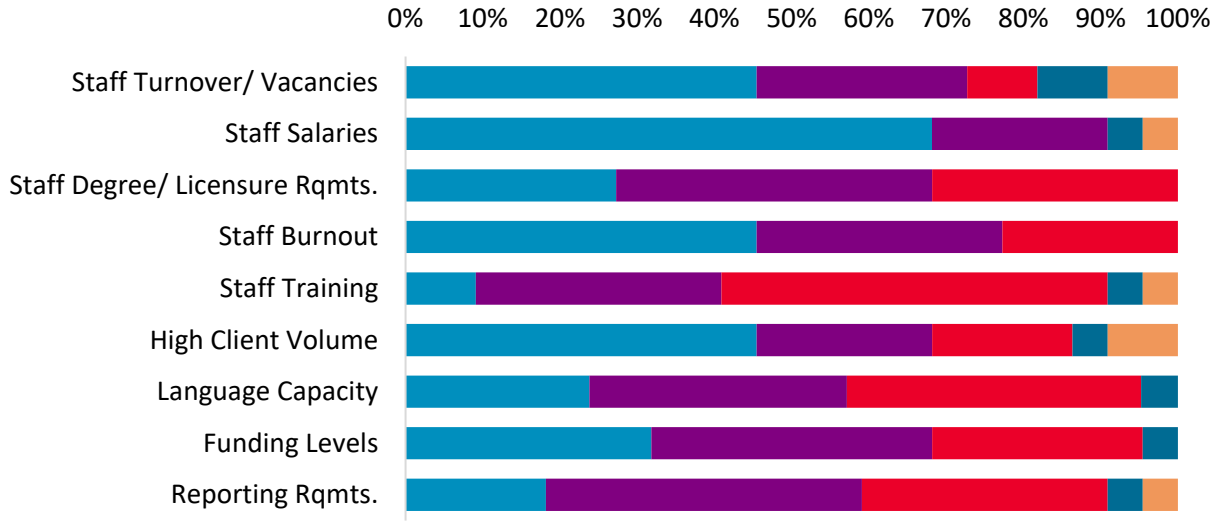
[54] It should of course be noted that FRC staff are not alone in facing these challenges; our entire housing and human services infrastructure has had to respond quickly and with little opportunity for advanced planning to the recent influx of migrants.

completing applications for public benefits and especially housing programs. (See Finding 5, below, for more on housing.)

FRC staff are stressed by turnover, vacancies, and salaries

As described above, FRC staff feel stretched too thin by the many new service demands, the heightened needs of some of the families they are seeing, and the waitlists for both behavioral health treatment and housing which the FRCs are unable to address. Staff report also that their stress levels are greatly exacerbated by staff turnover and vacancies. As shown in Figure 13, below, in a survey of FRC PMPDs, 45% described staff turnover/vacancies as "extremely challenging" while another 27% stated it was "somewhat challenging."

Figure 13:
Challenges Facing FRCs (n=22)



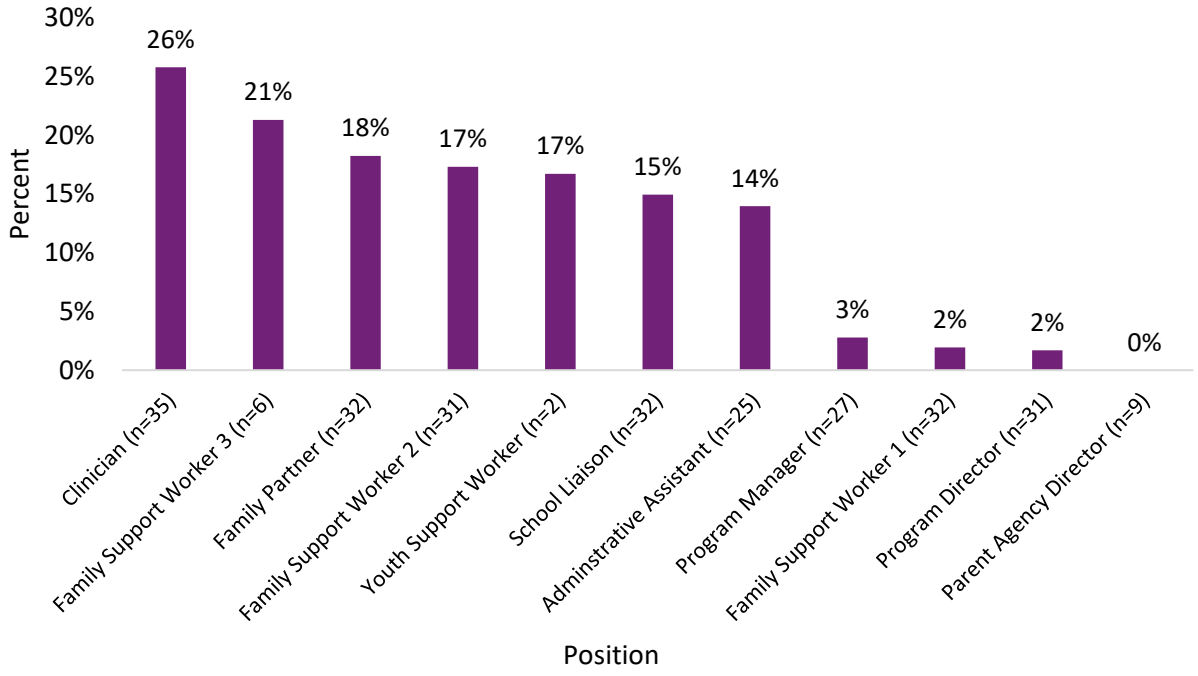
	Reporting Rqmts.	Funding Levels	Language Capacity	High Client Volume	Staff Training	Staff Burnout	Staff Degree/ Licensure Rqmts.	Staff Salaries	Staff Turnover/ Vacancies
Extremely Challenging	18%	32%	24%	45%	9%	45%	27%	68%	45%
Somewhat Challenging	41%	36%	33%	23%	32%	32%	41%	23%	27%
Neither Challenging or Not Challenging	32%	27%	38%	18%	50%	23%	32%	0%	9%
Somewhat Not Challenging	5%	5%	5%	5%	5%	0%	0%	5%	9%
Not at all Challenging	5%	0%	0%	9%	5%	0%	0%	5%	9%

FRCs are not unique in the human services field with regards to vacancy rates. Indeed, the overall vacancy rate for CY23 for FRCs was 11.9%,[55] which is lower than the Massachusetts human services average; a 2023 report conducted by the UMass Amherst Donahue Institute for the Human Services Providers Charitable Foundation found an average vacancy rate among

[55] Vacancies refer to any position that was vacant for at least one day in CY23 (not including positions that had not yet been filled in a newly established FRC.) The vacancy rate is calculated by the number of vacant positions divided by the number of available positions.

Massachusetts human service providers of 23%.[56] That said, some roles at the FRC – including clinicians, which have a vacancy rate of 26% – are comparable to, or higher than, average rates cited by the Donahue Institute. In the third quarter of 2023, the FRC turnover rate was 13%.

Figure 14:
CY23 Vacancy Rate for Most Common FRC Positions (n>1)



Given that FRCs usually only have one person in each specific role and cannot turn any families away or temporarily "close" intake, any vacancy at any time will likely cause stress for staff who must fill in as best they can for these vacancies.

Other stakeholders also spoke about the level of staff turnover and the **impact this has on both families and partnerships across the community.** One judge interviewed for this report said, "*Problem is they can't retain staff—too much turnover*." Another stakeholder who works with the courts and the FRCs said, "*Seeing a lot of turnover…. [you] develop a relationship with assessment person but then [there is a] new person in two months*."

FRC PMPDs also raised concerns about staff salaries, with nearly 70% of those surveyed listing salaries as "extremely challenging." In focus groups, PMPDs described FRC employees who work multiple jobs. Said one, *"No one says 'glad I'm leaving'. They say 'I have to leave. I can't afford to stay.'"* Another put it more bluntly: *"We should be able to pay them better than Walmart."*

[56] Human Services Providers Charitable Foundation. (2023). Essential or Not? The Critical Need for Human Services Workers. https://providers.org/assets/2023/05/EssentialOrNot.pdf

It is important to note that not all FRCs pay their staff the same amounts, which may account for differences in vacancy rates across FRCs.[57] EOHHS is the rate setting authority, and when setting a rate EOHHS uses program models, including model salaries. However, EOHHS does not dictate the compensation paid to provider agency staff. The amount paid to staff is ultimately the decision of the organization with which DCF contracts, and DCF is not able to require minimum salaries.

[57] Data that would connect specific salaries to specific vacant positions was not available for this report.

Finding 4: There are many more families across the Commonwealth who could likely benefit from FRC services

Even as the number of families served by FRCs has continued to grow each year, there are still a large number of families in Massachusetts who are showing up in, or are at significant risk of showing up in, other "downstream" systems, including:

- Families that have become involved with the CRA system or who are at significant risk of involvement (e.g. child is chronically absent from school)
- Families that have been reported to DCF for possible child abuse or neglect
- Families who are financially insecure

There are also a number of families living in areas where an FRC is not easily accessible, particularly if the family is dependent on public transportation.

All told, there are hundreds of thousands of children and families that fit into one or more of these categories. In CY23, FRCs served 30,612 individual family members. Serving a substantially increased portion of children/families in these categories would require a significant increase in funding.

The data we share in this finding is intended to demonstrate the scope of the need in Massachusetts. In our Recommendations, we make suggestions for how – given the large difference between the number of families currently being served and the number who could likely benefit from their services – FRCs could prioritize the families at the highest risk.

Families at risk of involvement with the Child Requiring Assistance system

If left unaddressed, behavioral health and/or school attendance issues can escalate quickly to a family or school filing a Child Requiring Assistance petition in court. FRCs were established by the Legislature to provide services that would help divert youth from the CRA Juvenile Court process. As discussed in the JJPAD Board's 2022 report on the CRA system, and further identified in research for this report, while some diversion is happening, **there are many more children and families experiencing behavioral health challenges and/or school attendance issues who could benefit from FRC support.**

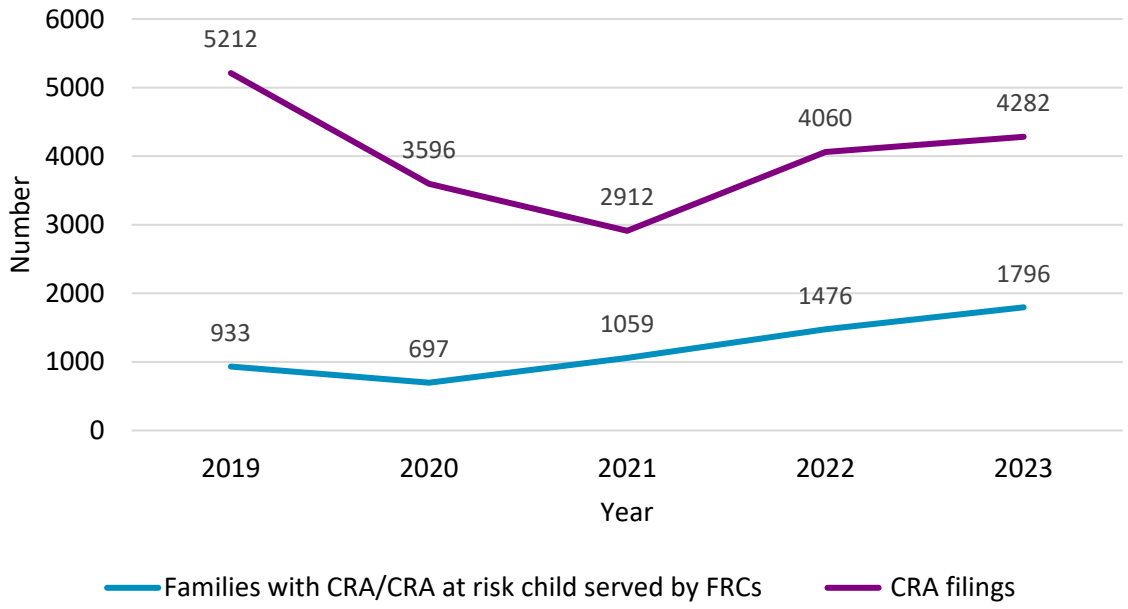
FRCs are still underutilized for CRA prevention. While it is true that, over the past five years, CRA filings to the Juvenile Court have declined and families coming to FRCs for support with CRA/CRA-at-risk issues have increased, as indicated by Figure 15, the number of CRA filings continue to far outnumber the number of CRA/CRA-at-risk cases handled by FRCs each year.[58]

[58] There are limitations to this comparison. CRA referrals to FRCs is reported by the calendar year, while CRA filings to the Juvenile Court are reported by the fiscal year (July 1 – June 30).

In FY23, there were 4,282 CRA petitions filed with the Juvenile Court – including 1,343 filed by schools for truancy.[59] In CY23, 1,796 families came to FRCs with at least one child who was at risk of, or already had, an open CRA case. (1,224 of those families had at least one child who was deemed "at risk" of a CRA filing; 583 had at least one child on whom a CRA petition had already been filed with the Juvenile Court.)

While the number of families with a CRA/CRA-at-risk youth served by an FRC has grown significantly over the past few years – in CY19, there were only 933 such families – the data overall still suggests there is an opportunity for FRCs to serve many more children in hopes of preventing a CRA case in the court system.

Figure 15:
CRA/CRA at Risk and CRA Court Filings (2019-2023)



Source: CRA data retrieved on 10/23/23 from the Massachusetts Trial Court's Tableau Public page here: https://public.tableau.com/app/profile/drap4687/viz/DemographicsofChildRequiringAssistanceFilings/CRACasesbyRaceEthnicity. FRC data retrieved from UMass ASO. Blue line indicates data for the calendar year, and purple line indicates data for the fiscal year.

For example, FRCs could be more frequently utilized to help with chronic absenteeism, one of the leading causes for a CRA petition. Almost one in four (22%) Massachusetts students were "chronically absent," which means they missed 18 or more days of school in 2022-23.[60] With 913,735 students enrolled in Massachusetts schools in 2022-23, that comes to over 200,000

[59] FY22 & FY23 data retrieved on 10/23/23 from the Massachusetts Trial Court's Tableau Public page here: https://public.tableau.com/app/profile/drap4687/viz/DemographicsofChildRequiringAssistanceFilings/CRACasesbyRaceEthnicity
[60] Massachusetts Department of Early and Secondary Education (DESE). (2024). Chronic Absence and Student Attendance. https://www.doe.mass.edu/sfs/attendance/default.html

students.[61] In comparison, 2,436 families came to the FRC with school-related issues (which may include attendance as well as other issues) in 2023.[62]

The definition of chronically absent includes excused absences, such as illness, and is not the same as truancy, which is, under state law, when a school-aged child who is not excused from attendance "willfully" fails to attend school for more than 8 school days in a quarter.[63] Still, it seems likely that some not-insubstantial percentage of the 200,000 children who were chronically absent – even if they were not technically truant and regardless of whether a CRA petition was filed – could have benefited from support from the FRC.

Ultimately, the most effective programs to address absenteeism must originate from the schools themselves, and there are many examples of such programs in Massachusetts. The goal, then, should be to determine what set of families could benefit from intervention and support from an FRC on top of school-based efforts, and develop a consistent expectation of how schools and FRCs can work together to support those families.

As shown in Figure 16 below, there is significant regional variation in the extent to which families with “CRA-like issues” end up referred to the FRC instead of the Juvenile Court, with some counties being more likely to utilize FRCs instead of the courts to handle CRA-related issues children and families face. For example, of all CRA filings in FY23, 15% came from Suffolk County. In comparison, of all CRA/CRA at-risk cases served by FRCs in CY23, only 3% went to FRCs based in Suffolk County. This suggests that practitioners in Suffolk County are less likely to direct families to an FRC for support, and instead more likely to suggest a family file a CRA petition. A similar pattern can be seen in Middlesex County.

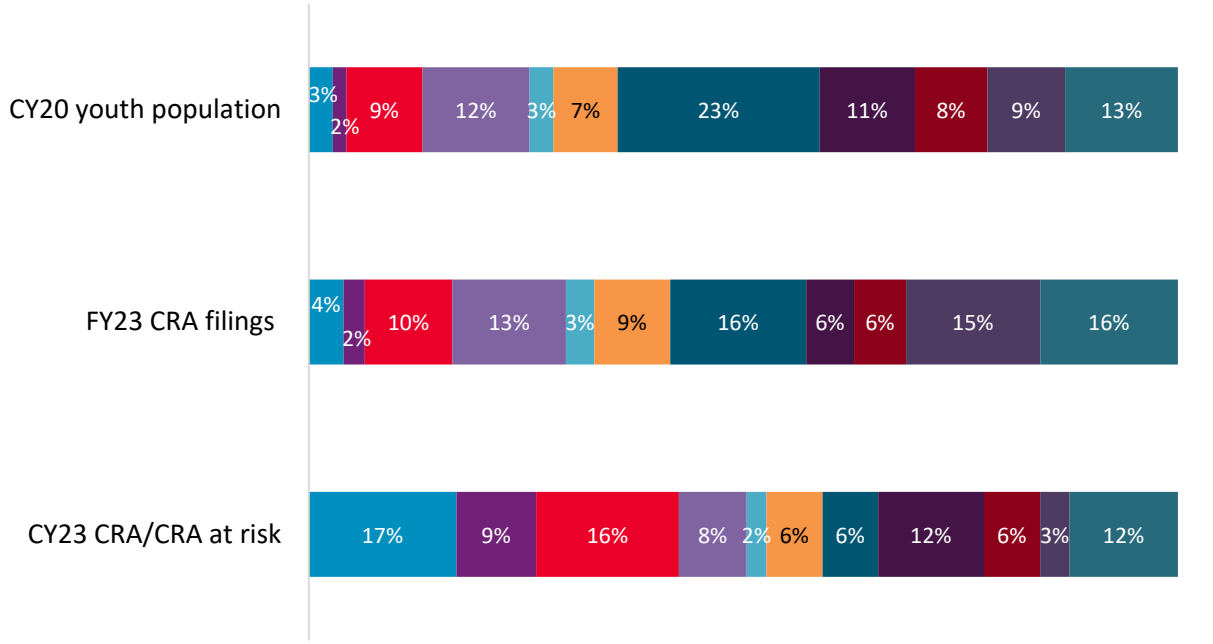
In comparison, practitioners in Norfolk, Barnstable, Bristol, and Berkshire Counties seem more likely to send families to an FRC. For example, 11% of youth 6-17 live in Norfolk County, but they make up only 6% of CRA filings – and 12% of CRA/CRA-at risk cases served by FRCs. In these counties, diversion to FRCs seems to be happening more often – although there is room for more even in these counties. This aligns with information gathered from interviews with practitioners in these counties about local practices designed to reduce CRA filings in these areas.

[61] Massachusetts Department of Early and Secondary Education (DESE). (n.d.). Enrollment Data. https://www.doe.mass.edu/infoservices/reports/enroll/default.html?yr=2223

[62] Note that a family may have more than one child with a school-related issue.

[63] M.G.L. c. 119 § 21

Figure 16:
CRA Court Filings (FY23) and CRA/CRA at Risk Families (CY23) by Court County



	CY23 CRA/CRA at risk	FY23 CRA filings	CY20 youth population
Barnstable	300	171	25,340
Berkshire	162	105	14,427
Bristol	290	431	80,269
Essex	138	560	112,973
Franklin/Hampshire	40	139	25,149
Hampden	114	375	67,714
Middlesex	113	670	213,133
Norfolk	215	236	100,547
Plymouth	114	256	76,574
Suffolk	60	661	81,920
Worcester	220	678	118,895

Source: CRA court filings data retrieved on 10/23/23 from the Massachusetts Trial Court's Tableau Public page here: https://public.tableau.com/app/profile/drap4687/viz/DemographicsofChildRequiringAssistanceFilings/CRACasesbyRaceEthnicity . Data on CY23 CRA/CRA at risk cases at the FRC level comes from the UMass ASO. OCA analysts aggregated cases to the County level to match available Juvenile Court data.

Families at risk of child protective services involvement

Children, families, our state systems, and society as a whole benefit from leveraging supports to prevent involvement with child protective services. A large body of research demonstrates that

family support services not only prevent child maltreatment and child protective services involvement, but also promote child wellbeing and safety and promote caregiver wellbeing.[64] **The key is making sure that families most in need of support are able to access it.**

The top family-level risk factors for child maltreatment are poverty, parental substance use disorder and/or mental illness, and intimate partner violence.[65] These are areas of need in which FRCs have experience supporting families.

While we cannot precisely identify the number of families at heightened risk of child protective services involvement in Massachusetts, we *can* identify a subset of families who have been reported to DCF as a potential case of child abuse or neglect but for whom a case was not ultimately opened. In FY22:[66]

- DCF screened out 34,510 51A reports because they did not demonstrate a child was at risk of maltreatment. This figure does not include reports screened out but referred to a District Attorney.
- An additional 16,613 51A reports were "screened in," but did not ultimately result in an open case because DCF did not find reasonable cause to believe that the child was abused and/or neglected or that the child's safety or well-being was compromised.

Not all of these families necessarily fall into the risk categories noted above, nor do all necessarily need FRC support – but some do. Indeed, without support, some of these families will eventually have a case opened with DCF.

In a perfectly functioning system, however, many of these families would be referred to an FRC *rather than* reported to DCF for neglect (a 51A).

There are likely also additional opportunities to ensure families with *current* DCF involvement are aware of, and well connected to, their local FRC, including those whose cases are being closed by DCF who might benefit from ongoing support and connection to an FRC. As noted above, an average of 862 families a year reported to the FRC that they were referred from DCF.

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[64] Anderson, C., et. Al. (2023). Family and child well-being system: Economic and concrete supports as a core component. [Power Point slides]. Chapin Hall at the University of Chicago. https://www.chapinhall.org/wp-content/uploads/Economic-Supports-deck.pdf , National Academies of Sciences, Engineering, and Medicine. (2019). *A roadmap to reducing child poverty.* https://nap.nationalacademies.org/catalog/25246/a-roadmap-to-reducing-child-poverty ; Kuhn, E. S., & Laird, R. D. (2014). Family support programs and adolescent mental health: review of evidence. *Adolescent Health, Medicine and Therapeutics*, *5*, 127–142. https://doi.org/10.2147/AHMT.S48057; Casey Family Programs. (2018). What are some examples of evidence-informed practices to keep children safe and promote permanency? https://www.casey.org/what-are-some-examples-of-evidence-informed-practices-to-keep-children-safe-and-promote-permanency/; Kutash, K., Garraza, L. G., Ferron, J. M., Duchnowski, A. J., Walrath, C., & Green, A. L. (2013). The relationship between family education and support services and parent and child outcomes over time. *Journal of Emotional and Behavioral Disorders*, *21*(4), 264-276. https://doi.org/10.1177/1063426612451329 ; Barnes M., Hanson C., Novilla L., Magnusson B., Crandall A., Bradford G. (2020). Family-centered health promotion: Perspectives for engaging families and achieving better health outcomes. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing,* 57. doi:10.1177/0046958020923537

[65] Austin, A. E., Lesak, A. M., & Shanahan, M. E. (2020). Risk and protective factors for child maltreatment: A review. *Current epidemiology reports*, *7*(4), 334–342. https://doi.org/10.1007/s40471-020-00252-3

[66] Massachusetts Department of Children and Families. (n.d.). "Child Protective Services Overview Dashboard". https://www.mass.gov/info-details/child-protective-services-overview-dashboard

In comparison, DCF had over 21,000 open cases in December 2023, opening approximately 1,100 to 1,400 cases per month throughout 2023.[67] **It is important to note, however, that FRC services are voluntary, and many more families may be referred to an FRC by DCF but choose not to act on that referral or choose not to share with FRC staff that they were referred by DCF.** Data on the total number of families that DCF refers to an FRC is not available.

In an interview, a DCF staff person explained that FRC staff have begun attending new social worker trainings because it was found that many Area Office staff were not aware of the FRCs. This is an excellent step forward, but more can be done to increase referrals to FRCs.

Families that are financially insecure

At the most basic level, many families that are financially insecure could likely benefit from FRC services – particularly given the connection between poverty and child protective services involvement described above. In 2022, 12.6% of children younger than 18 in Massachusetts, approximately 160,000 children, were living in households below the poverty level.[68] Although there is no way of knowing what specific percentage of these families would benefit from connecting with an FRC, nor what percentage of families have been helped in other ways or by other organizations, a simple comparison of the number of children served by FRCs (approximately 10,000) and the number of children living below the poverty level (approximately 160,000) provides a general sense of FRCs' reach compared to the scale of potential need.

At the FRC level, there is variation in the extent to which FRCs are reaching lower-income families in their communities. For the purposes of this report, we have roughly estimated the current geographic area and potential population served by each FRC. [69,70] We also looked at

[67] Massachusetts Department of Children and Families. (n.d.). Child Protective Services Overview & Dashboard. https://www.mass.gov/info-details/child-protective-services-overview-dashboard

[68] United Health Foundation. (n.d.). Children in Poverty in Massachusetts. https://www.americashealthrankings.org/explore/measures/ChildPoverty/MA; United States Census Bureau. (n.d.). Quick Facts Massachusetts. https://www.census.gov/quickfacts/fact/table/MA/AGE295222

[69] FRCs do not have designated catchment areas: they are required to serve any family member who comes to their FRC, regardless of where in the state they may live. This means it is impossible to *precisely* identify the geographic area each FRC is designed to serve, nor the total size of the population in that service area. There are many good reasons for this policy: an individual may choose an FRC because program offerings align more closely with their needs and interest, availability, and ease of access. Regardless, the "No Wrong Door" approach is consistent with the state's overall desire to increases service access and reduce barriers: turning a family away because they did not go to the "right" FRC for their zip code would be counter to the overall "easy access" philosophy of the FRC model. We do not argue with the merit of this policy, but instead simply note the challenges it creates for precise analysis.

[70] See Appendix B for a more detailed description of the methodology behind this analysis.

the number of individuals in those zip codes that are Department of Transitional Assistance (DTA) clients to adjust for level of need in a given community.[71,72]

Based on this analysis, we find the following:

- The estimated "potential population to be served" for each FRC ranges in size from 486,511 (Boston/Roxbury) to 13,861 (Nantucket), with an average in CY23 of 175,550. The percentage of the total population in each of these areas that are DTA clients ranges from 44.6% (Holyoke) to 3.2% (Nantucket).

- The 2023, the percentage of family members served by FRC per DTA clients served ranged from 42.3% to 0.7%, with a median of 2.4%.[73] Only five FRCs served more than 10%.

- In general, FRCs in the largest urban areas (e.g., Boston, Springfield, Worcester, Lowell, Holyoke, Brockton) have some of the largest "potential population to be served" (both total and by estimated need) and the lowest "family members served by FRC per DTA clients" percentage. Given that these urban areas have communities with some of the highest rates of poverty and concentrated disadvantage in the state**, it seems likely that FRCs in these areas could potentially serve a larger number of families** (with increased staffing to accommodate greater demand).

- In general, many of the FRCs with the highest percentage of family members per DTA clients served are in smaller and more rural areas, such as Athol, Martha's Vineyard, Nantucket, North Adams, and Greenfield. **This may be an indication that, in these areas, the FRC is located in a "service desert," compared to larger urban areas where families may have more service and support options.**

Families who cannot easily access an FRC

Transportation to and from FRCs is a significant barrier for individuals and families, particularly in parts of the state with limited public transportation, with 86% of PMPD survey respondents indicating that transportation availability is extremely or somewhat challenging for FRC consumers. Transportation was by far the most frequently mentioned topic raised by FRC PMPD

[71]There are a variety of metrics that might identify the level of need in a given community. "DTA clients" was chosen as it helps estimate the number of individuals in a given zip code who have demonstrated level of financial need and, on a more practical basis, because the data is recent and available by zip code. This analysis should be viewed as a "rough estimate" of need in a community, and not a precise calculation. (Indeed, families living in poverty who are NOT currently DTA clients might be an even more relevant appropriate comparison population, but that data is not available at the zip code level.)

[72] Massachusetts Department of Transitional Assistance. (2023 January). Department of Transitional Assistance caseload by zip code reports. "DTA Annual Caseload Summary Zip Code Report". https://www.mass.gov/doc/dta-annual-caseload-summary-zip-code-report-2023/download

[73] Data on FRC consumers and DTA clients has not been matched, so this should not be taken as an estimate of the *actual* percent of DTA clients served in a given area. Further, not all FRC consumers would qualify for DTA benefits. Instead, this serves as a ratio to understand how the number of family members served by FRCs in an area compares to the estimated number of individuals with significant financial need.

and staff when asked what if any populations would benefit from additional services, referenced nearly a dozen times during the focus groups with FRC staff. For example:

- *I think if transportation to and from the FRC was more accessible, then we would have a better turnout with families*."
- *"With no public transportation, there is limited participation after 5pm."*
- *"Buses don't run past 6pm and not on weekends. [We] used to have staff pick up families, but can't do that anymore with expanded programming."*
- *"Transportation in this community is pretty much non-existent."*
- *"[We] serve immediate area pretty well. Issue is with clients who are rural – in between two FRCs, they are in a different orbit. More affluent clients have access to transportation. For clients in rural areas, transportation is a barrier."*

Issues with transportation were also raised in consumer focus groups:

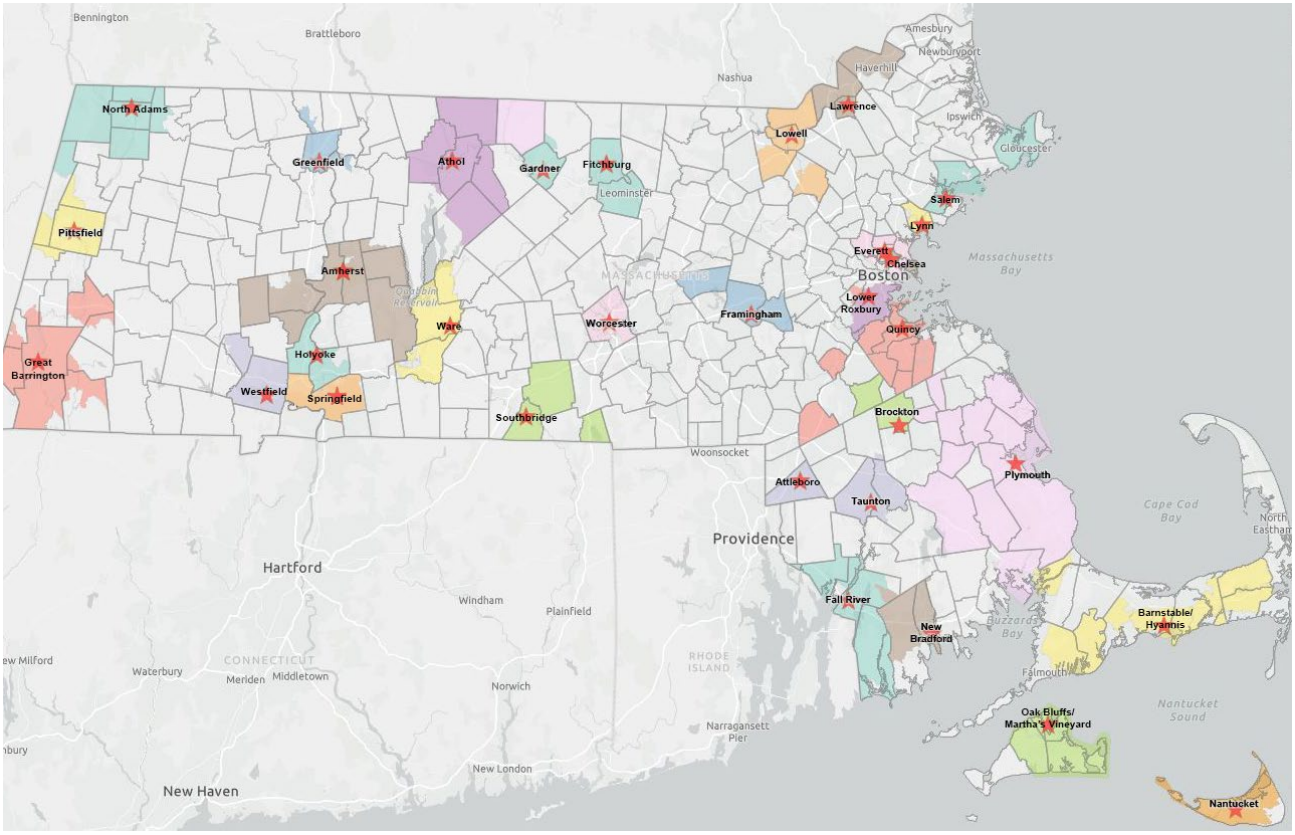
- *"There used to be a fund for transportation, but now there isn't. When the transportation fund dried up, that was sad… This could be an improvement"*
- *"[Western, MA is a] service desert… Families don't have ability to access some FRCs, because they don't have access to transportation."*
- *"I have transportation so I help my friends get to the FRC. I've been helping other friends come… I know it's hard for others to get to the group."*
- *"I don't have a car. At the beginning, it was difficult… it was hard to get to the FRC. I tried to come with a friend who was in a group, and she came by to pick me up and we went together."*
- *"We had lots of transportation issues taking a variety of buses or other public transport, and only buses were reimbursed. I see a problem with some towns not being fully accessible. The FRC was very connected to their local area, but weren't as helpful being further away."*

The increase in the number of Family Resource Centers across the state has certainly helped improve FRC accessibility, but there are still numerous areas across the state where residents have limited access.

The chart below indicates the zip codes in the state that had at least 10 families visit an FRC in 2023. This represents 91% of total families served by FRCs in 2023.[74] Whole swaths of the state remain grey, despite data indicating gaps in services and potential needs in some of those zip codes that FRCs could fill and support.

Figure 17:

Map of zip codes in the state that had at least 10 families visit an FRC in 2023. FRC locations are marked with a red star.



There are a number of areas in the state where there is a high level of need, as identified by a number of publicly available metrics, including the Social Vulnerability Index[75] and district level DESE data on student enrollment indicators.[76] Despite this high need, some areas experience relatively low use of an FRC.

[74] Excluding those with a zip code listed as "null".

[75] Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help local officials identify communities that may need support before, during, or after a disaster or public health emergency. For more information see: https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html

[76] Ideally, this analysis would include the number of 51As filed in a given location, or some other metric of DCF involvement, as well as metrics on CRA involvement. However, this data was not available to the OCA by zip code for this report and so is not included in this analysis.

One likely reason that some zip codes are less likely to have families served by an FRC is that access to the FRC by public transportation is either limited or time-consuming. As just one example, a large share of families in the City of Gloucester face significant economic and social challenges,[77] but the closest FRC is located 17 miles away in Salem (approximately an hour away by public transportation). In 2023, only 13 families from Gloucester visited the newly opened Salem FRC, accounting for 10% of the families visiting the Salem FRC in 2023.

As described in Finding 4, there are also areas that, based simply on population levels, level of need, and density, could likely support an additional FRC relatively close to an existing FRC, such as Boston, Worcester, or Springfield.

[77] With a population of nearly 30,000, has a higher-than-average percentage of children listed as "high needs" (59%) and "low income" (44%) in data published by DESE. Fifty-six percent of its student population was absent 10 or more days in the 2022-23 school year, thereby being at risk of becoming involved with the CRA system. Two Gloucester census tracks have medium-to-high levels of vulnerability, based on the Social Vulnerability Index.

Finding 5: Increased alignment with – and support from – other state and local entities would help improve FRC effectiveness

Despite the breadth and depth of the work FRCs do, and despite the very strong connections they clearly have in their local communities, **FRCs are in many ways isolated from the greater human services, educational, and legal systems in the state**.

In addition to speaking with FRC staff, DCF staff, and FRC consumers, the OCA interviewed a broad range of external stakeholders for this report as well as the 2022 JJPAD report on the CRA system: key leaders at a variety of state agencies and EOHHS, representatives from local school districts, members of the judiciary, court clerks, Juvenile Court clinicians, Chief Probation Officers, attorneys and other staff from the Committee for Public Counsel Services, members of law enforcement, and key members of the Legislature.

Through these interviews, it became clear that many of the critical stakeholders who *should* ideally know about FRCs and what they provide have a limited awareness of their existence and their role – and in some cases, an *incorrect* understanding of what FRCs do and don't do.

Some key stakeholders interviewed for this report indicated that they "didn't really know what FRCs do." Some indicated that they thought FRCs only worked with DCF-involved families or immigrant families. Similar issues with lack of awareness of FRCs and fully understanding the role they play seem to exist among many school and community leaders and judicial system practitioners, as well.

This lack of awareness and understanding leads to two key problems:

- There are **missed opportunities to capitalize on FRCs' strengths as a warm and welcoming "front door**" and align their work with other human service, housing, and economic development services provided by the state.

- Inconsistencies in relationships between FRCs, local schools, and courts result in **missed opportunities to provide timely referrals** to families who could benefit from FRC services.

In general, **FRCs report feeling as though the onus is on them entirely to build relationships with state agencies (through regional staff and local state-funded providers) as well as local school districts and court personnel,** rather than there being any coordinated and consistent effort at the state level to actively encourage state agencies to work in partnership with FRCs and schools, court personnel, and others who may recommend that a family file a CRA to make a referral to an FRC instead. If a local state agency representative, school, or court chooses not to work with a local FRC, the latter has no recourse; they do not feel there is anyone at the state level they can turn to for help in brokering an agreement.

EOHHS and DCF currently operate a number of monthly meetings designed to encourage connections between FRCs and other state agencies, including a monthly Youth Violence Prevention Partners meeting and a monthly meeting with all FRCs and all Community Connections programs. DCF has also made efforts to connect FRCs with the Grandparents Raising Grandchildren Commission, housing/homeless service agencies, agencies serving migrant families, agencies serving families with children who have special needs, and others. These are examples that could be built upon.

In this finding, we focus on the missed opportunities for greater collaborative and/or referral relationships in three key sectors: housing and human services, schools, and the court system.

Housing & Human Services

As time has gone on, FRCs have become the entry point for more and more types of services, and the level of need of families coming to the FRCs has increased. On any given day, FRC staff are asked to be experts on eligibility and enrollment procedures for a wide variety of state and local programs, many of which are complicated systems.

At the same time, **there are staff at the state agencies and contracted providers who *are* experts in each of these systems – but to date, there has been little effort at the state level to systematically connect and coordinate these relationships**. Some individual FRCs have built relationships with various state agencies, and as a result some have, at least at certain points in time, had a DTA worker who comes regularly to help with SNAP enrollment, or a relationship with a local housing agency to help with housing issues. Yet none of this has been implemented statewide, and individual FRCs have been left to negotiate these individual relationships with local offices.

As one DCF staff member said, *"Other FRCs just haven't developed that relationship*." Another said, *"[One FRC] used to have staff come in from [Local Housing Nonprofit] weekly. This was great for rental assistance, eviction prevention, etc. This stopped due to staffing needs, probably funding*." Another said, "*If DCF had more capacity, then they could create some of the partnerships so that each FRC didn't have to do so on their own."*

Throughout this report, we make the case that the FRCs' role has expanded over time, but that expansion has not come with an equal expansion in support from the state with regards to staffing, training, or connections to other parts of state government that have a role in providing or coordinating access to relevant services.

The most pressing example of this is with housing, which was far and away the most stressful challenge mentioned by FRC staff in interviews, focus groups, and when surveyed. Asked to rank the biggest challenges facing individuals and families visiting their FRC, 95% of PMPD survey respondents indicated that housing availability was extremely challenging. It was also the most frequently referenced service need in FRC staff focus groups, mentioned by nearly one-third of staff. For example, FRCs reported receiving multiple calls a day for housing support or assistance with RAFT applications.

FRC consumers who participated in focus groups also shared numerous concerns around housing access and availability, including needing support while residing in or seeking access to a shelter. In 2023, 9% of families who came to an FRC listed "Housing/Rent" as their reason for visiting – although 10% listed Family Hardship/Financial issues, and it seems likely that housing was also a stressor for many of these families.

Although it is one of the top reasons families come to an FRC, many FRC staff report feeling ill-equipped to help in this area. As one FRC staff put it, *"Housing and shelter work is hard. We have families couch surfing, sleeping in cars, and we can't help them. I lose sleep at night."*

Many FRC staff and PMPDs noted that in recent years, they have been "asked to become housing specialists" despite not receiving training or support to properly perform this role. Reported one staff member, *"Whether we like it or not, we've become housing specialists, and many families don't qualify for EA (emergency assistance). What do you do when the family has nowhere to go?"* Others questioned why FRC staff were asked to fill out RAFT applications when other organizations are funded by the Executive Office of Housing and Livable Communities to provide RAFT support.

Bright Spot: Community Partnerships to Address Housing

FRCs have adopted a variety of strategies to support families in their communities with housing-related needs. For example, in 2022 the Worcester FRC "connected with community partners to brainstorm the best way to unite and assist families. With a common goal, the partner began holding weekly one-hour housing clinic sessions. The goal of the housing clinics is to provide a one-stop shop. The FRC hosts the clinics and provides onsite support, and the partners provide fuel and housing assistance. The housing clinic calendar was booked through the winter [of 2022], and the FRC hopes to expand the clinic when staffing challenges are addressed."

Source: FRC 2022 Program Evaluation Report (March 2023) https://malegislature.gov/Reports/17075/(2)%20FRC%20Legislative%20Report%20CY2022_Final.pdf

Others noted that while they do provide support with housing applications, such as RAFT applications, they **lack strong connections with the state agency that administers these programs**. For example, one FRC staff suggested that "*It would be nice to have a specific contact at a state agency to answer questions on applications, for example housing RAFT applications.*" They went on to note, "*I am knowledgeable and understand the discrepancies, but I don't get call backs or emails when I reach out. This doesn't give the client a fair shot.*"

Many FRC staff also reported that families regularly come to the FRC for support with housing because they felt uncomfortable with, or were unable to get help from, more traditional housing support agencies. This was particularly true for non-English speaking individuals. For example:

- *"Many clients are intimidated to go to the housing authority in their town, because they get mistreated. It is even hard for us to get in touch with someone."*

- *"A recent migrant family from Ecuador was referred by the Community Facilitator because of homelessness. I am bilingual, and I coordinated contact with the Department of Housing and Community Development, but their caseworker sent only English documents. It took hours to interpret and get them emergency shelter."*

FRC staff also note that they feel that other organizations will send families to FRCs for housing support, putting FRC staff in a difficult position of disappointing expectant families:

- *"We have become a place where other local organizations are referring families for services they offer ex: housing authority referring a family to us for housing needs so our Family Support Worker can help the client complete and submit the application."*

- *"There is confusion about what the FRC is supposed to provide. We try to connect people to another organization in the community who can specialize in housing… DCF, schools, others tell them the FRC can do it all, but we cannot give you housing or a voucher. We bring it up at community meetings asking them not to give them false hope that we have to break."*

- *"Being listed on Mass 211 as a housing agency has been problematic. We can only do a DHCD [now the Executive Office of Housing and Livable Communities] EA application and a warm handoff to the local CAP [Community Action Program] agency who is funded for this… We are typically wasting time for families in a housing emergency. We are not funded for housing or rental assistance needs."*

Although housing was the example that was most frequently cited in interviews and focus groups, this general concept of the need for increased support and alignment of services from state government applies in a variety of other areas, including financial benefit applications and behavioral health.

Schools

FRCs work hard to build relationships with their local schools. For example, one FRC staff reported: *"We use all of our school contacts (family resource center staff as well as other programs) to reach out to various school personnel to remind them about referrals and services we offer. We find we have to remind folks on a regular basis to keep information flowing. The schools are so overwhelmed. We also go to many different schools to table and run activities."*

Another said, *"We have a team here with the Family Partner, and we take our team on the road to go to schools and the court. We educate them about preventative measures to intervene before CRA is filed for attendance or other issues."*

At the same time, at least some school personnel clearly lack awareness of FRC supports and services. In a survey of school personnel about their experiences with FRCs, conducted by the OCA in spring of 2023, most (90%) of respondents were aware of FRCs and the services they provide. At the same time, 10% said they were unaware of the services FRCs offer, forgot about FRCs, or did not know FRCs existed.[78] Said one survey respondent, "I forgot that it was a resource! I am certainly going to start providing it as an option." Another stated, "I did not know I could utilize the FRC for [other resources.] I have only been utilizing them for students who are truant, and I am told it is the step before filing a CRA."

Many FRC PMPDs and school liaisons reported having positive collaborations with local school districts. However, in interviews and focus groups, many more FRC staff described the various challenges in working with their local schools. These include challenges in connecting with school districts and receiving referrals.

- *"We spend a lot of time reaching out to at least 10 districts, superintendents, and principals, educating them on what the FRC is. We ask them to refer parents to us for support, but we get almost nothing"*

- *"It depends on the school district. Some are cooperative, but some just don't make referrals to us."*

- *"Don't have a strong relationship with the schools. They aren't sending referrals. Mostly parents with referrals from crisis services, looking for support around school. Most of the referrals don't come from school. They come from court or DCF, mostly from parents, sometimes pediatrician's office."*

FRC PMPDs and staff also report challenges in receiving referrals in a timely manner when they do receive them:

- *"By the time [the child] gets to FRCs, the situation has gotten too extreme. We sometimes get kids after missing 87 days of school... FRCs are in school doing programming and still get referrals after the whole school year, not earlier. Another school district doesn't let the FRCs in to do programming, [so there is] no collaboration, but the model is supposed to collaborative. Something needs to come from DESE. If a child misses seven days of school within a period of time, they should at least alert FRC."*

- *"The school districts need to have their own administration stress the importance of connecting with FRCs. We continue to outreach to schools and yet we still don't see*

[78] This survey was conducted by the OCA in the spring of 2023. It was circulated by the Department of Elementary and Secondary Education (DESE) through DESE's weekly email to school professions and received 70 responses. Although it is not a representative sample of all school professionals, it is an interesting data point that 10% of respondents to a survey *about FRCs* had this limited level of awareness. It seems likely, though is not provable, that the rates may actually be higher amongst individuals who were not motivated to respond to a survey about FRCs.

referrals in the early stages of student crisis. Higher administration and superintendents need to have regular communication and expectations to be collaborating with FRCs."

- *"Many times, the potential CRA is related to behavior early in the year, then we get a lot of referrals for truancy of 100-120 days. We know they knew the student's trajectory in Quarter one, but they don't refer to us at that point."*

Finally, some FRC PMPDs and school liaisons report that some school districts allow FRC staff into the school, while others do not. Similarly, some school liaisons report having on-site meetings with school officials and being allowed to support families during IEP meetings, while others described that schools prohibited them from participating in IEP meetings.

- *"Parents are told they can't have outside help attend their IEP meetings… We are now meeting with the schools to clarify that they can have a liaison, or advocate, or lawyer. I use PPAL a lot as a referral, since I am not officially qualified as an Advocate. It has to do with budgets, but parents are scared being alone."*

- *"We use Mass Health Law Advocates [MHAP for Kids]. They're helpful for information, but while not my first go-to, the school would rather me attend since I don't have a law degree. Good to remind them we are just an ear who is explaining things to the family and providers, not shut down anything or involve an attorney."*

Even when a positive relationship is established, it can be threatened by turnover at the school or FRC level. When a school liaison position is vacant, it can significantly impact an FRC's ability to maintain a relationship at the school. At the same time, when personnel change at school, FRC staff have to rebuild the relationship with the new hire. There is no legal expectation that school personnel are expected to build relationships with FRCs.

It is important to note that there has not been a significant, coordinated effort at the state level to truly push practitioners to refer to FRCs. For example, while DESE has issued guidance encouraging schools to work with their local FRCs on attendance issues,[79] no state entity has issued clear guidelines to schools on exactly when and how they should interact with their local FRCs, nor is the OCA aware of any significant, state-led effort in recent years to ensure school personnel are fully informed about what FRCs are and what they do.

[79] Massachusetts Department of Elementary and Secondary Education. (2022). Guidance for Attendance Policies. https://www.doe.mass.edu/sfs/attendance/attendance-guidance.docx

Due to Massachusetts's strong "local control" system, there are limits to what the state government can *require* school districts to do. This does not prevent the state from offering guidance on best practices, for example. Ideally such guidance might be developed through collaboration with DCF, DESE, and the Juvenile Court.

Figure 18: Bright Spot: North Adams FRC and CRA Prevention

Through strong relationships with their schools and courts and focused attention by the staff, the North Adams FRC has significantly grown the number of CRA/CRA-at-risk youth served in recent years.

What do these relationships with schools and courts look like? FRC and school staff from the five local high schools the FRC serves meet at the beginning of every school year to agree on how they will work together. As a result of this effort, school staff routinely refer families of youth with 8-10 unexcused absences to the FRC for support. In addition to the FRC staffing a table in the schools' cafeterias to increase awareness among the students and school staff about how the FRC can support them, the Program Manager provides regular updates to the schools on FRC programming. The Chief of Probation from Berkshire County also meets with school staff annually to explain the local Juvenile Court's policy of requiring a referral to the FRC before accepting a CRA filing from the school.

The FRC offers youth a mix of supports that the schools and the courts rely on, including after school programming for both middle and high school youth, including a once-a-week drop-in center for academic help; teen writing workshops; a youth empowerment self-help group; and teen leadership classes. All programs are free and transportation is available. The FRC Clinician provides "bridge therapy" sessions for youth who are on waitlists for mental health treatment. FRC staff help individual families navigate the special education system, including attending IEP and 504 meetings with them. Staff will meet families in their homes or at the school if that is best for them. The FRC also offers parenting classes several times per year for parents of teens.

Courts

Relationships with local courts also vary greatly across FRCs. Individual courts have broad latitude to decide if, when, and how to divert a CRA case. In some cases, the Court has set up a strong CRA diversion program with their local FRCs. For example, FRC PMPDs and staff report:

- *"Sometimes judges hold the cases open until the family has a chance to meet with us and put services in place. It could be basic needs or housing, and between family parents and clinicians we figure out a plan to help the family as much as we can."*

- *"If a school files with the court and has not referred to the FRC first, the courts will send a referral to us."*

- *We go to the clerk-magistrate meetings as diversion, which works great most of the time to assess the family's non-school needs, and the ones who engage are grateful."*

Some FRCs send staff to court to meet in person with parents who want to file a CRA petition and to build relationships with court clerks, judges, and probation officers. While this is a time-consuming practice that some FRCs have found hard to maintain due to workload and/or disruptions from COVID, those who do it report that it is effective:

- *"Go in-person weekly at the Juvenile Clerk's office. Meet with parents who present wanting to file CRA."*

- *"I used to go to the courts in-person, but since COVID, haven't been back. Now court probation officers have started doing hybrid meetings again."*

- *We struggle to get our relationship with the courts going since the Pandemic. We want to work more with the officers and court workers. It's been a challenge to get the schools and courts to understand where we fit into the [CRA] process."*

Like schools, however, many FRC PMPDs and staff also reported challenges in receiving referrals from their local courts:

- *"Courts do not refer families to FRCs."*

- *"Our Family Partner and Clinician usually deal with CRAs, but we aren't getting any referrals from the courts - not sure why. Trying to brainstorm on how to get more referrals from the courts."*

- *"We have only had one court referral in the past couple of months."*

- *"At one-point, [had a] strong connection with one probation officer, now a different PO and manager."*

As with schools, in some cases the relationship with the court is difficult to maintain due to staffing limitations and FRC or court turnover:

- *"The Family Partner and Clinician work with the court, but we don't have those positions right now, so currently we have no connection with the court."*

- *"We created a calling system so any parent coming in the local court can contact us directly prior to filing the CRA. Sometimes a worker will go to the court in person, or meet over the phone… Since this on-call system, [there has been] a significant decrease in CRA filings. They can't keep the children from problematic behaviors necessarily, but can connect parents to services and they're often surprised at what we offer. Our mission*

is to reach them pre-CRA but for our small team it's hard. We're drifting from our original mission and we need to pull back to it. We created on call system with our Clerks department, but meeting the need with such a small court diversion team has proven to be difficult."

Judges interviewed for this report also mentioned the variation in the relationships between FRCs and courts:

- *"Effectiveness of Court Liaison depends on the individual……One from [FRC] comes in and never says anything. The one from [FRC] is more proactive. They can't always be where they need to be on any single day. One from [FRC] will be there to meet with the CRA family and talk about resources."*

- *"The FRCs that are successful are those partnering specifically with truancy, doing meetings about prevention, offering programming to help with truancy numbers, and pre-CRA work as well. This requires buy-in though from the administration to demonstrate to the school the value of the FRC. The jurisdiction of different systems involved between the school, court, FRC and others are so variable and hard to align any specific region."*

- *"When there is turnover [at FRCs], then you can't develop rapport."*

While court clerks are required by law to give families who come to the court to apply for a CRA a brochure about FRCs, there is no additional guidance or requirement about *how* that referral is made (e.g., with a warm hand-off or by simply handing the caregiver a brochure).[80] Indeed, in interviews conducted by the OCA for the 2022 JJPAD report, it was clear that while some court clerks had embraced the notion of diversion and had set up specific pre-filing diversion mechanisms (such as requiring evidence that a school has engaged a local FRC before accepting a filing, as described above), other court clerks did little to actively encourage potential filers to utilize FRC services instead.

[80] M.G.L Chapter 240 of the Acts of 2012: https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter240

Figure 19: Bright Spots: Promising CRA Prevention Collaborations Led by/Involving FRCs

In many communities, FRCs are part of a cross-agency collaboration that brings together the schools, the Juvenile Court, FRCs, and families to work to address attendance concerns before a truancy CRA is filed. Examples include:

Lowell: Led by schools and the FRC, Lowell has weekly Attendance Intervention Meetings (AIM) to try to solve any truancy/failure to send issues prior to court intervention. AIM includes participation of school's Attendance Officer, Family Resource Center (FRC) School Liaison, Wayside, Department of Children and Families, Juvenile Court Clinician, and Probation. Some weeks families will attend the case review, other times the team does a "system review." The meetings take place at the FRC—a "neutral" place (rather than the school). While the Attendance Officer flags children who are CRA eligible, the Clerk Magistrate will refer the child to FRCs and this AIM group. They are trying to use CRAs as a last option.

Barnstable (Cape Cod): The "Keep Them Coming" program in Cape Cod brings together families, district attorneys, school personnel, and community-based orgs to ascertain why the child is missing schools and to work together to put a thoughtful intervention in place. In one example, a young man was chronically late to school. The school was prepared to file a CRA when the FRC recommended a Keep Them Coming meeting. Through one-on-one conversation with the student, he finally shared that he needed to work to help ensure his family was taken care of financially. The team was able to work with the school counselor to adjust his schedule so that he had study hall in the morning instead of the afternoon and even helped him earn work study credits for his job. This allowed him to work to help support his family while still getting to school in time to take his core classes.

Worcester: In Worcester's "Fresh Start" meetings, families join the meeting along with the school adjustment counselor, the district rep or the district school adjustment counselor and the program director from the FRC. Similar to the examples above, the goal is to get to the "why" behind the absences and build a network of support that helps the child and family get back on track.

Source: Massachusetts Office of the Child Advocate. (2021). Truancy Prevention Research and Best Practices. https://www.mass.gov/doc/truancy-prevention-research-and-best-practices/download

Finding 6: The landscape of human services has changed in critical ways since FRCs were first procured, resulting in duplication of services and/or lack of alignment in key areas

In Findings 1-3, we focused on the various ways the FRC role has expanded over time and the challenges that has created. We also discussed the large number of families with significant needs that are *not* currently being served by FRCs in Finding 4.

Given that FRCs are already overstretched, there is no way – absent a very significant increase in state resources and staffing capacity – that they can add to or expand on what they do or the numbers of families they serve without taking something *off* their plate. In this section, we explore the wider state service system to identify areas where FRCs may be offering overlapping or duplicative services, or where increased alignment and coordination with other systems could create efficiencies.

In particular, we focus on two areas where the state has focused in the years since the FRC model was developed: behavioral health services and parenting education and support for families with young children.

Finally, we discuss the increased need for navigation support for families given the increasing complexity of our behavioral health, financial support, and other family support systems.

Behavioral Health

The behavioral health landscape has changed considerably since the FRC service model was first designed. Over the past ten-plus years, existing behavioral health services for children, youth, and adults have been created or expanded, including:

- **The Behavioral Health Help Line (BHHL)**[81] allows anyone in the state to be connected 24/7, through call, text, or chat, to a trained staff member who will help callers assess their needs and connect them to appropriate referrals while the caller is still on the phone. BHHL staff also follow up after the initial interaction to ensure the caller's needs are met.

- **Community Behavioral Health Centers (CBHCs)**,[82] the culmination of the state's Behavioral Health Reform efforts, comprise a network of 26 centers across the state offering urgent and routine behavioral health services for adults and youth both in-person and via telehealth. CBHCs provide 24/7 mobile crisis services; community crisis stabilization; outpatient mental health and substance use services, including individual, group, and family therapy; peer support services; medication for addiction treatment;

[81] For more information, see: https://www.masshelpline.com/
[82] For more information, see: https://www.mass.gov/community-behavioral-health-centers

and care coordination. These services are available to all MassHealth members and covered by some commercial insurers.

- **Behavioral Health (BH) Urgent Care** is a range of services that include mental health assessments, substance use treatment, and referrals for MassHealth members.[83] Designed to provide both quick and easy access to behavioral health care in members' own community, there are currently 61 BH Urgent Care sites statewide offering same or next day evaluation, psychopharmacology appointments and addiction medication evaluation within three days of an initial evaluation, and all other treatment appointments, including follow-up appointments, within two weeks. Additionally, BH Urgent Care sites operate extended hours on weekdays and offer weekend hours.

- **Children's Behavioral Health Initiative (CBHI)[84]** offers an array of intensive home and community-based services for certain children under the age of 21 who are covered by MassHealth. Services include intensive care coordination, in-home therapy, family support and training, and therapeutic mentoring.

- **School-based behavioral health services:** At both the state and local school district level, there has been an increased focus on, and resources dedicated to support, students' behavioral health in schools. Examples of state initiatives include the 41 school-based health centers operated by DPH as well as MassHealth's School-Based Medicaid Programs.[85] The state has also recently created a Technical Assistance Center for School Based Behavioral Health, located at UMass Boston.[86] Many non-state initiatives to expand behavioral health support in K-12 settings are also successfully providing supports to students across Massachusetts.

- **DMH supports** include a variety of community and school-based therapeutic services for individuals (children, youth, and adults) with significant mental health challenges ranging from consultation and referral to group therapy, case management, and inpatient treatment.[87]

Finally, the state is currently working toward creating additional mechanisms to help streamline processes for **supporting cross-agency collaboration for youth with complex/high needs** and expediting decision-making regarding service eligibility and responsibility for youth who may need support from multiple agencies. As part of the Mental Health ABC Act, passed by the Legislature and signed by Governor Baker in August 2022, EOHHS and EOE have been tasked

[83] For more information see https://www.mass.gov/info-details/behavioral-health-urgent-care
[84] For more information, see: https://www.mass.gov/childrens-behavioral-health-initiative-cbhi
[85] For more information see: https://www.mass.gov/info-details/school-based-health-centers-who-we-are ;and https://www.mass.gov/school-based-medicaid-program-sbmp
[86] For more information see: https://www.umb.edu/birch/resources/
[87] For more information see: https://www.mass.gov/info-details/dmh-child-youth-and-family-services-overview

with leading a new interagency review team to collaborate on these complex cases.[88] Implementation of this law is ongoing, with the aim of facilitating service access for these youth.

The significant expansion of the behavioral health system in the Commonwealth over the past decade-plus provides an opportunity to re-think the role of FRCs in addressing the behavioral health needs of families who come to the FRC. Our system is not yet perfect – certainly gaps still exist, and there is strong demand for the behavioral health services FRCs currently provide. At the same time, there are many more services now than there were when FRCs were created, which requires a reconsideration of how FRCs should interact with these services and what role FRCs should play in this new behavioral health landscape.

Parenting education and support for families with young children

As with behavioral health services, over the past decade-plus there has been a significant focus in the Commonwealth on services and initiatives for families with children birth to age five. The result is a rich tapestry of programs – but significant overlap and a marked lack of coordination across the many local, state, and federal programs. Simply put, **the parenting education and support services FRCs currently provide for families of young children are also provided by a large number of other programs across the state.**

Of particular relevance to this report, there are three state agencies funding parenting classes and the provision of resources, referrals, and other supports for families with young children:[89]

- DCF funds **32 Family Resource Centers**, described extensively in this report.

- The Children's Trust currently funds and operates **seven Family Centers**, which are community-based centers that provide a range of support services to families with at least one child prenatal through age 8.[90] These centers aim to support overall child and family well-being by offering various resources, programs, and support networks. They typically provide parenting classes, workshops, support groups, some material support such as diapers or gift cards, individualized support during times of family stress, and connections to other community resources. Like FRCs, the Family Centers are scheduled for re-procurement in FY25.

[88] M.G.L. Chapter 177 of the Acts of 2022. https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177

[89] There have been some attempts to streamline these services, but progress thus far has been limited. The Children's Trust intentionally contracts with the same local agency that holds the CFCE contract to run each of their Family Centers. Additionally, there are three community agencies that hold a CFCE, Family Center, and Family Resource Center contract. Staff at those three agencies report that the CFCE and Family Center funds primarily support parenting education, while the FRC funds allow them to provide more individual support and respond to families in crisis. However, because each contract (FRC, FC, and CFCE) has different reporting requirements and data systems, these three agencies essentially host three different programs in one space, although when possible and authorized by contract, they try to "braid" funds and share resources across contracts.

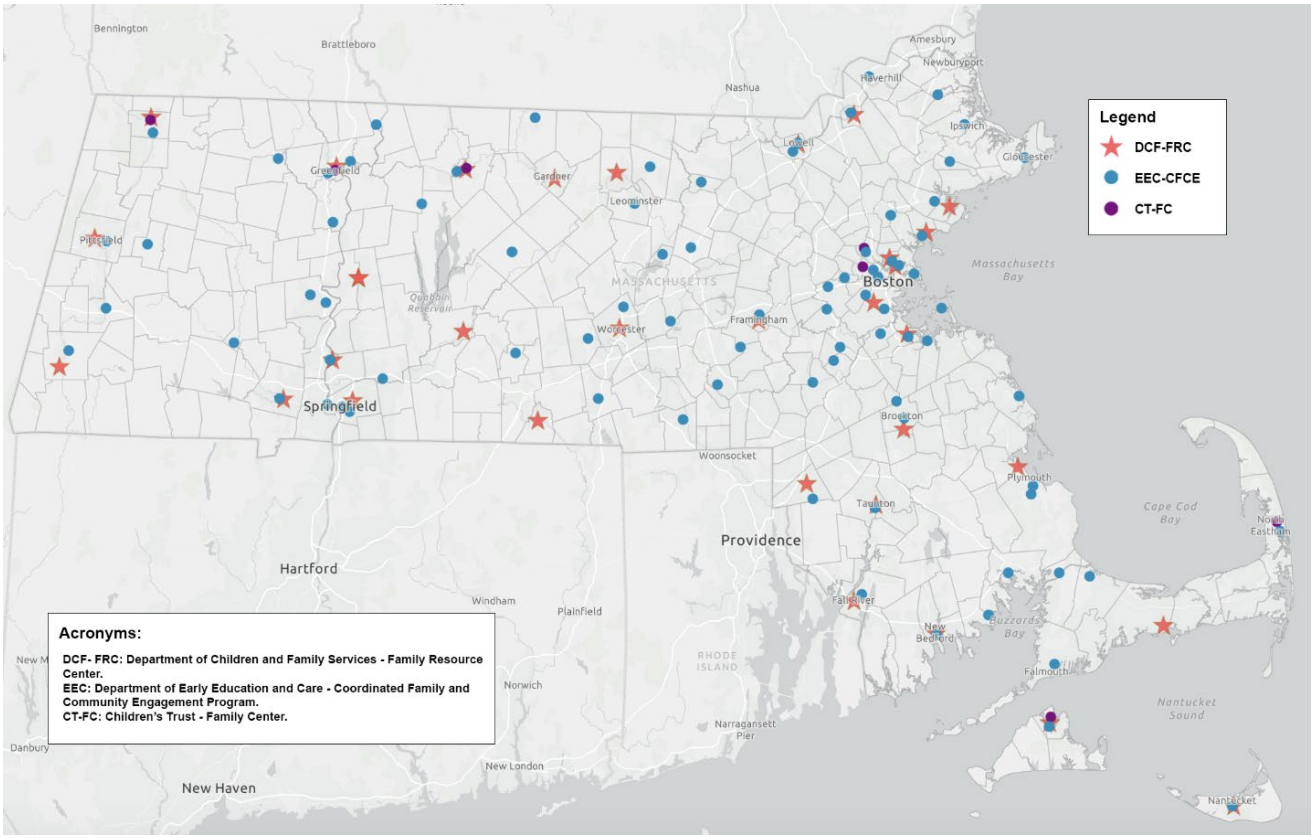
[90] Children's Trust. (n.d.). "Family Centers". https://childrenstrustma.org/our-programs/family-centers

- EEC funds **81 Coordinated Family and Community Engagement (CFCE) programs**, which serve all families with children from birth through age 6 with a particular emphasis on families not otherwise involved with state systems.[91] These programs are administered by a range of organizations (e.g. family services organizations, libraries, and public schools.) CFCEs offer formal parenting classes, networking opportunities, and playgroups as part of their services. They assist families by providing child development information, support during periods of family crisis, information and referrals for family support programs, and resources for family literacy and school readiness. CFCEs also organize family and community events and offer parent leadership opportunities. They help provide information and referrals for EEC programs, support applications for financial assistance, and coordinate closely with Mass 211, a statewide information and referral system for all family and individual needs.[92]

The sites for these various services are depicted on the map below.

Figure 20:

Locations of State Funded Family Support Services



[91] Massachusetts Department of Early Education and Care. (n.d.). "Coordinated Family and Community Engagement (CFCE) Network". https://www.mass.gov/info-details/coordinated-family-and-community-engagement-cfce-network

[92] Massachusetts 211. (n.d.). https://mass211.org/

In addition to these more "universal" services, other agencies have expanded family support services for specialized populations and/or specific geographies. For example, the Department of Developmental Services (DDS) has almost 50 Family Support Centers across the state that provide information and referrals, navigation support, training, consultation, networking, mentoring, support groups, and social and recreational events to children and adults with disabilities who live at home, as well as ten Autism Support Centers providing similar services to children and adults with autism spectrum disorder.[93] Although these services are not duplicative per se, there are likely more opportunities for alignment and connection between FRCs and other more specialized family support centers.

Finally, there are a variety of **home visiting programs** that provide services and support to families. Although these are not center-based models, they are still programs that provide parenting education and support to families with younger children:

- **Children's Trust provides, through community-based agencies, a statewide home visiting program called Healthy Families Mass (HFM).** Through its 23 sites, the program visits first time parents under the age of 23 and with a child under one year of age. HFM is funded both by state and federal dollars, through DPH.[94]

- **DPH funds several other home visiting programs** that provide information on child development, parenting advice, help with the parents' goal setting, and, for some, help finding employment and childcare. Most notably, DPH funds the **Early Intervention Parenting Partnership,** which is a team that includes a maternal and child health nurse, a mental health clinician, and a community health worker who visits a family during pregnancy and through the child's first birthday.[95] The team works with the family to assess their needs and connect the family to additional resources. This is a subset of **DPH's Early Intervention program** which provides statewide support to families with children under the age of 3 who are experiencing or at risk of experiencing developmental delays—which can be offered in the home or in other settings like early childhood education and care programs.[96]

- **EEC also provides an intensive home visiting program** called ParentChild+ through its CFCEs in a number of communities. ParentChild+ is a parenting, early literacy, and school readiness program to help strengthen families through verbal interaction and educational play between parents and their young children.[97]

This list of both center-based and in-home parenting education and family support services for families with younger children is far from exhaustive. Indeed, there are any number of other

[93] For more information, see: https://www.mass.gov/info-details/dds-family-support-centers
[94] For more information see: https://childrenstrustma.org/our-programs/healthy-families
[95] For more information see: https://www.mass.gov/early-intervention-parenting-partnerships-eipp
[96] For more information see: https://www.mass.gov/orgs/early-intervention-division
[97] For more information see: https://parentchildplus.org/our-work/

programs funded by local communities or operated by non-profits like the Parent Professional Advocacy League (PPAL).

The duplication with other programs may explain why **many FRC PMPDs reported low attendance and difficulty engaging families in the evidence-based parenting programs** required by the DCF contract. As one PMPD put it, *"It's hard to get a staff member committed to 3-4 hours weekly for 14 weeks and have only one person attend... it's not that it isn't beneficial, just hard."*

Another questioned whether it makes sense to dedicate resources to running intensive parenting classes given low attendance: *"Running evidence-based parenting takes a lot of effort for reaching few families. [I] get [the] value of parent education, but [it's] not worth the resources.*

This is not universally true across the state, however. One stakeholder interviewed for this report noted that, in the region where they lived, the FRC was the *only* provider of parenting classes. In focus groups with consumers, several noted that they would like to see more courses offered. Said one consumer, *"If there were more courses, we'd take them! I know they're short on staff, and I understand it, there are changes and emergencies, but they aren't doing as many classes as before… They've given me so much!"*

Other consumers asked for different kinds of group parenting supports, such as peer support groups with other parents of similar-aged children, more groups for grandparents raising children, and shorter workshops, particularly for parents with teenagers. FRC PMPDs and staff also expressed a desire for more flexibility in what courses they offer, particularly if similar courses are already being offered by others in their community or if required programs are not culturally appropriate for the target audience.

FRC PMPDs and staff also noted that many required courses were only available in English, which limited the ability of families for whom English was not a primary language to participate. Finally, several pointed out that online courses are available that are not community-specific, and that, post-COVID, many families would prefer a "Zoom" class to coming in person. In focus groups, some consumers conveyed a preference for virtual classes, while others preferred in-person.

It's clear that while the parenting education classes FRCs provides are valuable, there are opportunities for increased coordination and alignment with other parenting education and support providers to reduce duplication and free up resources to meet other, currently unmet, needs in this area.

Increased Importance of Navigation Support

Families in Massachusetts frequently have a hard time accessing services that could help them, at least in part due to the difficulty of navigating our complex system of family supports as well as our behavioral health and special education systems. This is despite the fact that

Massachusetts invests a significant amount of money each year in family support services, more per capita than the vast majority of other states.[98] Many other programs are funded by the federal government. A non-exhaustive list of these services include:

- **Economic support programs**, including the SNAP, Transitional Aid to Families with Dependent Children (TANF), a variety of housing and rental assistance, such as the RAFT program, emergency shelters for families, and Child Care Financial Assistance provided by EEC.
- **Healthcare support programs**, most notably MassHealth and the Children's Behavioral Health Initiative, as well as a variety of DPH contracted behavioral health services and DMH mental health services.
- **Family and parenting support programs,** including FRCs, Family Centers operated by the Children's Trust, DDS-operated Family Support Centers and Autism Support Centers, DPH-operated Early Intervention and Home Visiting programs, the Women Infant Children Nutrition (WIC) program, and a variety of programs for pregnant and parenting teenagers/young parents.
- **Early childhood support programs,** including HeadStart, Early Intervention, and CFCEs.
- **Programs for youth and young adults**, including a wide variety of mentoring and youth engagement programs, such as the Young Adult Access Centers run by DMH, as well as targeted programs for youth with disabilities, youth at high risk for violence, and youth at risk of homelessness.

The need for navigation support in Massachusetts has only increased over the past decade. As new programs and family support initiatives have been launched, the system has become more complex and more specialized. Increasingly long waitlists for two of the most frequently requested services at FRCs – behavioral health and housing – mean that families are more likely to need a partner who will stick with them longer and help them identify short-term strategies that can help while they work toward their longer-term goals.

A recent Urban Institute report analyzing 58 different initiatives in Massachusetts that support families through coordination of early childhood (birth to 5) services found that the Commonwealth "lacks cohesive linkages connecting initiatives to one another and many programs are unaware of each other."[99] The authors of that report go on to "hypothesize that this results in **duplication of efforts** and, consequently, **increases family confusion** about where to find reliable and trustworthy information on, and connections to, services." The need for more coordination of services and concerns about duplication were also consistent themes in interviews and focus groups conducted for this report.

[98] Puls, H., Hall, M., Anderst, J., Gurley, T., Perrin, J., Chung, P. (2021). State spending on public benefit programs and child maltreatment. *Pediatrics 148*, n. 5. https://doi.org/10.1542/peds.2021-050685

[99] Urban Institute. (2024). Coordinating Services for Families with Children from Birth to Age: A Landscape Review of Initiatives in Massachusetts. https://www.urban.org/research/publication/coordinating-services-families-children-birth-age-5-landscape-review

The idea of a navigator is not new. As early as 2009, the term Community Health Worker was considered an umbrella term for some 50 job titles that fit DPH's definition of that position, including patient navigator, family advocate, peer leader, peer advocate, peer specialist, and family support worker.[100] Since then, the function has been expanded beyond health care settings. For example, The Home for Little Wanderers, the community-based agency that operates the Chelsea FRC, employs parent support specialists who help families "navigate" behavioral and mental health systems and educational advocates who help them "navigate" special education systems through the DMH funded Family Support and Training Program.[101] Similar roles exist across health and human services.

There is often, but not always, an emphasis on the importance of hiring individuals with "lived experience" in navigator roles, based on the theory that they can offer unique insights and perspectives that stem from their own personal journeys, which can enhance empathy, understanding, and effectiveness in supporting those they serve.[102]

As described in Finding 2, above, system navigation is part of the role that FRCs play. While only the family partner position within the FRC is required to possess "lived experience", the FRC's family support worker, school liaison, and family partner all perform one or more of these system navigation functions. FRCs also work with MHAP for Kids attorneys to coordinate both navigation and advocacy support for youth and their families with unmet mental health needs who are court involved or at risk of court involvement.

However, as also described in Finding 2, there is considerable confusion about what specifically is expected of FRC staff in these roles and what level/intensity of support they should be providing families.

[100] Massachusetts Department of Public Health (DPH). (2009). Community Health Workers in Massachusetts: Improving Health Care and Public Health. https://www.mass.gov/doc/community-health-workers-in-massachusetts-improving-health-care-and-public-health-0/download.

[101] The Home for Little Wanderers. (n.d.). "Behavioral Health and Clinical Services Parent Support Group". https://www.thehome.org/programs/clinical-behavioral/parent-support-program/

[102] See, for example: Peer Support in Mental Health: Literature Review - PMC (nih.gov) See, for example: Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer Support in Mental Health: Literature Review. JMIR mental health, 7(6), e15572. https://doi.org/10.2196/15572

Recommendations

Every day, FRC staff provide real, concrete value to a diverse array of families, many of whom face significant challenges and have substantial need for support.

Over time, the mission and focus of FRCs has expanded considerably beyond the initial focus on helping prevent involvement with the child protective services and Child Requiring Assistance systems. The reasons for this expansion are understandable; FRCs have responded, over and over, to pressing needs of families in their community even as those needs have shifted and expanded over time. At the same time, because the expansion has not been accompanied by substantial increases in resources or other forms of support, FRCs have become stretched too thin – and implementation of the original core FRC services has varied in consistency across the network as a result.

Even as the number of FRCs has expanded over the years, there are tens of thousands more families each year who could benefit from their services, including those at risk of entry to the child protective services or CRA systems. Preventing involvement in these systems by connecting families to services and supports earlier and more effectively is beneficial for everyone – and given the significant per-person costs of those systems, likely much more cost effective as well.

This report makes three primary recommendations to enhance the reach and impact of FRCs:

- **Recommendation 1: Focus FRCs on a priority goal of preventing entry (or re-entry) to the child protective services and Child Requiring Assistance systems:** Focusing on a specific mission and target population can help the Commonwealth improve FRC service design, enhance consistency across FRCs, and allow for more targeted marketing and outreach efforts. As further discussed below, **this does not mean that FRCs should establish eligibility criteria or restrict access to families**, nor should we retreat from the goal of having FRCs serve as a central hub of their communities. Instead, focusing on a priority goal and population provides direction for inevitable decisions about strategy and prioritization of limited resources when making programming decisions. We recommend building an updated FRC model around this goal and priority population, while allowing for community-specific innovation and additions *so long as it does not divert resources and focus from the core priorities.*

  These recommendations to reduce redundancies and increase the level of focus on certain key priorities would be important at any point in time, but they become all the more important in times when state resources are more limited, as they may be in FY25 and beyond.

- **Recommendation 2: Expand funding for FRCs, which should be funneled toward expanding sites and increasing staff at existing sites:** Prioritization can only go so far. To

reach more families, as we propose in this report, *and* more effectively support families most at risk, funding to support more staff and more offices is needed.

- **Recommendation 3: Enhance support from, and integration with, other state systems and services:** While FRCs can and should serve as a central community hub, they cannot do this work alone. They need enhanced connections to, and support from, state agencies to both *reach* more families in the target populations and to better meet these families' needs.

Recommendation 1: Focus FRCs on a priority goal of preventing entry (or re-entry) to the child protective services and Child Requiring Assistance systems

Our child protective services and Child Requiring Assistance systems are costly and come with significant risk of trauma and harm to children and families. Yet many of the top risk factors for involvement with these systems – including poverty,[103] parental and child mental illness and substance use disorder, and intimate partner violence – can be addressed by connecting families with financial resources, behavioral health treatment, and other supports.[104]

> *"The FRCs need to get back to why they were created, and do that well. I would rather have quality over quantity. We need to be really good at the FRC prevention work, rather than doing a million things poorly."* – FRC Staff Member

All families need support – but families who are at the highest risk for involvement with these service systems often face significant barriers to accessing that support.[105] As a recent report from the Harvard Kennedy School Government Performance Lab put it, "families most in need may not find services on their own."[106] **Reaching these families requires extra attention, focus, energy, and resources.**

As described in Finding 4, there are tens of thousands of families each year who are at an elevated risk for system involvement and may benefit from FRC services. These include:[107]

- Families that schools and other mandated reporters are sending to DCF for reasons other than abuse or neglect (i.e. because they feel the family needs supports with basic needs)
- Families who have been reported to DCF for suspected abuse or neglect, but whose case was "unsupported" by DCF [108]
- Families who have had a DCF case closed who may still benefit from enhanced voluntary support

[103] Poverty alone is not a legal reason to remove a child from their family, but there is no denying that the stress of poverty can greatly exacerbate other challenges that contribute to abuse or neglect.
[104] Austin, A. E., Lesak, A. M., & Shanahan, M. E. (2020). Risk and protective factors for child maltreatment: A review. Current epidemiology reports, 7(4), 334–342. https://doi.org/10.1007/s40471-020-00252-3
[105] See, for example, Hodgkinson S, Godoy L, Beers LS, Lewin A. (2017 January). "Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting". Pediatrics. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/
[106] Toohey, M. (2023). The Journey to a Well-Being-Oriented System: A model for leaders in child welfare. Harvard Kennedy School. The Journey to a Well-Being-Oriented System: A model for leaders in child welfare (harvard.edu)https://govlab.hks.harvard.edu/sites/hwpi.harvard.edu/files/govlabs/files/the_journey_to_a_well-being-oriented_system.pdf?m=1692105583
[107] For the purposes of brevity, for the remainder of this report we will refer to these families as "at-risk".
[108] Not all of these families are at elevated risk of child maltreatment, but many *would* benefit from additional support. We also note, as further discussed in Recommendation 1A, that there are opportunities to refer more families directly to FRCs rather than through the 51A system.

- Families who are currently involved with, or at risk of involvement with, the CRA system
- Families with children who are chronically absent from school

However, many professionals who interact with these children and families are either unaware of FRCs or do not have full understanding of the wide range of services they provide. As a result, **too many families end up referred to the child protection system (through a 51A) or to the CRA system (through a CRA petition) who could have been helped faster, more effectively, less intrusively, and at significantly reduced cost to the Commonwealth through an FRC.**

We recommend that FRCs, with the support of other state systems, focus on these families.

This does not negate the importance of primary prevention and going "upstream," nor are we recommending that FRCs should close their doors to other families; **there is a benefit to FRCs continuing to be a place where all families are welcome and can seek support.** But with the large number of families who are already "midstream" every year, and in a landscape of limited resources, we recommend FRCs *focus* on a more targeted set of families.

This strategy was described in the Harvard Kennedy School report referenced above:[109]

> *Adopting a balanced strategy and set of messaging that all families need support, to decrease stigma and increase broad access to prevention supports, and targeted engagement of families most in need, recognizing that these are often the families who also face the most significant barriers to accessing supports;* ***often, this looks like broader eligibility criteria paired with clear target populations that agency staff and providers are actively trying to reach and engage.***

FRCs have a variety of pre-existing strengths that can be built on to implement this recommendation:

- They have systems in place to help families identify their needs and referral networks across their communities.
- They have strengths in engaging families and building trust, and experience in helping families navigate complex service systems.
- They are known for having diverse and often bilingual staff, many of whom have relevant lived experience.
- All of them provide a significant amount of basic needs support directly or through referrals already, and have experience connecting families with resources to help with substance use disorder, mental health, and intimate partner violence.
- Approximately one-half of them host MHAP for Kids attorneys onsite and all have access to MHAP for Kids services.

[109] Toohey, M. (2023). The Journey to a Well-Being-Oriented System: A model for leaders in child welfare. Harvard Kennedy School. https://govlab.hks.harvard.edu/sites/hwpi.harvard.edu/files/govlabs/files/the_journey_to_a_well-being-oriented_system.pdf?m=1692105583

Accomplishing this recommendation will require, as further describe below:

- A coordinated state effort to direct at-risk families to FRCs (Recommendation 1A)
- Redesigning the FRC service model to focus on this goal (Recommendation 1B)
- Eliminating or de-prioritizing some current FRC functions and/or offering them through partnerships with other state and local agencies (Recommendation 1C)

Recommendation 1A: There should be a coordinated state effort to direct at-risk families to FRCs

We recommend that the state **initiate a coordinated and comprehensive information campaign to educate families and child-serving professionals about what Family Resource Centers are, what they can do, and how to access them.** While a full-scale marketing campaign should likely wait until the FRCs are re-procured and when the FRCs have the staffing and partnerships required by that procurement, DCF should explore if there are earlier opportunities to share information about FRCs in coordinated ways at the state level.

One model the state can look to is the recent efforts to promote the Behavioral Health Helpline and CBHCs across the Commonwealth. This has been a cross-government effort, including a combination of mass marketing, targeted media buys, and significant direct outreach efforts to professionals in a position to make referrals.

We envision a coordinated state effort, with roles for FRC staff, DCF, other state agencies, the Juvenile Court system, and the Legislature.

Cross-System: Education of Mandated Reporters, State Employees, and other Child Serving Professionals

One area that seems especially promising to start with is to educate professionals who regularly file abuse/neglect reports with DCF and/or who may recommend a family file a CRA about FRCs.

Mandated Reporters: The OCA, through its prior role as chair of the Mandated Reporter Commission and other research conducted by the office, is aware that some mandated reporters believe that the best way to ensure a family gets the support they need is by filing a 51A, even in circumstances where they do not believe a child is being abused or neglected but they do believe a family needs help. A recent online training developed by the OCA provides information and materials to assist mandated reporters in connecting families to supportive services when the mandated reporter's concerns do not reach the threshold for reporting to DCF.[110]

As of the time of this report, there is legislation currently before the Senate Committee on Ways & Means that would require all mandated reporters to participate in training approved by the

[110] Massachusetts Office of the Child Advocate. (2023). Massachusetts Mandated Reporter Training. https://mandatedreportertraining.com/massachusetts/

OCA.[111] The OCA supports this requirement as one way of ensuring mandated reporters have relevant information about FRCs.

CRA Referrers: The 2022 JJPAD report found that "there is no coordinated effort for educating families or child-serving professionals (including schools, community-based providers, or healthcare providers) about the CRA process or viable alternatives – nor, to the best of the Board's knowledge, was there such a coordinated effort in the years following the CHINS to CRA reforms. While certain professional organizations or state agencies may issue information or conduct trainings for their sector, this is neither mandatory nor coordinated, and at times the lack of coordination of information can lead to the further perpetuation of misinformation and misunderstandings." The report went on to recommend that the state initiate "a coordinated, comprehensive and on-going information campaign about the CRA process (including any reforms made as a result of this report) and the various recommended alternatives, including FRCs." We reiterate this recommendation here.

State Agency Employees: In addition, there are a variety of state agencies and their contracted community-based partners who serve families who are at-risk of DCF and/or CRA involvement, as well as families who could benefit from help navigating to services other than the ones these agencies provide. More can be done to ensure these staff are aware of the role and services of FRC and how to make referrals.

Department of Children and Families

In addition to implementing a targeted marketing strategy, as described above, there is a significant opportunity to **increase coordination within DCF itself** and create a system-wide and systematized process for referring families to FRCs and other community-based resources. Recommendations to increase coordination and awareness include:

- **DCF should institute a process for identifying and referring (on a voluntary basis) families who come to the Department's attention and could benefit from FRC prevention services.** As discussed in Finding 4, there were over 16,000 cases that were investigated by DCF ("screened-in intakes") but were "unsupported", that is, DCF did not find reasonable cause to believe that the child was abused and/or neglected or that the child's safety or well-being was compromised.[112] At least some percentage of these families are at-risk of future DCF involvement and could benefit from the supports that FRCs provide.[113] We recommend DCF develop a process for identifying these families and making referrals when appropriate. This model of connecting families with FRCs was

[111] "An Act Authorizing the Commonwealth of Massachusetts to Establish Additional Mandated Reporters for the Purpose of the Protection and Care of Children." S.82. 193 General Court (2024). https://malegislature.gov/Bills/193/S82/BillHistory
[112] The Massachusetts Department of Children and Families (DCF). Annual Report FY2022. https://www.mass.gov/doc/fy-2022/download
[113] Note that DCF and FRCs do not "brand" the FRCs as being part of DCF, in hopes of ensuring families who may be fearful of becoming involved with DCF feel safe coming to an FRC. This practice should continue.

successfully adopted by Teller County, Colorado, and eventually expanded to the entire state, as described in Figure 21, below.[114]

- **DCF should ensure that all of their Area Offices are fully aware of FRC services, and that staff are trained on how and when to refer families to the FRCs—again, on a voluntary basis.** On average, only a small number of families coming to DCF report being referred from DCF (n=862). While recognizing that that number does not represent the full number of families who may have been referred but chose not to act on or report that referral, interviews conducted for this report suggest there may be inconsistency in DCF Area Office staff referrals to the FRCs, making this an area for potential improvement.

- **DCF should consider other opportunities to *systematically* refer families who are already involved with the Department to FRCs.** This should include ensuring families whose case is closing are made aware of the support they could receive at an FRC. Research suggests that family support services – like those provided at FRCs – can decrease the risk of the recurrence of maltreatment for families already involved in child protective services.[115] It could also include making sure families serving as kinship foster parents are aware of FRC services, particularly of the "grandparent raising grandchildren" groups run by FRCs.

Of note, several consumer focus group participants noted that they began coming to the FRC because it was required by DCF to regain custodial rights (e.g., a requirement to complete a parenting course). Although FRC staff report that not all consumers who come to the FRC as part of a family reunification goal engage with services, some do.

For example, one focus group participant stated *"I became involved with an FRC after court-involvement with my own children. It was hinted at me to use the FRC… Very welcoming, but I wasn't sure what to make of it… It was helpful getting to know about lots of their resources."* Another stated, *"DCF recommended it, but I also enjoy [the group]. I notice the thoughts I'm left with after our meetings. It's very positive."* Some also appreciated the connections with other DCF-involved families. As one put it, *"I've learned that my experiences with DCF, I'm not alone and other people are going through similar things... I've learned a lot about how I can change."*

The Legislature

In 2022, the JJPAD Board recommended shifting a significant portion of CRA cases from the court room to the community by revising the CRA filing process to ensure petitioners have "exhausted all community-based options", including engaging with an FRC, prior to accepting a

[114] We recognize that there are important questions to be answered in implementation with regards to how this information is communicated to a family and by whom, particularly given the need to protect the identities of individuals that have been the subject of an unsubstantiated 51A report and the goal of building trust with families.

[115] DePanfilis, D., & Zuravin, S. J. (2002). The effect of services on the recurrence of child maltreatment. Child abuse & neglect, 26(2), 187–205. https://pubmed.ncbi.nlm.nih.gov/11933989/; Morello, L., Caputi, M., Scaini, S., & Forresi, B. (2022). Parenting Programs to Reduce Recurrence of Child Maltreatment in the Family Environment: A Systematic Review. International journal of environmental research and public health, 19(20), 13283. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9603684/

filing. *An act relative to families and children requiring assistance*, filed by Senator Robyn Kennedy and Representative Natalie Blais, would implement this recommendation, and we urge its passage.[116]

Figure 21: CPFRC, Teller County CO

Colorado Community Partnership Family Resource Center (CPFRC), located in Teller County, Colorado, has been a hub for community-based services for families since its establishment in 1992. Now a part of Colorado's network of statewide FRCs, CPFRC has partnered with other state agencies to provide more preventative services to families particularly at risk for child welfare involvement.

In 2014, CPFRC began partnering with Teller County Department of Human Services (DHS) (Colorado's child welfare agency) to pilot the Colorado Community Response program (CCR). CCR is designed to fill a gap in the child maltreatment prevention continuum by providing a pathway for families from the child welfare system to local community supports/programs.

CCR is a voluntary service for families who are referred to the child welfare system but are either screened out, or their case is closed without any provision of child welfare services. Once screened out of the child welfare system, staff refer the family to their local CCR program.

Once referred, local CCR program staff contact families with more information on the program. Once the family is connected, program staff offer targeted support, which could include:

- Assistance with financial hardship, including one-time financial assistance and general financial coaching services.
- Assistance in accessing local family support services, focused on strengthening the family as well as the child-caregiver relationship.

CCR is designed to be a short-term program, lasting only 12-16 weeks.

A 2021 evaluation of the program found a 63% decrease in substantiated child maltreatment assessments between 2015 and 2018 in Teller County. The evaluation went on to find that due to the cost savings associated with fewer cases of maltreatment, for every $1 invested, Teller County received a return on investment of $2.92. This is largely due to the cost savings associated with fewer cases of maltreatment in the county. Due to the program's success, Colorado expanded it statewide.

Sources:
Community Partnership Family Resource Center. (n.d.) About. https://cpteller.org/about/
Colorado Department of Early Childhood. (n.d.) Family Support Programs. https://cdec.colorado.gov/family-support-programs
OMNI Institute (2021). Return on Investment of a Family Resource Center to the Child Welfare System: Community Partnership Family Resource Center, Teller County, CO. https://www.texprotects.org/wp-content/uploads/2021/12/186a7-communitypartnershipfamilyresourcecenterchildwelfarereturnoninvestmenttechnicalappendix_oct2021.pdf

[116] "An Act relative to families and children in need of assistance." S.101. 193 General Court (2024). https://malegislature.gov/Bills/193/S101/BillHistory

FRC Staff

There are also a variety of activities FRC staff could undertake to reach more at-risk families, both directly and through partnerships. Many of these ideas build upon work already being done by FRCs – some by all FRCs and others by specific FRCs. We elevate these promising practices here and recommend expansion (with additional resources to support this).

- **Staffing:** If additional funding is made available, as is recommended in this report, FRCs could hire additional staff who have proactive relationship management skills to open up and maintain the partnerships, as further described below—both to get referrals from them and negotiate arrangements where these agencies can bring their expertise on site at the FRCs or the FRC can go on site at those agencies. While school liaisons and program managers are now expected to do this, managing relationships with schools, community organizations, state agencies, and the courts at the level needed is impossible with current staffing levels and structures. Of note, 57% of PMPD survey respondents recommended adding a community engagement specialist position, 62% an outreach specialist, and 48% recommended adding both to the FRC staffing model. (See Appendix A for additional details on positions PMPD staff would like to see included in an updated FRC staffing model.)

- **Outreach and Marketing**: With additional resources, FRC staff could more proactively promote FRCs in settings in their communities where families at risk of child protective services and/or CRA system involvement might already be—such as subsidized housing communities and early childhood education programs, federally qualified health centers, licensed behavioral health clinics—as well as in school settings. Any new marketing efforts would need to estimate in advance the projected number of new families that will be brought into the FRCs. Staff hiring expansion, described above, would need to be linked to these estimates.

- **Partnerships:** With additional resources, FRC staff could dedicate more time towards enhancing, creating, and maintaining relationships with the organizations that see families most at risk of system involvement and have the expertise and services to help families. This would include increased focus on enhancing relationships with the truancy prevention and other school-based services focused on children at-risk and the Juvenile Court Probation departments, as well as state agencies serving higher risk families such as those managing low-income housing, helping with SNAP and other financial assistance benefits, running food pantries, and supporting behavioral health and substance use needs.

Recommendation 1B: The FRC Service Model should be redesigned to focus on this primary goal and population

Focusing FRCs on the goal of preventing entry (or re-entry) to the child protective services and CRA systems will necessitate changes in much of what FRCs do, including what services they

deliver, the number and type of staff they employ, the partnerships they are required to have, their approach to assisting families navigate to other community-based services, the data they are required to keep and report, the types of training they receive, and how their performance is assessed.

It is difficult to make sweeping statements about what FRCs should or should not do moving forward, in part because – as described in Finding 2 – there is so much variation in what they *currently* do.[117] Many of the suggestions we offer in this report build on activities which some FRCs are doing, or have done, in the past – but there is currently no consistent statewide approach to many of these.

As a general framework, we suggest that in determining the specific activities FRCs should undertake (as outlined in any future contracts), DCF and individual FRCs should focus on the following questions:

- Would this activity advance our goal of helping prevent child protective services and/or CRA system involvement – and if so, how?
- Which activities would be *most effective* in reaching these goals?
- Which activities would fill in gaps in what is available in local communities – and which might be duplicative of services already provided elsewhere?

Determining how exactly to do this is the work of detailed procurement planning once the state decides whether and how to implement the recommendations we will make in the next sections of our report. To make clearer what we are recommending, however, we make some suggestions in this recommendation on what we think should be **prioritized** in the new service model, as well as in Recommendation 1C on what should be **eliminated, de-prioritized, or offered in partnership** with another state/local agency.

Shifts in how *FRCs work with families*

Our highest priority recommendation in this category is that the redesigned FRC Service Model should emphasize the role of FRC staff in **helping families navigate our complex system of family supports.** While this is a role that FRC staff already play in at least some circumstances, we also found widespread confusion among FRCs – as documented in Finding 2 – about the extent to which they should be doing "case management" and what that work could or should entail.

[117] We also note that it was nearly impossible to connect the programming decisions of individual FRCs (as assessed through interviews and review of annual work plans) with any quantitative measure of impact/outcomes through available data.

Families experiencing high levels of stress or with multiple and/or complex needs often have difficulty following up on referrals and actually securing the supports they need, at least in part due to the difficulty of navigating our complex service systems. Indeed, a variety of studies have found that, despite having greater levels of need, these families often *underutilize* services due to barriers they face when attempting to access services.[118]

We recommend that the role of FRCs as **expert system navigators** be clearly defined in a new procurement, and that FRCs be staffed in such a way as to allow this work to be successfully executed.

Navigators would provide different levels of support, based on what the family needed, including:

- Information/referral
- Warm handoffs
- Attending a meeting with a family
- Acting as a bridge and translator (both literally and figuratively) for the family across service systems
- Helping families with benefits applications [119]
- Supporting families with self-advocacy skills and advocating for them as needed
- Continuing to follow up with and on behalf of the family until they feel their needs have been met

Figure 22: FRC Staff on the Need for More Intensive Individualized Family Support

"I have been with the FRC organization since 2015 when it began. At first, we offered parenting classes, support groups, events, information and referrals. Now, because of the high demand in our community, we have become more case management and with a very high demand on immigration needs such as legal assistance, housing, employment, educational needs for all family members. The demand on the staff has grown without growth in number of staff. ***We were designed to give the community what they need. They need case management.****"*

"*One barrier I see for FRCs in this area is we were not set up to do case management and have quickly become just that. We need more family support workers and school liaisons to help meet the needs of our community. Between meeting with individual clients and making referrals, helping with applications for either housing or financial assistance for overdue bills, support groups and parenting classes, our FSWs are overwhelmed. The program director and I try to help by doing intakes with individuals and at times assisting with these applications.* ***The need just keeps growing for these services."***

[118] See, for example, Haley, et. al.(2022). Parents with Low Incomes Faced Greater Health Challenges and Problems Accessing and Affording Needed Health Care in Spring 2021. Urban Institute. https://www.urban.org/research/publication/parents-low-incomes-faced-greater-health-challenges-and-problems-accessing-and-affording-needed-health-care-spring-2021 ; and Hodgkinson, et. al. (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. Pediatrics 139 (1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/

[119] Ideally, as described in Recommendation 3 below, this would be done in partnership with other state agencies.

Figure 23: What Do We Mean by Expert System Navigator?

The terms "navigator," "case manager," "family support worker," "family partner," and a myriad of other terms are used throughout the human services and health field, sometimes interchangeably and sometimes with specialized definitions.

For this report, we have chosen to use the term **Expert System Navigator,** and "navigation" for short, to mean the following:

"Someone who is supporting a family through every step on the way to getting the help they need: helping them identify *what* support they need, *where* they can get that support and *what they qualify for*, helping them *access* or *sign up* for those services, *staying with them* throughout the process until they secure services, and being available to help *overcome* any additional bumps in the road over time."

It is an approach that empowers the family to determine what they want and need, but provides guidance and support to help the family make informed decisions. Depending on the needs of the family, this may be more than a warm handoff (although warm handoffs may be involved), and it is likely much more than providing information and referrals. The expert system navigator may be one person or it may be a team of people – for example, a clinician, a family support worker, a school liaison, and a family partner – each playing different roles but ultimately working as a team to support the family.

Not every family will need a significant level of support, and some might ultimately be more appropriately served by a navigator/case manager at a different agency – but many of the most at-risk families will, at least initially.

Staff should receive specific training on the role and, potentially, tools to help them determine the level of assistance and follow up families will need. Families at risk of child protection services or CRA involvement should have priority for enhanced support, but if other families do need and desire help accessing referrals (beyond warm handoffs to other service systems) and the FRC has the capacity to provide that enhanced help, then they should. Referring and referral partners should also be given clear communication about what they can expect from the FRC navigator.

As a part of the procurement, we recommend DCF work with current FRC staff to "scenario plan": using their experience, identify prototype families and map the level of assistance each prototype would need and the resources required.

Expert navigation often goes beyond making referrals, and sometimes requires advocating on behalf of a family to help ensure they receive services to which they are entitled. In addition to the relationship management skill sets, the **FRCs would need more staff trained in individual child and family advocacy and/or an expanded use of MHAP for Kids and other programs such as PPAL and the Federation of Children with Special Needs** that both support families to

advocate for themselves and also utilize lawyers, paralegals, and other educational advocates to enforce a family's rights when necessary. This requires knowledge of child and family rights—be they to services from schools (like IEPs or 504 plans), housing assistance, or access to behavioral health services—and negotiation and advocacy skills to help families secure those rights.

As part of this redefinition of the role, the new procurement should enhance the role of FRC staff in supporting families who are at-risk of a CRA. Building on recommendations made by the JJPAD in its 2022 report on the CRA system, we recommend creating a mechanism by which FRC staff could **escalate "stuck" cases to a designated multi-disciplinary team** of school and regional state agency staff who are empowered to negotiate agreements (within state law and agency policy) necessary to expedite connections to services with the goal of preventing a CRA filing. This may include interfacing with the complex case resolution process described above. This multi-disciplinary team approach is not meant to substitute for existing processes, such as IEP meetings, nor would it solve every barrier related to eligibility requirements, waitlists, and funding concerns. There are a variety of laws and regulations such a team would continue to be bound by. At the same time, elevating a case to a higher level can – in the OCA's experience – promote collaboration and often times state agency staff and their school counterparts (at senior enough levels) can overcome barriers an FRC staff member cannot.

Shifts in Service Areas/Areas of Focus

As described in *The FRC Model,* FRCs' work currently falls into seven key areas:

- Group parenting support (Parenting classes & peer support groups)
- Individual and family supports (assessments, consultations, referrals, system navigation)
- CRA prevention & support (assessments, service planning, supports with school attendance and special education issues, referrals to mentors and youth programming)
- Basic needs support (food banks, holiday drives, helping families access financial assistance programs)
- Access to health and behavioral health systems
- Recreational activities and events
- Education (life skills, adult basic education, ESL)

All of these areas of work are important, and we don't recommend eliminating any of them. Instead, we recommend prioritization of some activities over others, and shifts in areas of focus **within** each category – focusing, as described above, on those activities that are most likely to help FRCs achieve the goal of helping prevent child protective services and CRA system involvement.

First and foremost, and in alignment with the above recommendation on expert system navigators, we recommend prioritizing the provision of **Individual and Family Supports**. Given the close connection between financial stress and involvement with the child protective services system, addressing **Basic Needs** should continue to be an area of focus and prioritized

where possible. This should include a heavy emphasis on expert system navigators helping connect families with on-going financial supports.

CRA Prevention and Support activities should also be prioritized. The specific activities may vary based on community need, but this might include one-on-one trust building with youth and support by trained youth workers, more classes focused on parenting of older youth, increased mentoring opportunities, facilitation of peer-to-peer groups, life skills and education workshops for youth, activities (and space) designed for older youth, and more support with negotiating and helping families advocate for services, such as special education through the IEP process.

While still a priority, the services offered in **Parenting Support** could be better tailored to the specific needs of the priority population. This could include more classes focused on parenting of older youth (to help address potential CRA-related issues), or, as suggested by FRC staff focus group participants, more classes on "Parenting in America" that may help recent immigrants understand expectations (and legal requirements) around parenting in America with a goal of reducing DCF involvement. It could also include more short workshops on common issues faced by families seeking to avoid DCF/CRA involvement, such as a workshop on navigating the special education/IEP process. (Recommendations on what group parenting supports could be de-prioritized or offered in partnership with others are included in Recommendation 1C.)

Similarly, **Recreational Activities** and **Education** activities could (as noted above) focus more on filling gaps in services available for at-risk youth, such as increased mentoring opportunities, and activities (and space) designed for older youth. It may also include identifying services available in the community and connecting families to those activities. FRCs may consider hiring a Youth Worker to help support these activities, as proposed by 62% of survey respondents.

New Metrics of Success

To assess the success of the new FRC model in reaching the target population of at-risk families and achieving the goal of preventing system involvement, DCF should adopt new methods of evaluating both process and outcomes. For example, DCF could examine:

- What is an appropriate target number of "focus families" for each FRC and what number are reached?
- Which schools and courts have put in place systematized processes for referring families to FRCs prior to filing a CRA?
- What percentage of FRC clients have an open case with DCF, after receiving services from the FRC?
- What percentage of FRC clients are enrolled in other state service systems, and which services?
- What is it that families are prioritizing as their highest needs, is the family able to access support to address those needs, and how long does it take?
- What are the barriers to families accessing supports?

There is understandable sensitivity about sharing data on FRC clients with DCF or other state agencies. However, in recent years a number of new analytic techniques have been implemented by government agencies in Massachusetts and across the country that allow for a third party to link individual records from multiple data sets across organizations, and create a combined master research file.[120] The linking process is often done by an administrative data center (ADC), a central, often third party, organization that enables a significantly richer analysis of data that can better inform policy, practice, and service delivery than individual agencies' siloed datasets.[121]

Currently, DPH operates an ADC, the Public Health Data (PHD) warehouse. The PHD links individual administrative records across multiple state systems in order to analyze population health trends, with a special priority on the analysis of fatal and nonfatal opioid overdoses. By collecting and linking data from different databases, the PDH is able to help analysts better understand disparities in health outcomes, with a particular focus on high-risk populations. Policymakers can then use this information to inform programming, and to tailor interventions to help eliminate disparities.[122] All ADCs, including the PHD, have strict data protection standards, and any information shared is stripped of any personal identifiable information before being published. Potentially, this research work could be done through the PHD.

Through techniques such as these, these questions can—and we argue, should – be answered without risking families' privacy.

We note that there are a number of other questions related to FRC clients' involvement with the CRA system as well as school attendance/success that would ideally also be evaluated. Although from a technical standpoint these questions could be answered using the same techniques described above, we acknowledge that there are current legal barriers, including barriers to sharing of information on juvenile court proceedings in some circumstances, with regards to matching data using Juvenile Court data or data from schools that would need to be addressed.

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[120] Data can be linked by one, or both of the following methods:

- By using one or more unique identifiers across datasets, such as a social security number, that identifies the same person across two or more datasets, called "deterministic matching."
- By using a common and widely accepted statistical approach that measures the probability that two records represent the same individual in a process, called "probabilistic matching."

This process is often done by a third-party administrative data center. For more information on data linking and administrative data centers, see the JJPAD's FY22 Annual Report here: https://www.mass.gov/doc/jjpad-2022-annual-report/download

[121] For more information see: Office of the Child Advocate. Massachusetts Juvenile Justice Policy and Data Board. (2023 January). "Massachusetts Juvenile Justice System 2022 Annual Report". Page 23. https://www.mass.gov/doc/jjpad-2022-annual-report/download

[122] For example, by linking criminal justice and public health data, the PDH found that individuals with a history of incarceration are at very high risk of opioid-related overdose death, especially during the initial months after being released from an incarceration. This finding helped inform legislation that now requires seven of the county jails and several prison facilities to provide medication for opioid use disorder upon release. For more information see: https://www.mass.gov/doc/jjpad-data-subcommittee-october-13-2022-meeting-presentation/download and the PHD website: https://www.mass.gov/public-health-data-warehouse-phd

Recommendation 1C: Some current FRC functions should be eliminated, de-prioritized, made optional, or offered only in partnership with other state agencies

Although we recommend, below, additional funding for FRCs to support expansion, we also recognize the reality of resource constraints – particularly given the expected budget pressures in FY25 and possibly beyond. Enhancing or adding to the activities currently performed by FRCs likely requires that other activities are eliminated, de-prioritized, or shifted to other agencies.

We did not, in our review, identify activities conducted by FRCs that *are not* worthwhile. There are a variety of services FRCs provide that consumers, staff, and community partners find valuable – and yet still might need to be de-prioritized. When resources are limited, hard choices need to be made.

With the changes in the family support landscape over the last 10 years described in Finding 6, however, there are other agencies that could take responsibility for some of the functions now performed by FRCs, and there are other ways the FRC could more clearly align with, rather than duplicate, work done by others.

Eliminate or heavily de-prioritize: crisis response work

The demands on the Commonwealth's Emergency Assistance Shelter System and the lack of affordable housing has dominated headlines over the past year and occupied a significant amount of time and resources across state government, including FRC staff time. But this is not the first emergency crisis that FRCs have been unexpectedly pulled into. Over time and in response to specific, often more regional, crises like the influx of families from Puerto Rico after Hurricane Maria (2017) or the Merrimack Valley gas explosion (2018), MEMA has reached out to the FRCs as the first point of contact for families affected by a variety of emergency/crisis situations.

Although FRC staff bring many strengths to this work, and have made diligent efforts to meet the community and humanitarian needs as they arise, **FRCs are not staffed or trained to provide the level of intensive supports families in crisis often need –** particularly housing, helping families apply for financial supports, and immigration support —and in the languages they speak.

Several Family Welcome Centers were established in 2023, and all newly arrived families are now diverted to these Centers. The Healey-Driscoll Administration has also established an Incident Command Center, which is focused on transitioning from responding to a crisis to creating a system – which includes Welcome Centers as well as work authorization clinics, legal consultations, and funding dedicated to resettlement agencies. All of these efforts have helped lessen the demands on FRC staff in recent months. This is welcome progress, and also suggests lessons for the future.

> *"[The] FRC is not Red Cross equipped… [we] weren't prepared or trained for dealing with those crises, staff were overwhelmed with many requirements…[The] current training doesn't include anything about emergency response."* – FRC Staff Member

Our strong recommendation is that FRCs not be tapped for this kind of crisis response work in the future. While FRC staff are certainly equipped to help families once they are settled in a given community with basic needs and parenting supports, they should not be the "first line" for supporting families living in shelters in obtaining housing, emergency basic needs support, or navigating our immigration system. Crisis response requires an immediate "all in" response; when FRC staff try to meet this need, it necessarily diverts their energy and attention from their other important functions. It also contributes to high levels of stress, burnout, and turnover. If we want FRCs to be successful at their core functions, we need to allow them to focus.

Designing a new crisis response system goes beyond the scope of this report, but we highlight it here because, **in the absence of an alternative state crisis response system, FRCs will continue to be asked to step up in times of crisis** – and if history is any indication, they will step up to the detriment of other important work. The state must make a concerted effort to determine what other agencies are better positioned to be this first responder, building on the work already being done by the Healey-Driscoll Administration as described above.

If this recommendation is not implemented, our alternative recommendation is that funding, staffing, and training for FRCs be adjusted to ensure they have staff with the capacity to focus on crisis work and access to flexible funding to respond quickly in emergencies *without* diverting them from their other core functions.

Develop partnerships for support: housing

Supporting families in obtaining affordable housing and/or avoiding eviction is a complex process, and it requires someone with expertise in navigating the myriad of housing support services, housing authority waitlists, and federal and state voucher systems. Although FRC staff could conceivably learn these systems – and some clearly have already – this service area is complex enough that it would be more efficient to develop partnerships with agencies who specialize in this area.

The recent creation of a new Secretariat focused on housing (the Executive Office of Housing and Living Communities) presents such an opportunity. EOHLC could co-locate housing support services at FRCs. FRC expert system navigators could still help families connect with these resources, but the specific work of identifying which housing programs a family might be eligible for and navigating application processes would be done by a housing specialist.

Recommendations for how DCF, EOHHS, and EOHLC can support FRCs in negotiating these partnerships is further discussed in Recommendation 3.

Re-align the work of FRCs with the work of other state and local agencies and reduce/eliminate duplication: behavioral health

As described in *The FRC Model*, FRCs employ a full-time clinician and family partner, which provide a variety of clinical services to families. Although these staff are primarily expected to conduct screenings/assessments and develop and help families implement service plans for families experiencing CRA-related issues, they also facilitate groups and provide consultation to other family members. In practice, clinicians and family partners are a part of the staff team, and regularly "pitch in" to support families who come to the FRC in a variety of ways.

These services are clearly valuable to the families that receive them, many of whom are on lengthy waitlists for behavioral health services already. Several focus group participants specifically discussed how helpful peer support and therapeutic groups run by FRCs were to them and their family.

At the same time, as described in Finding 3, **many FRCs have struggled to hire and retain clinicians.** The CY23 vacancy rate for clinicians was 26%, with five FRCs reporting that the clinician position at their site had been vacant more than 300 days.

> *"Severe understaffing. Haven't had a clinician for two years or maybe longer. School Liaison is out on extended medical leave, so [I am] taking on those roles, no clinical support, and incredibly difficult to find clinicians to help out with CANS."* - FRC Staff

While many PMPDs strongly support having clinicians on staff, a couple of FRC PMPD focus group participants suggested that the clinician role should be eliminated and replaced with something else, given both the hiring and retention challenges as well as the limitations on what FRC clinicians can and cannot do. As one PMPD put it, "*As part of a parent program that is not a mental health clinic, it is difficult when clients come to us thinking we can offer therapy… I would like to not have clinician here as it is confusing and frustrating for the community."* Another stated, "*I strongly encourage a look at adding more Family Support Workers to each FRC and not having a Clinician in a time when they are in such high demand and we cannot offer competitive wages."*

However, all PMPD survey respondents proposed having clinicians on staff, while 43% proposed having more than one clinician.

As detailed in Finding 6, the behavioral health landscape has changed considerably since the FRC service model was designed. In light of these current and planned changes to the behavioral health landscape, as well as the current challenges FRCs have faced in hiring and retaining clinicians, the state should consider what the best role for FRCs is as part of this larger system moving forward.

There are likely redundancies that can be eliminated; for example, if the state is operating a Behavioral Health Help Line to track service availability and make referrals, it is duplicative and likely unnecessary for each local FRC to separately identify local behavioral health providers and

keep referral lists. It seems likely that processes for streamlining referrals to CBHCs can also be streamlined.

At the same time, our behavioral health system is extraordinarily complicated – insurance and other eligibility requirements can be difficult to navigate, terminology, jargon, and acronyms for all the various services can be confusing, and the provider landscape is constantly changing. FRC staff have the capacity to build trust with families and help them overcome any individual barriers and frustrating situations.

The goal, then, is to determine how the state can best utilize the strengths of FRCs while reducing unnecessary areas of overlap. To do this, the state – including representatives from EOHHS, DCF, MassHealth, DMH, DPH (BSAS), and DDS – should develop **a coordinated plan to ensure that families with behavioral health challenges who use the FRCs are able to access the most appropriate services available to them when they need them.**

This review should consider:

- Whether the current FRC screening and assessment procedures related to behavioral health are necessary and in alignment with best practices, or if adjustments should be made. Such a review might include developing agreement on common screening and assessment tools that schools, court clinics, BHHL, CBHCs, CBHI providers, and FRCs would use with families to determine what supports best meet CRA-at risk families' needs and how organizations will work together to prevent duplicative screenings/assessments prior to families accessing services.
- What steps FRCs should take to connect caregivers with behavioral health services when a need has been identified, and how this process can be streamlined
- What formal connections should exist between FRCs, CBHCs, and CBHI providers
- What unique role FRC staff should play in helping families navigate the behavioral health system as part of their expert system navigator role
- If there is a role family partners can play, assuming adequate staffing and training, to help families with less intensive behavioral health needs
- If it is determined that the clinician role is still a vital part of the model, what steps can be taken to address challenges in filling vacancies, including reconsidering licensure requirements
- What gaps exist that FRCs are especially poised to help fill, particularly for the proposed new target population

Re-align the work of FRCs with the work of other state and local agencies and reduce/eliminate duplication: parenting education

As described in Finding 6, there are a variety of state agencies providing and/or funding group parenting support that is available to all caregivers: DCF through FRCs, the Children's Trust through seven Family Centers, and EEC through 81 CFCEs. Other agencies also offer parenting support to specialized populations. All of this is in addition to parenting classes organized at the local level through municipal governments and/or community non-profits organizations, like

PPAL, and in-home parenting support/education provided through services like Early Intervention.

The re-procurement of the FRCs provides an opportunity to examine this patchwork of group parenting supports more holistically, how they can and should interconnect, and develop a coordinated statewide plan with defined roles for each relevant state agency.

To start, we recommend that EOHHS, DCF, EEC, and the Children's Trust jointly develop a statewide plan for group parenting classes/support that is universally available to families with children from birth to 17. This plan should:

- **Ensure that the appropriate array of group parenting classes is available statewide**, reducing redundancies where possible. This includes groups that meet the needs of parents and other caregivers of children of various ages as well as caregivers who speak a primary language other than English. It also includes groups that meet DCF's needs for classes that DCF-involved caregivers can attend as part of their DCF case plans. Given the success some FRCs have had with virtual classes, the array should likely include a mix of in-person and virtual options. Transportation and access barriers should be considered when looking at class availability across the state.

- **Identify which state agenc(ies) should provide which group parenting classes,** and how parents will be referred to the appropriate class. Shared locations could also be explored: one agency might be responsible for delivering a certain class but it could take place at multiple locations, including the FRC, a local library or community center, or a school.

- **Identify a mechanism for coordination with local efforts.** Keeping track of *every* parenting class offered by every local organization is likely difficult but if the state designated *one* agency to lead this effort, that agency could likely identify mechanisms for improving coordination or at least mutual awareness of efforts at the local level—for example, all state funded organizations could agree to maintain one online calendaring systems.

- **Establishing core curricula** that is adapted for various age ranges and recognizes the cultural and linguistic needs of all families, including evidence-based and informed classes as well as more informal workshops and groups, and enhancing training for individuals teaching parenting classes and delivering group support. Ideally, identifying and developing curricula and training would be centralized and delivered by one entity.

Without prejudging the outcomes of such a coordinated planning process, it might be that FRCs' role as a provider of some group parenting classes, especially for parents of younger children, may shift as a result of this process. If so, this could free up time that FRC staff can spend on

highly targeted parenting classes and/or providing *individual* parenting and other supports to families at risk of child protective services or CRA involvement.

We recognize that classes and support groups help build trusting relationships and lead families to be more comfortable asking for help, so any shift must weigh that benefit with any benefits of moving classes to another venue and consider ways to ensure "warm connections" exist between externally led classes and the FRC. At the same time, as described in the findings, above, many FRCs have found it difficult to fill certain classes, possibly due to the fact that there are "competing" offerings in the same community.

Consider de-prioritizing or shifting focus: recreational activities and food/clothing/holiday drives

Focus groups of both FRC consumers and staff emphasized the value of **recreational activities** in building community, reducing social isolation for parents, and increasing awareness of the FRC. Similarly, **food/clothing/holiday drives** both help increase awareness and address the basic need issues we have highlighted as an important priority for FRCs. We agree with these assessments and recognize the value of these activities.

We note, however, that there seems to be wide variation in the extent to which specific FRCs emphasize these activities and how much staff time they devote to them. This may be driven by variations in what is available in given communities, staff interest/preference for hosting these activities, or some combination of the two. We also note that hosting these activities can be logistically complicated and can occupy significant staff time and attention.

We recommend that FRCs continue to play some role in connecting families with food/clothing/holiday drives to support basic needs, ideally in partnership with others, taking into account the extent to which such services may or may not exist in their local community. Similarly, we recommend that FRCs continue to host some recreational activities for families. However, we also recommend that DCF and FRCs take a close look at the overall *volume and intensity* of recreational activities and food/clothing/holiday drives and their role in the overall FRC Service Model as part of re-procurement.

Recommendation 2: Expand funding for FRCs, which should be funneled toward increasing staff and expanding sites

De-prioritization and/or shifting of some activities to other agencies can only create so much additional time in an FRC staff member's day. To reach the much larger universe of families we believe could benefit from FRC support *and* increase the level of individualized supports FRCs are able to provide at-risk families, additional resources are needed. We recommend three ways additional resources should be deployed:

- **Recommendation 2A:** Open more FRC sites to improve access for families who are most in need of services
- **Recommendation 2B:** Expand funding available to each FRC through a more flexible contract model in the next procurement
- **Recommendation 2C:** The state should explore whether all available federal funding – especially Medicaid funding – is being secured to support FRC budgets and whether there are ways to better leverage other state funds

Recommendation 2A: Open more FRC sites to improve access for families who are most in need of services.

As described in Finding 4, above, there are still many areas of the state where an FRC is not easily accessible, particularly for families reliant on public transportation. **Opening more FRC offices across the state would make it easier for families who most need help to participate in services.**

Expanding virtual options (which were often effectively used during the pandemic when offices were closed) **should be part of the solution to reaching more families– but they are not the whole solution.** We heard in focus groups of FRC staff, as well as FRC consumers, that families have very busy lives and some prefer accessing supports, especially classes, virtually. We also know of examples from other services, such as EEC's Professional Development Centers where certain PDCs took responsibility during the pandemic for offering virtual classes for the entire network, that online and other virtual approaches can work. However, some FRC consumers also expressed a strong preference for in-person activities as a way of reducing isolation and building community, and some also raised issues related to technology barriers. We also know from research that for families facing complex challenges, ongoing and relationship-based approaches are likely to be the most effective.[123]

Appendix C provides examples of a number of areas in the state that data suggests would benefit from an FRC. This is not meant to be a specific recommendation for an FRC in these

[123] Urban Institute. (2024). Coordinating Services for Families with Children from Birth to Age: A Landscape Review of Initiatives in Massachusetts. https://www.urban.org/research/publication/coordinating-services-families-children-birth-age-5-landscape-review

areas, however. We recognize that DCF has taken into account some of the same factors, and more, when it has expanded the number of FRCs in the past – including rates of poverty, crime, school discipline, single parent families, unemployment, and involvement with DCF. We include these examples simply to provide support for our argument that the state is not yet "saturated" with FRCs, and that expansion should be considered as a part of re-procurement.

We also note that there may be opportunities to **open more satellite offices to expand access.** With support from state government where possible, FRCs could develop partnerships with local housing authorities, schools, municipalities, courts, and community-based organizations to host "FRC Office Days" in areas where an FRC is not readily accessible. Although families accessing a satellite may not be able to take advantage of every service an FRC offers, this option would work for families who are primarily in need of navigation support. This would help reduce barriers to access for families who are not near an FRC or able to easily get to one.

Recommendation 2B: Expand funding available to each FRC through a more flexible contract model in the next procurement

As discussed above, we believe that at least some and possibly all FRCs need additional staff to meet the needs of their communities. Here, we discuss four recommendations for changes DCF should consider in a new contract model as part of an upcoming procurement:

- **Create a flexible staffing model to allow for the possibility of increased staffing/budget at some FRCs:** The current contract model provides for the same funding level for all FRCs.[124] We endorse DCF's approach of requiring minimum staffing levels and certain staff functions that must be included within the FRCs core staffing. We also note that the necessary minimum number of staff and specific staff functions may change if other recommendations in this report are adopted. However, we also recommend that the new procurement provide for the possibility of increased staffing – and budget—above the minimum at some FRCs to reflect differences in both the size of the population and the geography to be covered as well as specific service needs in various communities. Even if the number of FRCs is expanded in the next procurement, it is likely that there will still be differences across FRCs in factors that will have an impact on workload.

  The analysis that will need to be conducted to determine where to add additional FRCs should also be helpful in determining what additional staffing will be needed for FRCs covering larger numbers of the families we are recommending they focus on—those who are at risk, or continued risk, of child protective services and/or CRA system involvement. There is also data from DCF, DTA, other state agencies, schools, and the Juvenile Court that will allow each FRC to have a "target" number of families they are expected to reach.

[124] In FY24, DCF did offer the FRCs the opportunity to request additional one-time funding to reflect additional workload they were taking on. However, without the commitment of ongoing funding at a higher level, FRCs, like most organizations, may be hesitant to use those funds to increase permanent staff.

While setting this target will likely be as much “art” as “science”, it will allow DCF and the FRCs to consider staffing levels for outreach, direct delivery of core services, and referral partnerships needed to reach these target focus families, as well as the level of staffing for navigation support available for all families. In addition, FRCs serving larger geographic areas will also likely need adjustments to the minimum budget/staffing to account for time they will likely spend in satellite offices to minimize some of the transportation challenges families face.

- **Adjust staffing and budgets to account for differences in the referral sources and services that are available in communities.** For example, if there are more schools and/or courts in an FRC service area than the average number built into the methodology to calculate minimum staffing levels, FRCs should be given the option to request funding for staff above the minimum levels to work with the schools and courts to provide more direct supports to families at those sites.

  In addition, DCF should require updated needs assessments prior to awarding new contracts to identify availability of, and waitlist trends for, services that will most meet the needs of the populations we are recommending for FRC focus. With this information, agencies bidding in the next procurement should be given the option of bidding for additional resources, above the minimum budget, to address those gaps.

  For example, in areas with fewer activities for older youth, FRCs could be given the option to add more staff to build relationships with youth and offer specific programming for them—such as mentors, stipended peer led groups, or workshops on finding jobs. Or, in response to the challenge of inadequate behavioral health clinical services, FRCs might have the option of seeking additional funds to increase training, professional development, and possibly certification opportunities for their staff to increase their skills in one-on-one support for families with less intensive clinical needs who need guidance with more day-to-day problem management. Flex funds could possibly also be used to support running therapeutic groups for families awaiting other behavioral health services if there was a demonstrated need.

  Implementation of the above two recommendations for more flexible funding based on demand (size of population and geography) and supply (availability of services) will require careful consideration of the components of the minimum staffing and budget levels and whether to offer specific categories for which FRCs could require specific funds or leave it open-ended. It will also be important that FRCs periodically re-apply for any increase in additional funds above the minimum staffing and/or budget level. The landscape in which FRCs operate will change, just as it has over the last ten years.

Requiring FRCs to justify the continuing need for the increases, or for new/additional increases, will be important.[125]

- **Examine FRC salaries and annual underspend at specific FRCs:** While every FRC currently receives the same funding level from DCF and has the same required minimum staffing levels, staff compensation at different FRCs varies. Some FRCs have expressed concern in interviews, focus groups, and a survey about the level of salaries the contract amount allows them to pay and the differences across the network in the salary levels.

  As described above, EOHHS is the rate setting authority. While the established rates support certain salary levels, providers are not obligated to compensate at that level. The amount paid to provider staff is ultimately the decision of the community-based organization with which DCF contracts, and DCF does not set minimum salaries.

  DCF can request information at the end of a contract year to better understand any underspending by contractors, and we recommend that such an analysis occur prior to re-procurement. To the extent it is possible under state contracting requirements, we recommend that DCF explore pathways to establishing minimum salary ranges for the FRC positions, and to require reporting on the rationale if an FRC pays salaries outside of the range.

- **Consider limiting future FRCs' contracts to agencies that operate a CBHC or otherwise provide behavioral health services to children and adults:** Finally, the current FRC contract requires that an FRC partner with a Licensed Mental Health Clinic, either through a subcontract or through an internal agreement where the FRC parent agency operates a LMHC.[126] It also requires that the LMHC provide priority access to ongoing clinical services for CRA-related families referred by the clinician and family partner to the LMHC.[127] While 90% of PMPD survey respondents reported that they do refer to LMHCs and other community organizations, including CBHCs and CBHIs, we heard from many that families they refer face long waitlists for behavioral health treatment.

  As detailed in Recommendation 1C, prior to re-procurement DCF should work with EOHHS's Office of Behavioral Health and DMH to determine what behavioral health supports exist — that were not available when the FRC service model was designed — that FRC families can access and the best ways for FRCs to leverage them. As a part of those discussions, we recommend that the agencies consider where and how to provide

[125] How often to require this? Certainly, less often than annually as it will take time for FRCs to add any capacity authorized and begin to see differences. This will require more discussion with FRCs, but every 3 or 5 years might be a reasonable starting point. This should also be tied to new success metrics: evaluating both the need for the additional funds and the effectiveness of a particular use of them will be an important part of FRC's self-evaluation and DCF's contract management.
[126] Seventy-two percent of FRC parent agencies are either behavioral health providers (63%) or offers some licensed mental health services (9%).
[127] For more information, see DCF's 2014 RFR establishing FRCs: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-15-1039-EHS01-EHS01-00000001071&external=true&parentUrl=close

warm handoffs for FRC families in need of behavioral health services (both CRA-related and those at risk of child protective services involvement), what type of screening (potentially instead of a full assessment) the FRC should do prior to that referral, and how to ensure priority access at least for those FRC families in need of immediate support. To streamline referrals and potentially give priority access agreements more "teeth," we also recommend that DCF consider limiting future FRC contracts to agencies that operate CBHCs or that otherwise provide behavioral health crisis and ongoing treatment to both adults and children.

Recommendation 2C: The state should explore whether all available federal funding – especially Medicaid funding – is being secured to support FRC budgets and whether there are ways to better leverage other state funds

Once agreement is reached on an expanded and consistent set of FRC functions, the state should determine whether there are sources of federal money which have not yet been tapped or other state dollars that could be better leveraged to fund the expanded FRCs. Such an analysis should also look at any increased administrative burden on FRCs or the state to access such funding.

This analysis is beyond the scope of this report. However, a few examples which may be worth further study include:

- **Federal Medicaid Administrative Activities (MAA**): A network of 15 FRCs in San Francisco are piloting a program that taps into federal MAA funds to reimburse some of their work. A team identified FRC activities that met MAA program guidelines and helped connect Medicaid-eligible families to services, including:
    - Resource navigation
    - Referral and care coordination
    - Eligibility and enrollment
    - Outreach

  While this has entailed a two-year planning process, identifying appropriate billing codes and training staff, it is estimated by a team lead in the article that this approach may yield an annual revenue stream of $750,000 of *unrestricted* reimbursable funds for the participating agencies.[128]

- DCF already uses **Medicaid funds for targeted case management**. The targeted case management services include comprehensive assessment and periodic reassessment of eligible individuals to determine service needs; development (and periodic revision) of a specific care plan; referral and related activities to needed services and monitoring and follow-up of needed services. Depending on what, if any, case management services FRCs

[128] Casey Family Programs. (22023). Can Medicaid be leveraged as a sustainable source of prevention funding for family resource centers?". https://www.casey.org/medicaid-frc-san-francisco/

will be required to provide through the next procurement, this source of funds could be considered.

- Certain **CBHI** activities might be able to be offered on site at FRCs. One likely candidate would be therapeutic mentors, a service which we heard in focus groups of FRC staff would be valuable if more available to CRA at-risk youth with mental health challenges.

- Some of the clinicians working in the FRCs are now providing some short-term treatment to FRC families, but none currently bill MassHealth or private insurance when providing those services to eligible individuals. If clinical mental health services continue to be an offering in some or all of the FRCs, **insurance billing could be considered**.[129]

[129] We include this idea with reservations, as many Clinicians interviewed for this report noted that "not having to deal with insurance and billing" was a major draw of the job, and understandably so. However, low pay was also a frequently cited concern for the Clinician position. If billing could allow for increased pay rates, it may be a trade-off worth considering.

Recommendation 3: Enhance support from, and integration with, other state systems and services

To maximize the impact of FRCs, the Commonwealth needs a more coordinated approach to family support. Family support services are community-based services that assist and support parents in their role as caregivers.[130] All families can benefit from support in some way, but family support services are often designed to meet the unique needs of families who are at the highest risk for poor outcomes (including involvement with the child welfare system) including, but not limited to, families who experience financial insecurity, adolescent parents, immigrant parents, and families facing health, mental health, substance use, or other disability issues.

We do not have one central agency in the Commonwealth that focuses on family support. These supports are scattered across state government, with various family support services housed at multiple agencies. This decentralized service structure has led to services being designed and delivered to solve a specific issue in a specific area of a family's life (e.g., housing insecurity, substance misuse, domestic violence, child maltreatment) rather than looking at the needs of the child and family holistically and serving those needs in an integrated, coordinated fashion. This makes it more challenging for families to access the full array of needed services, and more likely that important needs are missed.

As an EOHHS report highlighted over a decade ago, this approach has "created an unintentional burden on individuals and families who have to navigate multiple government agencies to identify and obtain services."[131]

FRCs often help provide navigation support for families, and in Recommendation 1 we recommend this function be enhanced in a new procurement. **They could serve as a much more effective "front door," however, if the Commonwealth better aligned our multiple family support programs into a more coordinated system.**

The Commonwealth's family support strategy is ultimately beyond the scope of this report – and yet **it is the fundamental challenge that needs to be addressed to elevate FRCs to their full potential and, more importantly, ensure a true family support system in the Commonwealth**. In this section, we make both short and long-term recommendations toward a more coordinated approach to family support and prevention, and how FRCs should fit into that, without offering a full vision for what that strategy and system should be. These include:

- **Recommendation 3A:** FRCs should be operated by a state agency (or division within a state agency) with a strong focus on family support

[130] Children's Bureau. (n.d.). Family Support Services. Child Welfare Information Gateway. https://www.childwelfare.gov/topics/supporting/support-services/

[131] Children, Youth, and Families Advisory Committee. (2012, January). Recommendations for strengthening children, youth, and family services in Massachusetts. Commonwealth of Massachusetts Executive Office of Health and Human Services. https://www.mass.gov/doc/children-youth-and-families-cyf-advisory-committee-final-report-january-10-2012/download

- **Recommendation 3B:** DCF (with support from EOHHS as needed) should negotiate formal partnerships at the state or regional level to expand the expertise available to families at FRCs and to ensure consistent referral options for FRC families
- **Recommendation 3C**: The State should enhance EOHHS's ability to plan and oversee the management of a family support system that meets the needs of the Commonwealth families
- **Recommendation 3D:** The advisory structure for the FRCs should be revised

Recommendation 3A. FRCs should be operated by a state agency (or division within a state agency) with a strong focus on family support

FRCs are providing critical support for families across the state – and, as this report suggests, they can be doing even more. Yet, they are a small program with a small budget in the context of DCF's broader structure, mission, and budget, most of which is focused on child protection rather than prevention of maltreatment. Indeed, many of the Commonwealth's family support programs are relatively small line items in a variety of agencies, most of which have much larger budgets. This makes it understandably difficult for the programs to rise to the level of attention of a Commissioner or Secretary when they have pressing problems or otherwise need support.

Other states have taken a different approach, creating operational divisions or entire agencies specifically focused on family support and prevention. These divisions or agencies look at the state's system of family supports more holistically, while giving them the higher-level attention and focus they need.

Ultimately, FRCs should be operated by a state agency (or division within a state agency) that has a strong and central focus on family support and be better connected to other family support efforts in the Commonwealth. Recognizing that this recommendation is beyond the scope of this report and that additional work is needed to determine the best path forward, we offer some suggestions on potential options to advance the conversation:

- **Create an expanded family support division with additional staffing and sufficient funding within DCF that focuses specifically on prevention and family support.** This approach could have the benefit of enabling our child welfare system to increasingly focus on a tiered approach to the prevention of maltreatment and promotion of family preservation. Similar organizational structures in other states that could serve as a model include:
    - New York's Division of Child Welfare and Community Services within the State's Office of Children and Family Services,[132] which oversees child protection and foster care, in addition to preventative services such as home visiting, domestic violence supports, and respite care.

[132] New York Office of Children and Family Services. (n.d.). About OCFS. https://ocfs.ny.gov/main/about/

- The Division of Prevention Services within the New York City Administration for Children's Services,[133] which oversees and monitors community-based preventive services for children and their caregivers at high risk of involvement with the child welfare system (e.g., team conferencing, crisis intervention).
- The Division of Family and Community Partnerships within the New Jersey Department of Children and Families,[134] which includes an office of Early Childhood Services, an Office of Family Support Services, and an Office of School-Linked Services. These offices work across state government and with state and local advocates to ensure coordination of services, particularly for families of children birth to five.
- The Division of Child and Family Services in Utah[135], which houses services related to child protection as well prevention services (e.g. home visiting, Help Me Grow), in-home services to support family preservation, foster and kinship care, and services for transition age youth.

- **Integrate family support programs in an agency dedicated more broadly to financial support, such as DTA.** This approach is similar to Vermont's Department for Children and Families which, in addition to more traditional child welfare programs, operates a wide array of programs to help families meet basic needs, such as employment, housing, child care, and food assistance. This approach could have the benefit of integrating a broader continuum of child, individual, and family support services within one umbrella agency and addressing some of the reluctance families may have in reaching out to a child protection agency.

Whatever approach is taken, FRCs will remain critical to ensuring the overall system has a warm and welcome "front door" to support families.

Recommendation 3B. DCF (with support from EOHHS as needed) should negotiate formal partnerships at the state or regional level to expand the expertise available to families at FRCs and to ensure consistent referral options for FRC families

The statute creating the FRCs requires FRCs to identify a network of community-based supports to which the FRCs can refer. As discussed in *The FRC Model,* the FRC contract lists 23 specific service types that are required to be part of this network. Currently, each FRC is expected to find and develop referral relationships on their own with the appropriate organizations providing these services. While this may make sense in some cases when the services are provided entirely at the local level – coordinating with an independent local food bank, for example – many of these services are funded and/or operated by state agencies.

[133]NYC Administration for Children's Services. (n.d.). NYC Children. https://www.nyc.gov/site/acs/index.page
[134] New Jersey Department of Children and Families. (n.d.). About Us. https://www.nj.gov/dcf/about/
[135] Utah Department of Health and Human Services (n.d.). Division of Community Health and Well-Being. https://dhhs.utah.gov/divisions/#communityhealth

Recently, DCF has begun facilitating conversations among FRCs about the types of partnership arrangements they have negotiated, but there are likely certain relationships where more formal and consistent agreements could be negotiated at the regional or statewide level with state agencies that are either the direct provider of a service, such as DMH, or the funder of a service, or large community-based agencies themselves.

While implementation of this recommendation will require a more detailed analysis of the types of relationships that will most benefit families, the following models should be considered:

- **Co-location of state services:** DCF/EOHHS could negotiate or expand co-location agreements with other state agencies that provide (directly or through vendors) specialized support that families coming to FRCs need. For example, FRCs could provide space in an FRC office where, on a regular and scheduled basis, a representative from DTA helps families complete SNAP, WIC or TANF applications, or where a representative from EOHLC (or an EOHLC-funded provider agency) helps with RAFT housing applications. This could help reach families who, because of transportation challenges or schedules or their own complex lives, find it difficult to access those services.

  At the same time, FRC staff can help serve as expert navigators to these various services, including providing linguistic and/or cultural navigation support where needed. The agreements could also identify situations where the FRCs would deliver services, including navigation support, on-site at other agencies, such as organizations providing basic needs supports, like a local food pantry or, specialized services for families like Community Health Centers, CBHCs, or schools.

- **Increasing alignment between FRCs and other family service centers**, including Family Centers operated by the Children's Trust, CFCEs operated by EEC, and family centers operated by DDS.

- **Expansion of the relationship between FRCs and MHAP for Kids** so that at least one MHAP for Kids attorney is in every FRC office, expanding and enhancing the individual case consultation and training MHAP for Kids provides to FRC staff as well as individual family advocacy.

- **Development of Memoranda of Understanding (MOUs) outlining clear processes for how FRCs and the other agencies that refer to or from FRCs will work together.** For example, the MOU may designate specific individuals to serve as a point person for each FRC and lay out options for offering families warm handoffs with the family present and continued follow up to be sure they receive the help they need.

- **Agreements for streamlined intake processes and/or sharing information where relevant and agreed to by the family to create more efficient enrollment processes for**

families the FRC assesses as needing specialized or more intensive services to prevent child protective services or CRA system involvement, such as home visiting or behavioral health services.

Importantly, the work to evaluate the feasibility of, and implement, these recommendations cannot be done at the community level alone. Although the landscape of each community will need to be considered to decide what is possible/necessary, DCF and the state agencies funding these other services need to provide the direction and the guidance for how to implement this recommendation, taking into context individual community needs and existing infrastructure.

Recommendation 3C. The State should enhance EOHHS's ability to plan and oversee the management of a family support system that meets the needs of the Commonwealth families

As discussed in the introduction to this section, family support services are provided by multiple agencies—directly and through contracts—which are part of EOHHS, EOE, and EOHLC. FRCs can and should be the community-based agency that "connects the dots" across all these supports – but they cannot do it without significant planning and coordination across the state agencies responsible for delivery of those services.

As the OCA has found in other reviews, **greater coordination across all family and child serving services and agencies would both streamline and make more effective the supports families receive.** Examples of the areas where a greater level of coordination across agencies and secretariats would be valuable include service planning and purchases; data collection, evaluation, and reporting; needs assessment; selection and implementation of screening and assessment tools and processes; communication and marketing of state services; and resource finding and data sharing platforms and navigation tools. There are examples from other states where structures have been created to do this. (See Appendix D).

For purposes of this review of FRCs, however, the OCA will focus this recommendation more narrowly on *family support services*, recognizing that if the above functions can be strategically coordinated for family support, then the same systems and structures could eventually be broadened to other child and family services.

The Healey-Driscoll Administration already has an infrastructure in place at EOHHS that can be built on to coordinate the planning and procurement of all family support services: there is an Undersecretary of Human Services, an Office for Children, Youth and Families, as well as a Purchase of Service Policy Office, all of which could be leveraged to implement the recommendations in this report. Ideas for capitalizing on this existing infrastructure include:

- **Service Procurement Planning and Alignment:** M.G.L. Chapter 257 of the Acts of 2008 authorizes EOHHS to set reimbursement rates for all human and social services procured

by EOHHS agencies.[136] The Purchase of Service Policy Office could be expanded with a planning function for all family support services—assessing what needs families have, what service models would best meet those needs, what outcomes can be expected from these models, and how program implementation and outcomes should be tracked and evaluated. Part of this planning function could include determining which of its agencies should have responsibility to procure what services and aligning contract requirements and procurement timetables and scopes. The Office could also be given responsibility for negotiating agreements with non-EOHHS agencies regarding their roles in supporting the EOHHS agencies in these roles.

As just one example, there could be a coordinated planning process to determine a menu of services which should be available in communities to address the needs of families at risk of involvement with the child protective services or CRA system. It could then broker agreements regarding which agency will deliver or procure those services in communities.

- **Standardized State and Community Needs Assessment:** This Office could also be responsible for standardizing EOHHS agency use of community needs assessments. Agencies responding to the FRC procurement were required to submit a community needs assessment as a part of their bid—and we recommended earlier that new assessments should be submitted as part of the reprocurement. While it is important that FRCs understand the resources in their communities and how to access those resources, there are already multiple types of needs assessments conducted by local and state agencies, which are often required as a condition of federal and state contracts and grants.[137] Some of these are also required to be updated on a regular basis. Instead of requiring FRCs and other state funded agencies to find and adapt, as needed, those to family supports in their specific communities, we recommend that EOHHS review currently required needs assessments that most address a community's family support systems—its strengths and gaps—and either (1) provide guidance to its agencies on how to use these to more consistently document and periodically update community needs, or (2) implement a regular and standardized community needs assessment process. As part of this, EOHHS could also consider how FRCs and other referring agencies document any needed services that are persistently unavailable in their community —a "living" needs assessment—and determine responsibility for how that information is "rolled up" on a regular basis and analyzed so that it can be acted

[136] Massachusetts Office of the State Auditor. (n.d.). "Overview of Chapter 257 of the Acts of 2008". https://www.mass.gov/info-details/overview-of-chapter-257-of-the-acts-of-2008

[137] See, for example, DPH 's statewide needs assessment in 2020 for the Maternal, Infant, and Early Childhood Home Visiting Program (https://www.mass.gov/doc/needs-assessment/download), Boston Children's Hospital's Community Health Needs Assessment (https://www.childrenshospital.org/community-health/needs), or a 2023 assessment done by Community Action Pioneer Valley (https://wpcapv.wpengine.com/wp-content/uploads/2023/08/CAPV-2023-Community-Assessment-BoD-approved-1.pdf.)

upon when significant gaps statewide or in a community are identified.

- **Centralized Vendor Support Services:** This Office could also determine what supports the state could offer all contracting human service agencies, which would make services more effective and efficient and reduce some redundant efforts that individual agencies (state and/or contracted) now undertake alone. These might include a centralized translation service, access to the language line state agencies use, standard marketing materials, a standard platform or portal for all family support resources, or one data management system that can be customized by service types and used for consistent data collection and reporting across multiple programs.

We could make much more detailed recommendations for each of the functions we are suggesting, but we recognize that just putting in place the infrastructure to plan and execute this is a massive undertaking that would require commitment, staffing, and a plan to be implemented over a multi-year period. We believe the ultimate payoff would be a significant increase in efficiency of state spending on family support services and a substantial improvement in outcomes for children and families.

Recommendation 3D. The advisory structure for the FRCs should be revised

As a state, we regularly create new boards and commissions to oversee implementation of legislation; less frequently do we sunset these groups when they have achieved their initial purpose.

We believe the Families and Children Requiring Assistance Advisory Board (FACRA) is an example of a group that has achieved its purpose.[138] The FACRA Board has monitored and reported on the work of the FRCs since their inception. In 2013, Advisory Board members participated in multiple public dialogue sessions sponsored by EOHHS to obtain community input regarding program design for FRC services. Since then, the FACRA has continued to receive information on the work of the FRCs and challenges they face and offer advice to EOHHS and DCF on the continued growth of the network and best practices which can be expanded. They do this through quarterly meetings where DCF, UMass (the ASO for the FRCs), the FRCs, and other providers and experts within the family support field present on the work of the FRCs, the challenges they face, and other initiatives that are available to support the families served by the FRCs.

FACRA has done this work well for over a decade – but over time, it has become clear that as FRCs have moved from “start up” to “full implementation” mode, there are fewer strategic questions for FACRA’s consideration.

As detailed throughout this report, however, there are multiple opportunities to strengthen FRCs within the context of the overall family support landscape. If we continue to focus solely

[138] We note that the Child Advocate is an appointee to the FACRA Board.

on what the FRCs are doing, we miss a critical opportunity to examine how FRCs can fit into, and be supported by, the larger systems of health, human services, housing, and education.

As FRCs move into a new phase, as recommended in this report, we believe it is time to develop a new structure that can help coordinate the multiple agencies and initiatives which are delivering valuable, but often disconnected, services to families. We believe this structure should be led by the Secretaries of EOHHS, EOHLC, and EOE. It could be called the Family Support Coordinating Council (FSCC), and it could be convened by the Administration without any action by the Legislature.

The FSCC could meet on a semi-regular basis, perhaps bi-annually, to discuss – and, ultimately, document for the public – the various family support initiatives and ensure alignment across agencies, secretariats, and even branches and levels of government. This could be an opportunity to ensure that FRCs are well connected to the larger system of government – that FRCs have the connections to other state agencies that they need, and that other agencies know about any relevant changes at the FRCs.

In addition to the three Secretaries (or high-level designees), membership of this FSCC should include the Chief Justice of the Juvenile Court, the Commissioners of DCF, DTA, DMH, DPH, DYS, DDS, EEC, DESE, the Executive Director of the Children's Trust, and the Child Advocate.[139]

There should also be appropriate mechanisms for incorporating the perspective of providers, advocacy organizations, and consumers. This could include adding representatives from these organizations to the FSCC and/or holding regular public comment sessions. Acknowledging that many public stakeholders may not be able to attend meetings to share their thoughts, the FSCC could also implement surveys, feedback sessions, and/or focus groups. The OCA would be happy to offer support for these feedback-gathering activities.

[139] Or high-level designees

Conclusion

It has been nearly twelve years since the passage of *An Act Regarding Families and Children Engaged in Services* and the first procurement of the Family Resource Centers. It took time to implement FRCs across the state, establish and fine tune the original model, and collect sufficient data to understand how FRCs are working and what impact they are having. In this period, there have also been substantial changes in the behavioral health and human services landscape in Massachusetts.

After approximately a decade of implementation and with all of the learnings and new information we have, **this is the right moment to revisit the original vision and plans for the FRC network and forge a plan for the future with the new information available.**

It is clear from this report that much about the FRC model is working well to support families and children in the Commonwealth; there is a strong foundation to build upon. At the same time, there are also opportunities to expand access and improve service delivery, as outlined in this report.

Many of the recommendations of this report would ultimately need to be implemented by the Department of Children and Families and the Executive Office of Health and Human Services through a detailed procurement planning process, as well as other planning efforts to align the FRC work with other family support and behavioral health programs operated and/or funded by EOHHS and its related agencies as well as EOE, EEC and DESE and EOHLC.

However, there are a number of concrete actions the Legislature could take to advance these Recommendations, through statute change and allocations in the state budget. Those actions are summarized in the table below. **We strongly recommend coordination with EOHHS and DCF prior to any statutory changes to ensure alignment between statute and practice.**

Recommendation	Potential Legislative Action
Recommendation 1A: There should be a coordinated state effort to direct at-risk families to FRCs	• Pass H134/S101, *An Act Relative to Families and Children in Need of Assistance* • Pass legislation requiring all mandated reporters to participate in training • Fund information and outreach campaigns to reach mandated reporters and those who make recommendations regarding CRA referrals
Recommendation 1B: The FRC Service Model should be redesigned to focus on this primary goal and population	• Modify M.G.L. Chapter 6A Section 16U to revise the statutory authorization for Family Resource Centers
Recommendation 1C: Some current FRC functions should be eliminated, de-prioritized, made optional, or offered only in partnership with other state agencies	• Fund other state agencies to operate services currently performed by FRCs, including building an alternative crisis response system • Some ideas contained in this recommendation require further study, which the legislature could direct
Recommendation 2A: Open more FRC sites to improve access for families who are most in need of services	• Increase budget allocation for FRCs
Recommendation 2B: Expand funding available to each FRC through a more flexible contract model in the next procurement	• Increase budget allocation for FRCs
Recommendation 2C: The state should explore whether all available federal funding – especially Medicaid funding – is being secured to support FRC budgets and whether there are ways to better leverage other state funds	• This recommendation requires further study, which the Legislature could direct.
Recommendation 3A. FRCs should be operated by a state agency (or division within	• This recommendation requires further study, which the Legislature could direct. Implementing this

a state agency) with a strong focus on family support	recommendation would ultimately require a change in statute and likely budget, however.
Recommendation 3B. DCF (with support from EOHHS as needed) should negotiate formal partnerships at the state or regional level to expand the expertise available to families at FRCs and to ensure consistent referral options for FRC families	• N/A, although funding to support some of the ideas in this recommendation may ultimately be needed (including added funding for the MHAP for Kids program)
Recommendation 3C. The State should enhance EOHHS's ability to plan and oversee the management of a family support system that meets the needs of the Commonwealth familie	• This recommendation requires further study, which the legislature could direct. Implementing this recommendation may ultimately require additional funding and, potentially, statutory changes.
Recommendation 3D. The advisory structure for the FRCs should be revised	• Modify Section 34 of Chapter 240 of the Actions of 2012

The OCA is deeply committed to the success of the Family Resource Center program because we understand the impact FRCs have in their communities on a daily basis as well as the potential for them to do even more – with more resources and the right support. We offer our continued policy analysis and implementation support to both the Legislature and the Executive Branch should it be helpful in advancing the Recommendations contained in this report.

Appendix A: Data Charts

This report uses the most up to date full year data available to us. In some cases, the data was available through the end of CY23, while in other cases the most recent available data was through CY22.

Data in sections entitled "Family Members Served and Family Member Demographics", "Reasons for FRC Visit", "Unique Days of Service, Services Provided, and Event Attendance", "CRA Data", and "FRC Staffing" was provided to the OCA by ForHealth Consulting at the UMass Chan Medical School, which serves as the Administrative Service Organization (ASO) for the FRC Network. Data in the section entitled "Survey Results" comes from an online survey conducted for this report, which was made available to all FRC PMPDs.

Family Members Served and Family Member Demographics

Table 3: Unduplicated Families Served

	2018	2019	2020	2021	2022	2023
Mean	558	473	468	499	610	604
Median	547	418	354	427	571	531
Min	67	78	35	130	121	58
Max	1183	956	1280	1708	1615	1736
Total, All FRCs	**12284**	**10869**	**12623**	**13466**	**16464**	**19333**

Table 4: Unduplicated Family Members Served

	2019	2020	2021	2022	2023
Mean	802	740	885	1039	957
Median	768	554	615	768	718
Min	129	64	202	185	80
Max	2453	2987	4390	3729	3733
Total, All FRCs	**18452**	**19977**	**23890**	**28047**	**30612**

Table 5: Ethnicity (% of Family Members Served by FRCs)

	2019	2020	2021	2022
Not Hispanic	33%	32%	38%	44%
Another Hispanic, Latino, or Spanish Origin	12%	15%	16%	20%
Brazilian	0%	0%	1%	3%
Cuban	0%	0%	0%	0%
Mexican, Mexican American, Chicano	1%	1%	1%	2%

Table 5: Ethnicity (% of Family Members Served by FRCs)				
	2019	2020	2021	2022
Puerto Rican	14%	11%	8%	10%
Other	1%	2%	3%	4%
Not Applicable	0%	0%	0%	1%
Choose Not to Answer	0%	0%	0%	3%
Blank / No Answer	38%	39%	33%	13%

Table 6: Race (% of Family Members Served by FRCs)				
	2019	2020	2021	2022
American Indian	0%	0%	1%	1%
Asian Indian	0%	0%	0%	0%
Black/African American	12%	10%	10%	14%
Chinese	0%	0%	1%	1%
Filipino	0%	0%	0%	0%
Guamanian	0%	0%	0%	0%
Japanese	0%	0%	0%	0%
Korean	0%	0%	0%	0%
Native Hawaiian	0%	0%	0%	0%
Samoan	0%	0%	0%	0%
Vietnamese	0%	0%	0%	0%
White	34%	34%	38%	49%
Other Race	2%	3%	11%	17%
Not Applicable	0%	0%	0%	2%
Choose Not to Answer	0%	0%	0%	4%
Blank	51%	53%	40%	15%

Table 7: Language Spoken (% of Family Members Served by FRCs)				
	2019	2020	2021	2022
African Dialects	0%	0%	0%	0%
American Sign Language	0%	0%	0%	0%
Amharic	0%	0%	0%	0%
Arabic	0%	0%	0%	0%
Armenian	0%	0%	0%	0%
Brazilian Portuguese	1%	2%	1%	2%
Burmese Dialects	0%	0%	0%	0%
Cantonese	0%	0%	0%	0%
Cape Verdean Creole	1%	1%	1%	1%

Table 7: Language Spoken (% of Family Members Served by FRCs)				
	2019	2020	2021	2022
English	55%	49%	51%	60%
French	0%	0%	0%	0%
Haitian Creole	1%	1%	1%	1%
Hmong	0%	0%	0%	0%
Italian	0%	0%	0%	0%
Khmer/Cambodian	0%	0%	0%	0%
Mandarin Chinese	0%	0%	0%	0%
Moldovan	0%	0%	0%	0%
Null	24%	29%	32%	17%
Other	0%	0%	1%	1%
Portuguese	1%	1%	1%	1%
Russian	0%	0%	0%	0%
Spanish	16%	17%	13%	17%
Unknown	0%	0%	0%	0%
Vietnamese	0%	0%	0%	0%

Table 8: Gender Categories (% of Family Members Served by FRCs)				
	2019	2020	2021	2022
Female	63%	64%	62%	65%
Male	33%	30%	31%	30%
Non-Binary/Gender Fluid	0%	0%	0%	0%
Questioning/Not Sure	0%	0%	0%	0%
Tell Us in Your Own Words	0%	0%	0%	0%
I Prefer Not to Answer	0%	0%	0%	0%
Blank/Unknown	4%	6%	7%	5%

Table 9: Age Categories (# of Family Members Served by FRCs)				
	2019	2020	2021	2022
0-3 Years	1069	1326	1831	2299
4-6 Years	817	919	1498	1563
7-12 Years	1819	1948	3319	3421
13-15 Years	1232	1150	1795	2096
16-18 Years	816	808	1031	1273
19-20 Years	317	280	313	399
21-30 Years	2378	2605	2913	3706
31-40 Years	3664	4173	4708	5695

Table 9: Age Categories (# of Family Members Served by FRCs)				
	2019	2020	2021	2022
41-50 Years	2075	2231	2513	2899
51-60 Years	1065	1290	1286	1584
61-70 Years	439	464	516	627
71-79 Years	109	181	103	140
80+ Years	61	56	26	42
No Age	2591	2546	2038	2303

Reasons for FRC Visits

Table 10: Reasons for Visit (Number of Families, All FRCs)					
	2019	2020	2021	2022	2023
Food/Nutrition	1154	2401	1812	2502	2851
Family Hardship / Financial Issues	2061	2764	3248	4384	2619
Health / Mental Health Concerns	2561	2506	3028	4264	2507
Housing / Rent	2901	2615	2665	3520	2503
School Issue / School Info	2848	2251	2590	3397	2436
Teen/Young Adult Activities	823	720	1096	1836	1582
Seeking Information on Parenting / Parenting Education	1978	2103	2014	2440	1509
DCF Involvement / Support	1342	1266	1452	1346	1048
Child Care Info	680	550	424	607	665
SNAP Application / Benefit Assistance	462	477	509	637	588
Immigration/Legal Issues	228	216	190	330	455
Afterschool Info	613	457	303	598	453
Job Issues	772	567	374	524	452
Domestic Violence Services	259	236	303	437	360
Transportation	499	327	265	366	306
Substance Use Concerns	374	358	295	363	227
Health Crisis Outbreak	36	1144	992	453	217
Continuing Education for Caregiver	273	289	296	396	216
Families Displaced by Natural Forces	306	245	114	125	114
LGBTQIA+ Support	3	3	2	52	79
Other	2734	3765	4346	6381	5432

Table 11: Reasons for Visit (% of All Reasons)					
	2019	2020	2021	2022	2023

Table 11: Reasons for Visit (% of All Reasons)					
Food/Nutrition	5%	10%	7%	7%	11%
Family Hardship / Financial Issues	9%	11%	12%	13%	10%
Health/Mental Health Concerns	11%	10%	12%	12%	9%
Housing / Rent	13%	10%	10%	10%	9%
School Issue / School Info	12%	9%	10%	10%	9%
Teen / Young Adult Activities	4%	3%	4%	5%	6%
Seeking Information on Parenting / Parenting Education	9%	8%	8%	7%	6%
DCF Involvement / Support	6%	5%	6%	4%	4%
Child Care Info	3%	2%	2%	2%	2%
SNAP Application / Benefit Assistance	2%	2%	2%	2%	2%
Immigration/Legal Issues	1%	1%	1%	1%	2%
Afterschool Info	3%	2%	1%	2%	2%
Job Issues	3%	2%	1%	1%	2%
Domestic Violence Services	1%	1%	1%	1%	1%
Transportation	2%	1%	1%	1%	1%
Substance Use Concerns	2%	1%	1%	1%	1%
Health Crisis Outbreak	0%	5%	4%	1%	1%
Continuing Education for Caregiver	1%	1%	1%	1%	1%
Families Displaced by Natural Forces	1%	1%	0%	0%	0%
LGBTQIA+ Support	0%	0%	0%	0%	0%
Other	12%	15%	17%	18%	20%

Unique Days of Service, Services Provided, and Event Attendance

Table 12: Percentage of Families with Unique Days of Service, All FRCs (2019-2023)					
	2019	**2020**	**2021**	**2022**	**2023**
1 Day	50%	46%	54%	47%	47%
2 to 5 Days	30%	36%	30%	37%	37%
6 or More Days	20%	17%	16%	17%	15%

Table 13: Percentage of Families with One Day of Service, by FRC					
	2019	**2020**	**2021**	**2022**	**2023**
Median	54%	41%	48%	47%	42%

Table 13: Percentage of Families with One Day of Service, by FRC					
	2019	**2020**	**2021**	**2022**	**2023**
Min	13%	23%	17%	15%	12%
Max	92%	85%	75%	71%	79%
Average Across FRCs	**50%**	**46%**	**54%**	**47%**	**47%**

Table 14: Parenting Services Provided					
	2019	**2020**	**2021**	**2022**	**2023**
Mean	199	661	902	718	642
Median	173	450	595	647	432
Min	4	6	198	57	3
Max	669	4781	5514	2203	2694
Total ALL FRCs	**4584**	**17851**	**24348**	**19387**	**20537**

Table 15: Parenting Services Provided as a Percentage of All Services					
	2019	**2020**	**2021**	**2022**	**2023**
Median	13%	16%	21%	16%	14%
Min	0%	1%	5%	5%	2%
Max	23%	55%	60%	44%	41%
Average Across FRCs	**12%**	**18%**	**20%**	**16%**	**16%**

Table 16: Health/Mental Health Services Provided					
	2019	**2020**	**2021**	**2022**	**2023**
Mean	120	137	177	245	212
Median	61	79	128	180	127
Min	7	4	0	4	2
Max	1063	652	626	1070	1383
Total, ALL FRCs	**2756**	**3704**	**4774**	**6605**	**6777**

Table 17: Health/Mental Health Services Provided as a Percentage of All Services					
	2019	**2020**	**2021**	**2022**	**2023**
Median	5%	3%	3%	5%	4%
Min	0%	1%	0%	0%	0%
Max	21%	13%	21%	13%	23%
Average Across FRCs	**7%**	**4%**	**4%**	**6%**	**5%**

Table 18: Individual/Family Support Services Provided					
	2019	**2020**	**2021**	**2022**	**2023**
Mean	245	581	626	676	631
Median	97	314	305	385	361
Min	0	0	0	1	7
Max	1202	3423	2592	2739	2560
Total, ALL FRCs	**5631**	**15678**	**16906**	**18249**	**20178**

Table 19: Individual and Family Support Services Provided as a Percentage of All Services					
	2019	**2020**	**2021**	**2022**	**2023**
Median	9%	10%	12%	13%	11%
Min	0%	0%	0%	0%	0%
Max	37%	32%	38%	38%	56%
Average Across FRCs	**15%**	**15%**	**14%**	**15%**	**16%**

Table 20: Total Attendees at Recreational Events					
	2018	**2019**	**2020**	**2021**	**2022**
Mean	931	947	280	691	855
Median	674	482	97	248	576
Min	0	14	0	0	0
Max	3255	3741	1857	4714	3221
Total, All FRCs	**20484**	**21772**	**7547**	**18656**	**23090**

Table 21: Total Attendees at Drives (Clothing, Holiday, Food, Etc.)					
	2018	**2019**	**2020**	**2021**	**2022**
Mean	499	471	1796	847	1195
Median	85	40	69	78	161
Min	0	0	0	0	0
Max	6600	7443	27136	10968	16070
Total, All FRCs	**10974**	**10836**	**46700**	**22857**	**32262**

Table 22: Attendees as a Percentage of All Group/Event Attendees at Teen and Youth Support Events			
	2020	**2021**	**2022**
Median	2%	3%	4%
Min (FRC with lowest %)	0%	0%	0%
Max (FRC with highest %)	37%	57%	41%
Average Across FRCs	**4%**	**6%**	**5%**

CRA/CRA At Risk Youth and Services

Table 23: CRA/CRA at Risk Youth as a Percentage of All 6-17 Year Olds Served by FRCs						
ALL FRCs	**2019**	**2020**	**2021**	**2022**	**2023**	**Average**
CRA/CRA at Risk Youth	933	697	1059	1476	1796	1192
n Kids 6-17	3979	4070	6452	7052	6573	5625
% CRA/CRA at Risk Youth	23%	17%	16%	21%	27%	21%

Table 24: CRA Data for Families with Children Ages 6-17 (2023), by FRC				
	# Families with a Child 6-17	**Total Families Served with at least 1 Child 6-17 years old with CRA/CRA at Risk**	**Total Families Served with at least 1 Child 6-17 years old with CRA Application Filed**	**Total Families Served with at least 1 Child 6-17 years old that meets CRA Risk Guidelines**
Average	170.8	56.1	18.2	38.3
Median	109	44	10	26
Minimum	9	0	0	0
Maximum	748	267	123	167
Total, All FRCs	5465	1796	583	1224

Table 25: CRA Data for Families with Children Ages 6-17 (2023), by FRC				
	% Families with a Child 6-17	**Total Families Served with at least 1 Child 6-17 years old with CRA/CRA at Risk**	**Total Families Served with at least 1 Child 6-17 years old with CRA Application Filed (out of CRA/CRA at Risk Total)**	**Total Families Served with at least 1 Child 6-17 years old that meets CRA Risk Guidelines (out of CRA/CRA at Risk)**
Average	28%	36%	33%	67%
Median	25%	36%	31%	69%
Minimum	7%	0%	0%	5%
Maximum	56%	80%	96%	100%
Total, All FRCs	28%	33%	32%	68%

Table 26: CRA Specific Services					
	2019	**2020**	**2021**	**2022**	**2023**
Mean	96	118	174	206	139
Median	62	64	66	126	72

Table 26: CRA Specific Services					
Min	0	0	4	0	0
Max	342	440	948	689	613
Total ALL FRCs	**2311**	**3181**	**4711**	**5553**	**4461**

Table 27: CRA-Specific Services as a Percentage of All Services					
	2019	**2020**	**2021**	**2022**	**2023**
Median FRC	6%	2%	3%	3%	2%
Min (FRC with lowest %)	0%	0%	0%	0%	0%
Max (FRC with highest %)	31%	18%	18%	23%	12%
Average Across FRCs	**6%**	**3%**	**4%**	**5%**	**3%**

Table 28: CRA Prevention and Support Services *Includes CRA-Specific Services as well as other relevant services, such as school-related services*					
	2019	**2020**	**2021**	**2022**	**2023**
Mean	209	241	335	454	425
Median	160	235	89	409	275
Min	18	1	16	4	2
Max	792	768	2058	1577	2157
Total, All FRCs	**4807**	**6520**	**9052**	**12263**	**13608**

Table 29: CRA Prevention and Support Services as a Percentage of All Services *Includes CRA-Specific Services as well as other relevant services, such as school-related services*					
	2019	**2020**	**2021**	**2022**	**2023**
Median	12%	7%	5%	12%	9%
Min	3%	0%	1	1%	1%
Max	42%	19%	26%	23%	33%
Average Across FRCs	**12%**	**6%**	**7%**	**10%**	**10%**

FRC Staffing

Figure 24:
FRC Staff Turnover Rates by Quarter - All FRCs (2023)

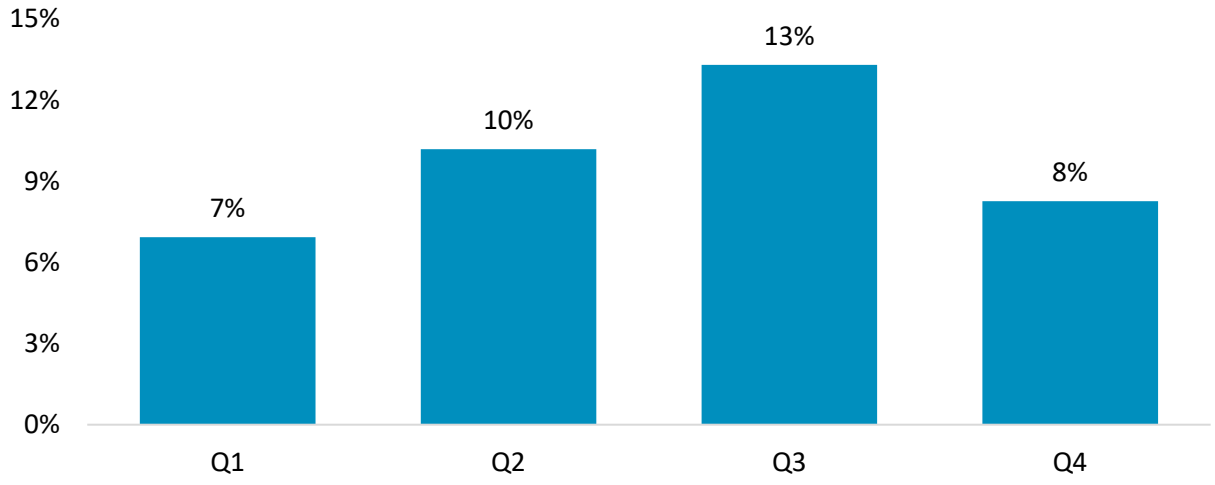
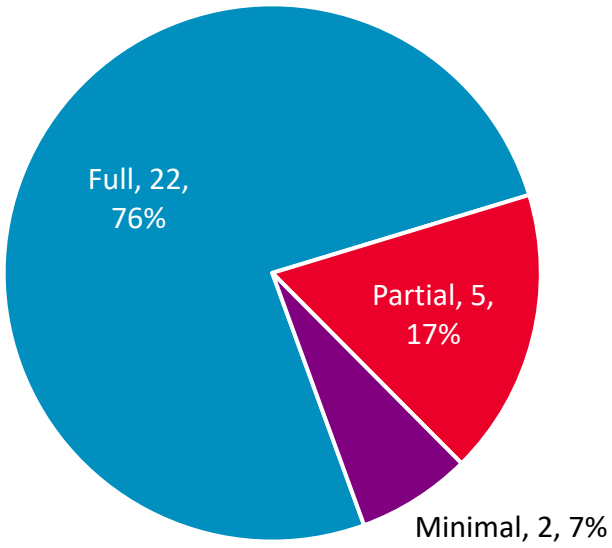
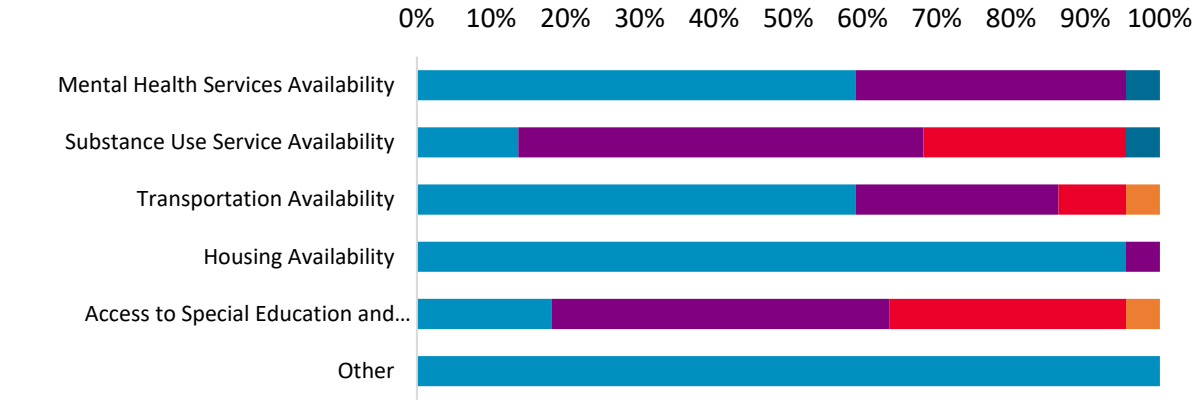


Figure 25:
FRC Staff Language Concordance (n=29)



Language Concordance = FRCs with staff that spoke the most common languages (comprising 5% or more) of total clients at that FRC

Figure 26:
Challenges Facing Consumers (n=22)



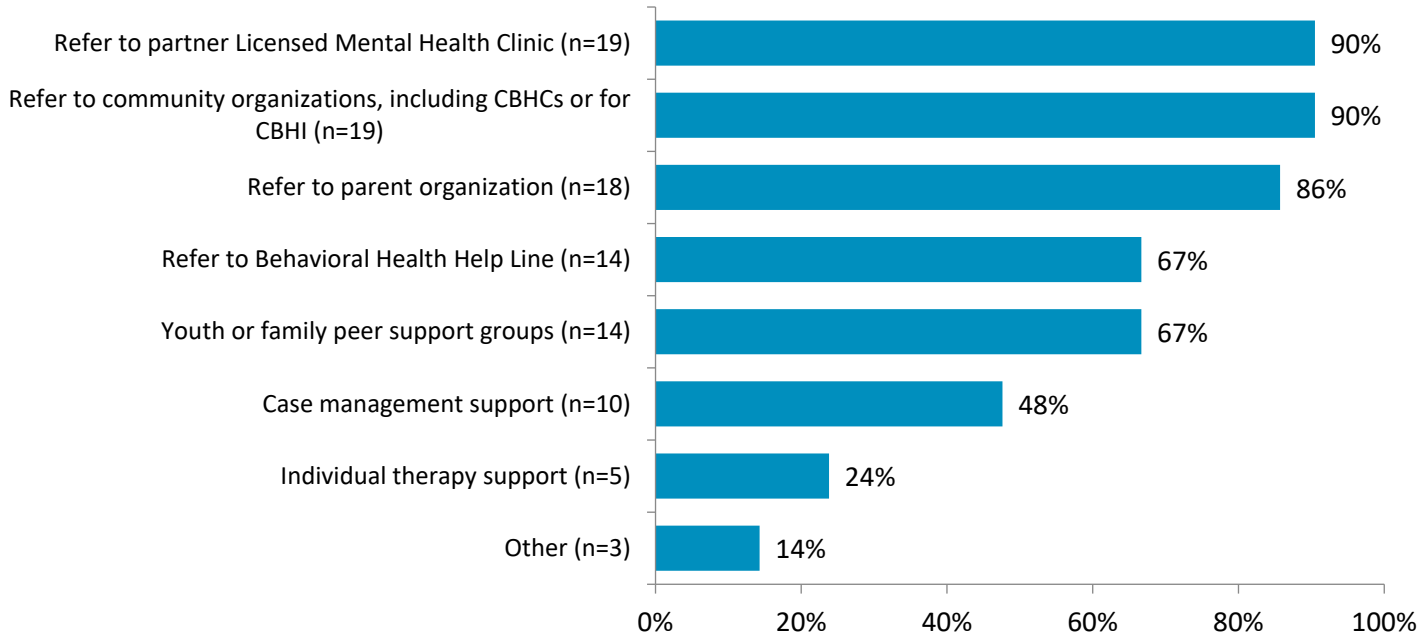
	Other	Access to Special Education and Other School Supports	Housing Availability	Transportation Availability	Substance Use Service Availability	Mental Health Services Availability
Extremely Challenging	100%	18%	95%	59%	14%	59%
Somewhat Challenging	0%	45%	5%	27%	55%	36%
Neither Challenging or Not Challenging	0%	32%	0%	9%	27%	0%
Somewhat Not Challenging	0%	0%	0%	0%	5%	5%
Not at all Challenging	0%	5%	0%	5%	0%	0%

Table 30: Percentage of FRC PMPD Respondents Indicating Desire for Each Positions and Number of Full Time Equivalents Preferred												
	Existing FRC Positions								New Positions Suggested			
Number of Full Time Equivalents Desired	Program Director	Program Manager	Clinician	Family Partner	Family Support Worker	Trainer/ Facilitator	Youth worker	School Liaison	Outreach Specialist	Community Engagement Specialist	Housing Specialist	Data Specialist
0						5%	14%		10%	5%	10%	5%
1	86%	100%	48%	62%	14%	29%	43%	81%	38%	43%	52%	67%
2				38%		14%	14%	19%	10%	10%	10%	
2-3					57%							
4					29%							
All should be able to facilitate						5%						
More than 1.0			43%									
Part Time	14%		10%			5%	5%		14%	5%	5%	10%
Blank						43%	24%		29%	38%	24%	19%

Note: The data in this table is derived from a survey of FRC staff who were asked which FRC positions, current or not yet created, they wanted to see staffed at FRCs.

Figure 27:

FRC Supports for Mental Health and Substance Use (n=22)



Appendix B: Methodology: Geographic Areas and Potential Population Served by FRC

For the purposes of this report, we have *roughly* estimated the current geographic area and potential population served by each FRC by doing the following:

- Identifying the top five zip codes from which families are visiting for each FRC[140]
- If the top five zip codes did not make up at least 90% of families visiting a specific FRC in 2023, we added more zip codes to either reach that 90% threshold, or to hit a maximum of 15 zip codes per FRC – whichever happened first.[141]
- In some cases, families in the same zip code visit multiple FRCs. To address this, if an FRC had five or fewer visits from a given zip code and a different FRC had a higher number of visits from that zip code, we assigned the zip code to the FRC that had the higher number of visits. (If there were more than five visits from a given zip code to more than one FRC, that zip code will appear in the "geographic area served" for both FRCs.)

We then took the total estimated population for each zip code from the US Census[142] to identify the total "**potential population to be served**" for each FRC. We also looked at the number of DTA clients in those zip codes and calculated an estimated percentage of individuals in those zip codes that are DTA clients to adjust for level of need in a given community.[143,144]

Finally, we looked at the number of family members served by each FRC in 2023 to identify the "**family members served by FRC per DTA clients"** in the estimated catchment area to create a percentage that can be compared across FRCs.

[140] Note that this analysis focuses on zip codes where families are *currently* going to an FRC. This analysis does not account for zip codes from which families are not currently going to an FRC, at all or in significant numbers. It is possible, as discussed elsewhere in this report, that there are zip codes where families may benefit from FRC services but do not go to the FRC for any number of reasons, including logistics/convenience or lack of awareness.

[141] A handful of FRCs serve a significantly larger number of zip codes that most other FRCs. We chose to cap the maximum number of zip codes to 15 in an attempt to control for this; the result is that on average the zip codes included make up 88% of families visiting an FRC. All but three FRC sites reached a threshold of at least 80%.

[142] U.S. Census Bureau. "ACS Demographic and Housing Estimates." *American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05*, 2022

[143] https://www.mass.gov/lists/department-of-transitional-assistance-caseload-by-zip-code-reports

[144] There are a variety of metrics that might identify the level of need in a given community. "DTA clients" was chosen as it helps estimate the number of individuals in a given zip code who have demonstrated level of financial need and, on a more practical basis, because the data is recent and available by zip code. This analysis should be viewed as a "rough estimate" of need in a community, and not a precise calculation.

Table 31: Population Estimates, DTA Clients, and Number of Family Members Served							
FRC (area served)	Total Estimated Population	% of Total Population that are DTA clients 2023	Sum of DTA Clients 2023	2023 Family Members Served	2023 Fam Members per 10k Pop Ratio	2023 Fam Members per DTA Clients	% Family Members Served 2023 as one Touch
Mean	175551	21.6%	39974	957	82	5.9%	43.8%
Median	147936	21.0%	29347	718	56	2.4%	41.8%
Min	13861	3.2%	450	80	11	0.7%	12.3%
Max	486511	44.6%	147893	3733	548	42.3%	79.3%

Appendix C: Underserved Areas for Potential FRC Expansion

This appendix describes underserved areas that could be sites for potential FRC expansion. To conduct this analysis, we looked at a variety of data elements that were available to the OCA at the town and/or zip code level, including:

- Data on Census Bureau, including population and poverty rates
- Data from the Department of Elementary and Secondary Education (DESE) about the student population in that town (e.g. high needs, low income, racial breakdowns, absenteeism)
- Data from the Youth Risk Behavior Survey (YRBS) when available
- Data from the Center for Disease Control's Social Vulnerability Index[145]

We recognize that DCF takes into account some of the same factors, and more, when it has expanded the number of FRCs in the past – including rates of poverty, crime, school discipline, single parent families, unemployment, and involvement with DCF. Our analysis here uses somewhat different factors (in part due to differences in what data was available to us at the town or zip code level at the time of drafting this report), but this should not be taken as a critique of the current methodology DCF uses to site FRCs.

The purpose of this appendix, then, is simply to demonstrate that there are a variety of areas in the state that are, we argue, underserved and would benefit from having a closer FRC office. We also note that, in addition to the towns listed here, opening a second or third office in some of the larger cities – including Boston, Springfield, and Worcester – would help improve access to FRCs.

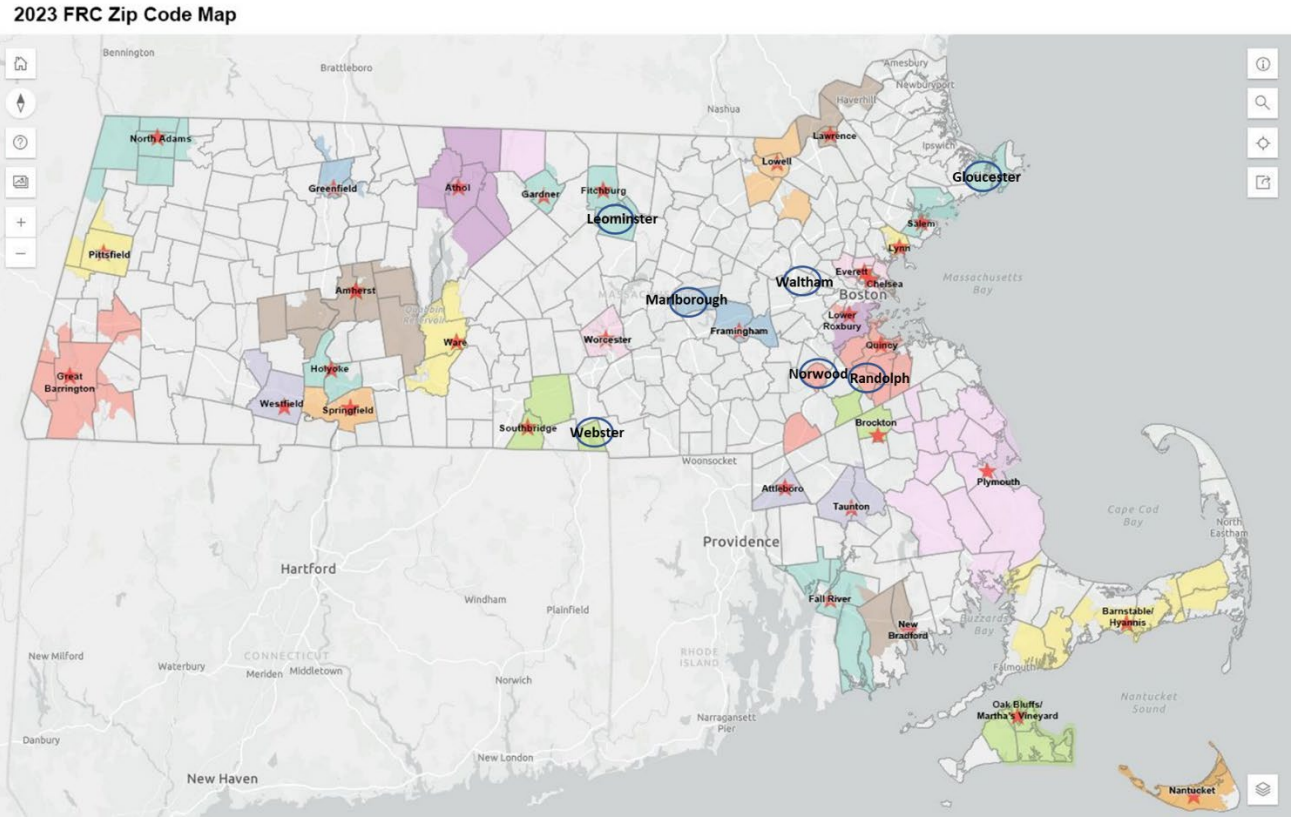
Details about each proposed community are described below in order of descending "High Needs (%)" DESE data.

- Webster
- Randolph
- Marlborough
- Leominster
- Waltham
- Gloucester
- Norwood

[145] Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 U.S. census variables to help local officials identify communities that may need support before, during, or after a disaster or public health emergency. For more information see: https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html

Figure 28:

FRCs by Zip Codes Served by 10 or more families in 2023



Circled towns indicate potential areas for expansion. Map produced by DMA Health Strategies for the OCA.

Potential FRC Expansion Community: Webster

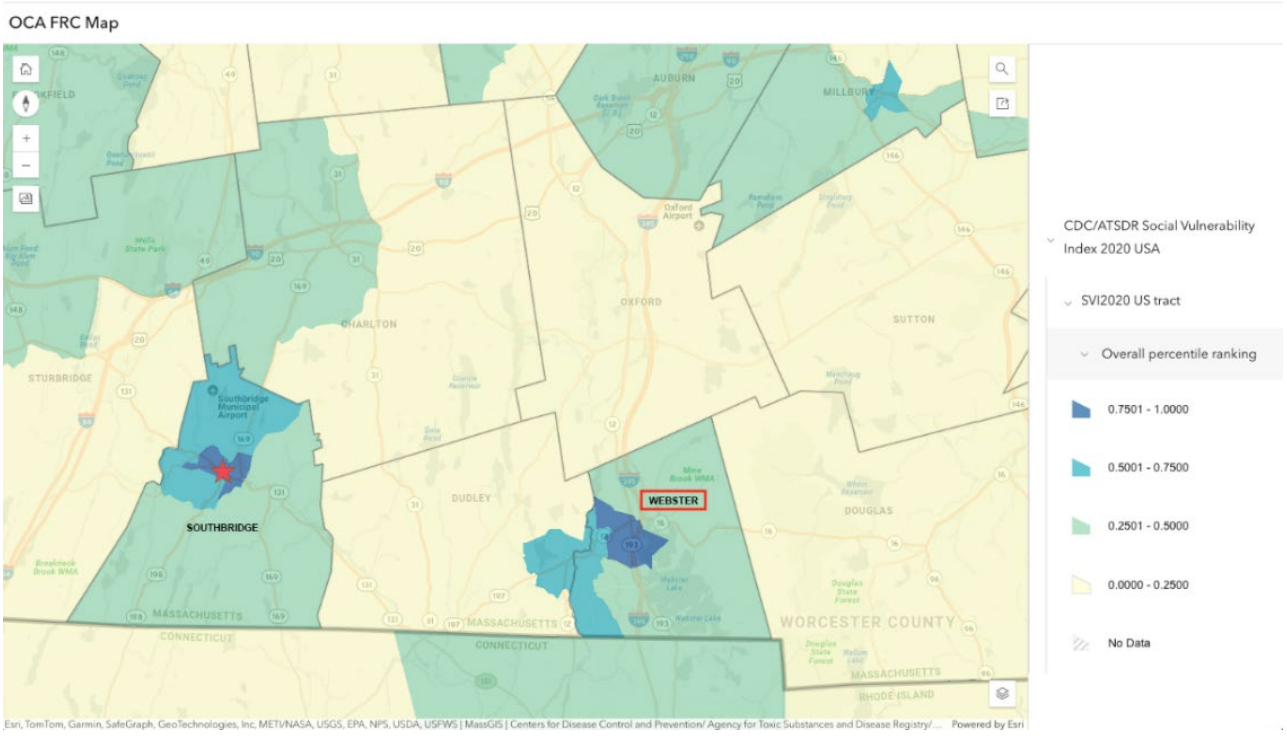
Table 32: Webster[146]		
Census Data	**Webster**	**State of MA**
Population	17,601	6,982,740
% Population under 18	21.1%	19.20%
County	Worcester	
% Poverty	14.3%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Webster**	**State of MA**
2023-24 Student Enrollment	1,699	2,293
First Language Not English (%)	21.7%	26.0%
High Needs (%)	80.40%	55.8%
Low Income (%)	70.3%	42.2%
African American	7.2%	9.6%
Asian	1.9%	7.4%

[146] https://www.census.gov/quickfacts/fact/table/MA, https://profiles.doe.mass.edu/, Red text= higher than state average

Table 32: Webster[146]		
Hispanic	40.3%	25.1%
White	45.4%	53.0%
2022-23 Absent 10 or More Days	55.6%	49.5%
2022-23 Unexcused > 9 Days Rate	0.2%[147]	25.9%

The Social Vulnerability Index map shows that one Webster census tract has a high level of vulnerability, while three have medium to high levels.

Figure 29:
Webster Map



Map produced by DMA Health Strategies for the OCA.

FRC visits from Webster Families

- Despite the percentage of high needs students enrolled in the Webster public school district, only 95 families from Webster visited an FRC from 2019-2023.
- From 2019-2023, 75 families from Webster visited the Southbridge FRC.
- From 2019-2023, only 15 families from Webster visited the Worcester FRC.
- In 2023, out of those with known zip codes, 21 families (9%) visiting the Southbridge FRC and less than 1% visiting the Worcester FRC were from Webster.
- Although close geographically, average public transportation time from Webster to

[147] But 30% chronically absent on a different measure

Southbridge is 41 minutes.

Table 33: FRC Visits from Webster Families					
Nearest/ Visited FRCs	**Miles from FRC**	**Avg. Driving Minutes**	**Avg. Public Transport Minutes**	**# visits to an FRC 2023**	**# visits to an FRC 2019-23**
Southbridge	10	19	41	21	75
Worcester	19	25	76	3	15
Fitchburg	45	53	177	2	3
Ware	30	52	1140	0	1
Lowell	59	66	255	1	1

Youth Risk Behavior Survey data was not available from the Webster Public Schools to assess health related social needs of Webster youth.

Potential FRC Expansion Community: Randolph

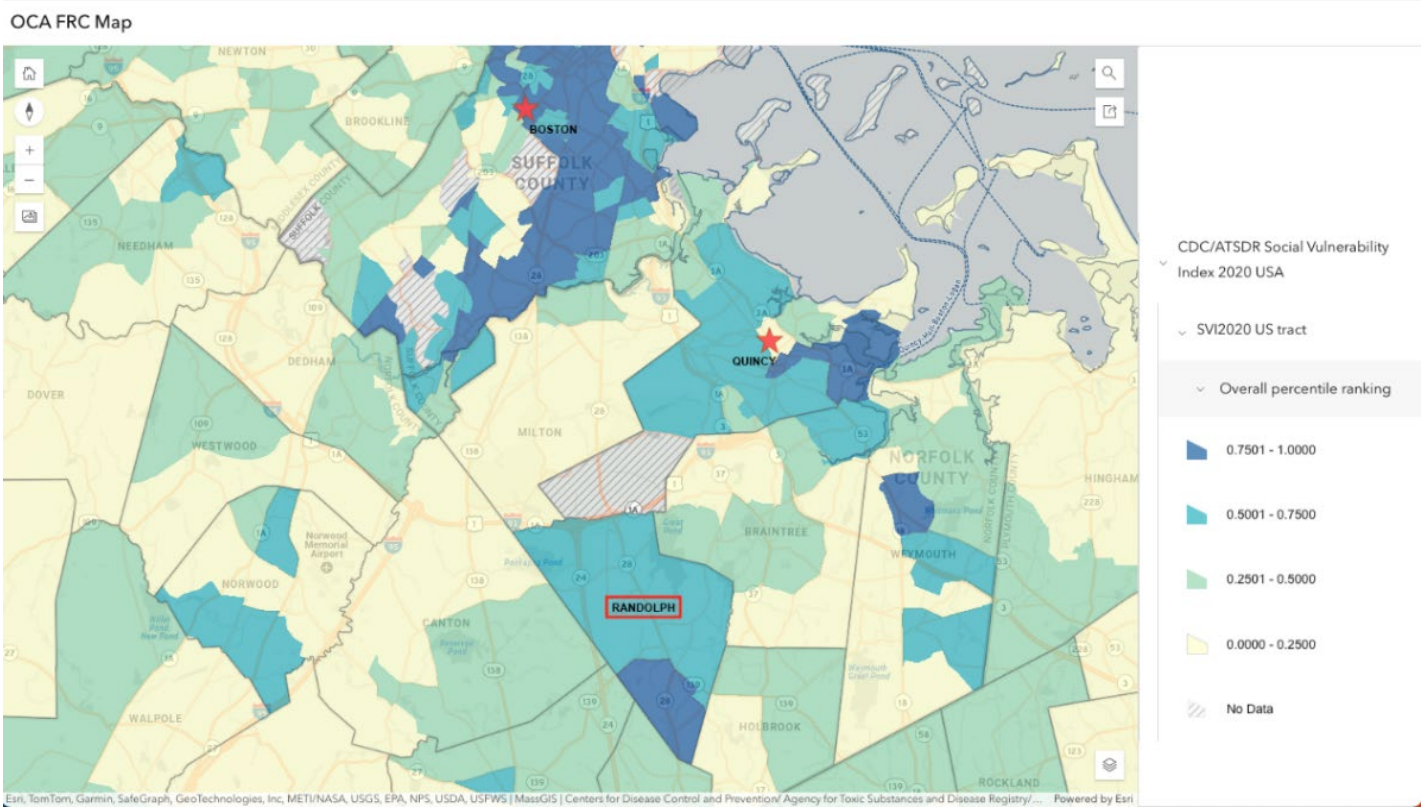
Table 34: Randolph[148]		
Census Data	**Randolph**	**State of MA**
Population	34,530	6,982,740
% Population under 18	18.5%	19.20%
County	Norfolk	
% Poverty	9.3%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Randolph**	**State of MA**
2023-24 Student Enrollment	2,685	2,293
First Language Not English (%)	39.7%	26.0%
High Needs (%)	75.8%	55.8%
Low Income (%)	60.7%	42.2%
African American	50.9%	9.6%
Asian	16.7%	7.4%
Hispanic	16.2%	25.1%
White	11.3%	53.0%
2022-23 Absent 10 or More Days	50.9%	49.5%
2022-23 Unexcused > 9 Days Rate	17.5%	25.9%

The Social Vulnerability Index map shows that one Randolph census tract has high level of vulnerability, and the others have medium to high levels.

[148] https://www.census.gov/quickfacts/fact/table/MA, https://profiles.doe.mass.edu/, Red text= higher than state average

Figure 30:

Randolph Map



Map produced by DMA Health Strategies for the OCA.

FRC visits from Randolph Families

- From 2019-2023, 310 families from Randolph visited the Quincy FRC (25 in 2023), accounting for 9% of families visiting the Quincy FRC. During this period, 27 Randolph families also visited the Brockton FRC, and nine visited Plymouth FRC.
- Although only a 17-minute drive, average public transportation time from Randolph to the Quincy FRC is almost one hour and just over 45 minutes to the Brockton FRC.
- Based on existing numbers served, opening an FRC in Randolph would help reduce the burden on the Quincy FRC, which has exceeded the network average of number of families served annually since 2020, by a minimum of 40% higher in 2022 and most notably by serving 93% more families than the network average in 2021.

Table 35: FRC Visits from Randolph Families

Nearest/ Visited FRCs	Miles from FRC	Avg. Driving Minutes	Avg. Public Transport Minutes	# visits to an FRC 2023	# visits to an FRC 2019-23
Quincy	10	17	53	35	310
Brockton	8	24	46	8	27
Plymouth	29	40	n/a	5	9

Table 35: FRC Visits from Randolph Families					
Boston	20	40	120	0	3
Cape Cod	63	68	n/a	0	3

Youth Risk Behavior Survey data was not available from the Randolph Public Schools to assess health related social needs of Randolph youth.

Potential FRC Expansion Community: Marlborough

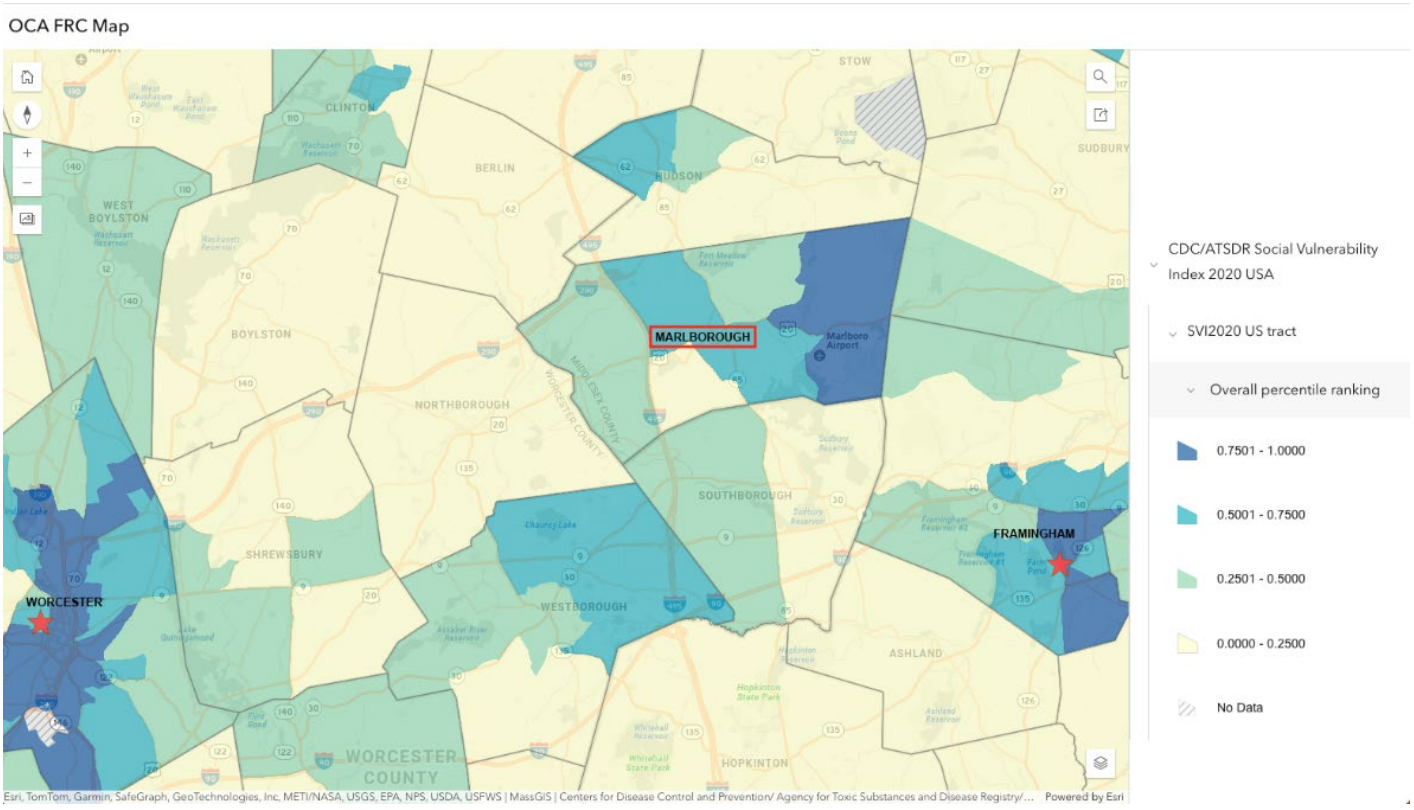
Table 36: Marlborough[149]		
Census Data	**Marlborough**	**State of MA**
Population	40,971	6,982,740
% Population under 18	20.4%	19.20%
County	Middlesex	
% Poverty	8.8%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Marlborough**	**State of MA**
2023-24 Student Enrollment	4,729	2,293
First Language Not English (%)	58.6%	26.0%
High Needs (%)	73.8%	55.8%
Low Income (%)	58.3%	42.2%
African American	4.9%	9.6%
Asian	1.0%	7.4%
Hispanic	57.1%	25.1%
White	32.6%	53.0%
2022-23 Absent 10 or More Days	58.4%	49.5%
2022-23 Unexcused > 9 Days Rate	42.1%	25.9%

The Social Vulnerability Index map shows that one Marlborough census tract has a high level of social vulnerability and three have medium to high levels of vulnerability.

[149] https://www.census.gov/quickfacts/fact/table/MA, https://profiles.doe.mass.edu/, Red text= higher than state average

Figure 31:

Marlborough Map



Map produced by DMA Health Strategies for the OCA.

FRC visits from Marlborough Families

- From 2019-2023, 88 families from Marlborough visited the Framingham FRC, 18 of which were in 2023.
- The Worcester FRC is a similar driving distance as the Framingham FRC, but only five families from Marlborough have visited the Worcester FRC since 2019.
- Although only a 22-minute drive to both of the closest FRCs, average public transportation time is over one hour to the Framingham FRC and over two hours to the Worcester FRC.

Table 37: FRC Visits from Marlborough Families

Nearest/ Visited FRCs	Miles from FRC	Avg. Driving Minutes	Avg. Public Transport Minutes	# visits to an FRC 2023	# visits to an FRC 2019-23
Framingham	10	22	65	19	88
Worcester	18	22	132	2	5

Youth Risk Behavior Survey data was not available from the Marlborough Public Schools to assess health related social needs of Marlborough youth.

Potential FRC Expansion Community: Leominster

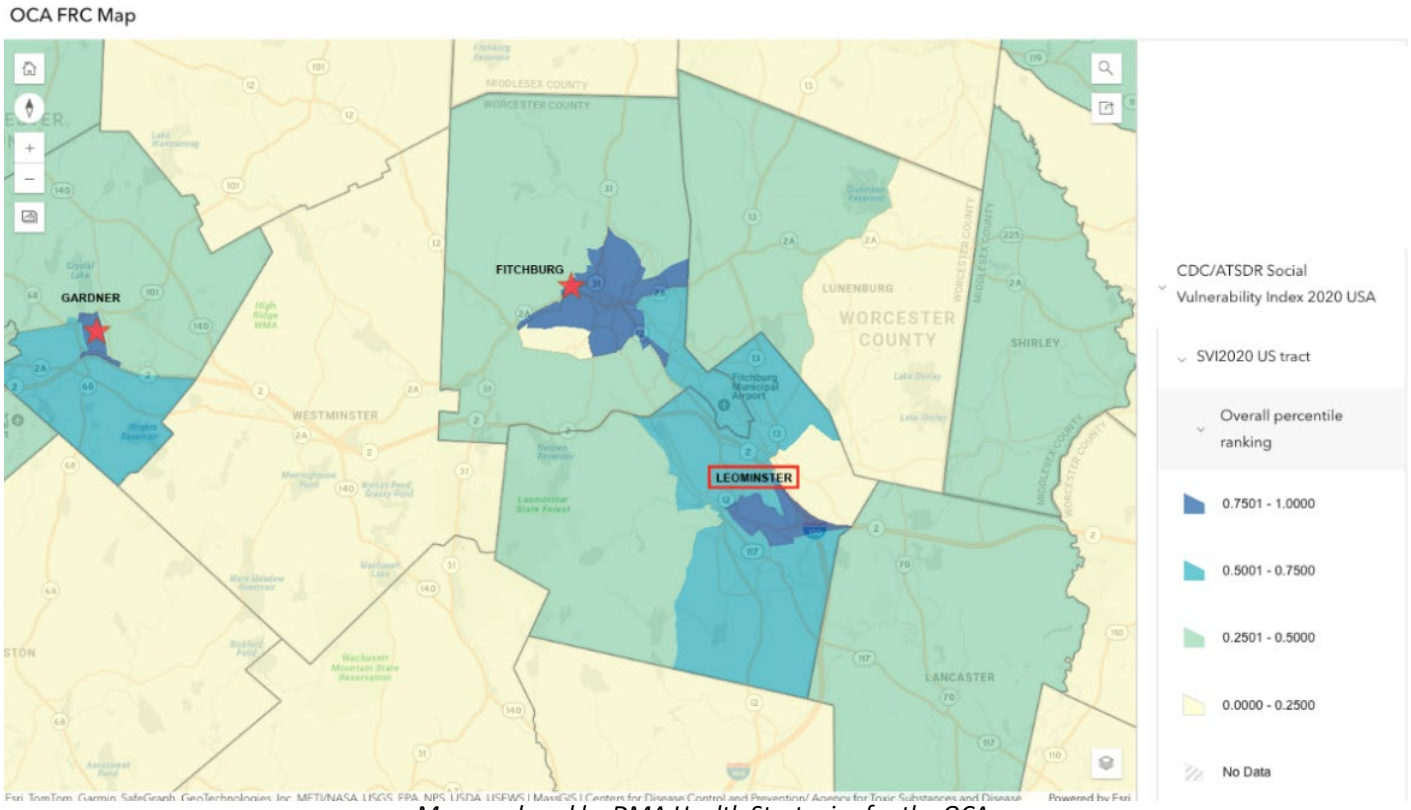
Table 38: Leominster[150]		
Census Data	**Leominster**	**State of MA**
Population	43,646	6,982,740
% Population under 18	19%	19.20%
County	Worcester	
% Poverty	9.1%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Leominster**	**State of MA**
2023-24 Student Enrollment	6,012	2,293
First Language Not English (%)	32.30%	26.0%
High Needs (%)	67.20%	55.8%
Low Income (%)	54.50%	42.2%
African American	9.50%	9.6%
Asian	3.10%	7.4%
Hispanic	41.80%	25.1%
White	41%	53.0%
2022-23 Absent 10 or More Days	50.60%	49.5%
2022-23 Unexcused > 9 Days Rate	41.70%	25.9%

The Social Vulnerability Index map shows that one Leominster census track as a high level of vulnerability, while the others have a medium to high levels.

[150] https://www.census.gov/quickfacts/fact/table/MA,leominstercitymassachusetts/PST045223, https://profiles.doe.mass.edu/,
Red text= higher than state average

Figure 32:

Leominster Map



Map produced by DMA Health Strategies for the OCA.

FRC visits from Leominster Families

- From 2019-2023, 446 families from Leominster visited the Fitchburg FRC.
    - In 2023, out of known zip codes, 19% of families (n=101) visiting the Fitchburg FRC were from Leominster.
- The Fitchburg FRC has consistently served higher than the average number of families.

Table 39: FRC Visits from Leominster Families

Nearest/ Visited FRCs	Miles from FRC	Avg. Driving Minutes	Avg. Public Transport Minutes	# visits to an FRC 2023	# visits to an FRC 2019-23
Fitchburg	6	21	35	101	446
Gardner	15	22	131	2	2
Athol	28	38	150	2	9
Worcester	42	58	150	2	7

Youth Risk Behavior Survey data was not available from the Leominster Public Schools to assess health related social needs of Leominster youth.

Potential FRC Expansion Community: Waltham

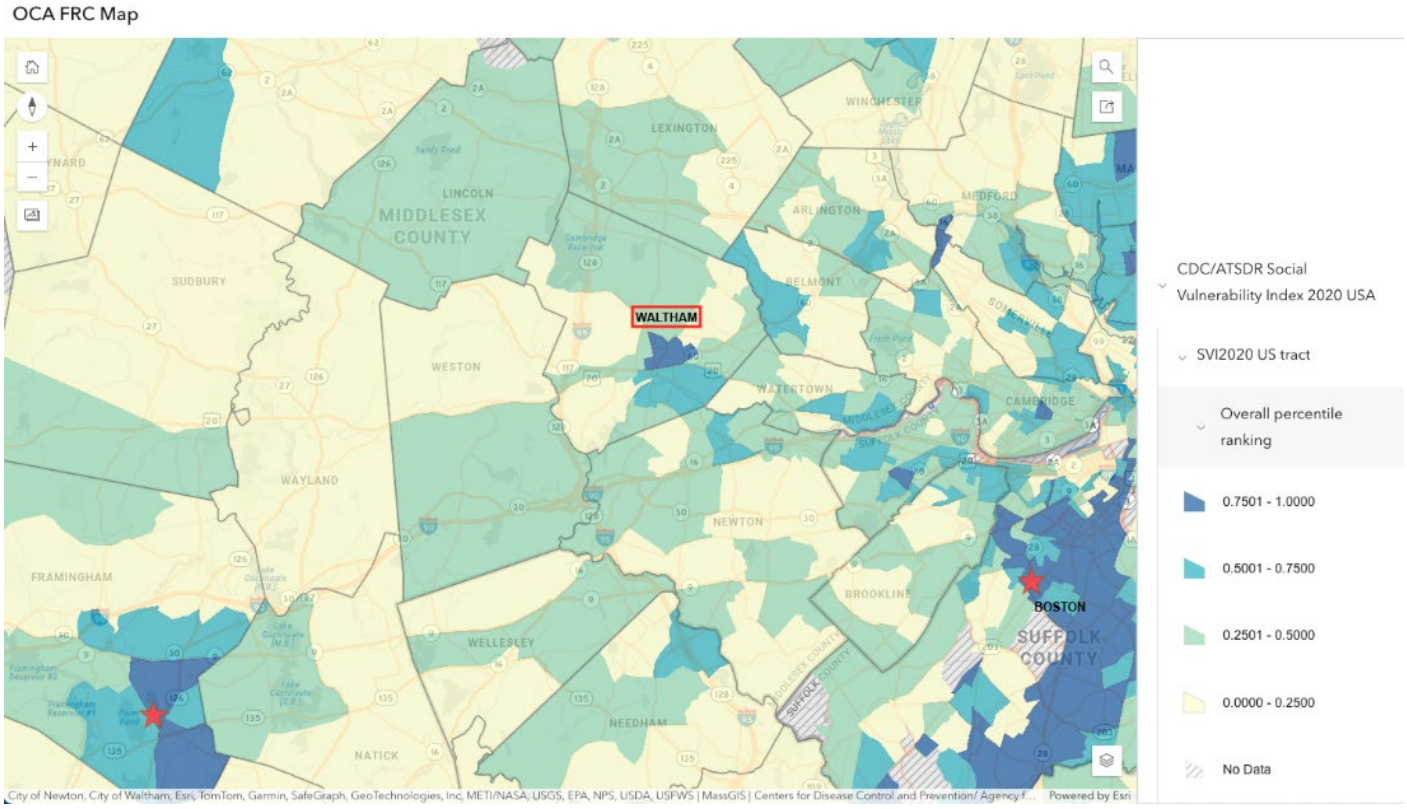
Table 40: Waltham[151]		
Census Data	**Waltham**	**State of MA**
Population	64,065	6,982,740
% Population under 18	13.30%	19.20%
County	Middlesex	
% Poverty	8.90%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Waltham**	**State of MA**
2023-24 Student Enrollment	5,709	2,293
First Language Not English (%)	57.5%	26.0%
High Needs (%)	62.7%	55.8%
Low Income (%)	47.6%	42.2%
African American	8.0%	9.6%
Asian	5.1%	7.4%
Hispanic	47.5%	25.1%
White	36.1%	53.0%
2022-23 Absent 10 or More Days	49.1%	49.5%
2022-23 Unexcused > 9 Days Rate	44.6%	25.9%

As indicated by the Social Vulnerability Index map, one Waltham census track indicates a high level of vulnerability. The other tracts indicate medium to high levels of vulnerability.[152]

[151] https://www.census.gov/quickfacts/fact/table/MA,walthamcitymassachusetts/PST045223, https://profiles.doe.mass.edu/; Red text= higher than state average

[152] https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

Figure 33:
Waltham Map



Map produced by DMA Health Strategies for the OCA.

FRC visits from Waltham Families

- Despite the percentage of high needs students enrolled in the Waltham public school district, only 25 families from Waltham zip codes visited an existing FRC from 2019-2023, of which only eight visited in 2023.
- Families most frequently visited Framingham (14 miles away) and Quincy (26 miles away). Some Waltham families visited Everett (n=5), Boston (n=3), and Fitchburg (n=1).
- Families from Waltham made up just 0.5% of Framingham's families served and 0.2% of Quincy families served over the five-year period.

Table 41: FRC Visits from Waltham Families[153]

Nearest/ Visited FRCs	Miles from FRC	Avg. Driving Minutes	Avg. Public Transport Minutes	# visits to an FRC 2023	# visits to an FRC 2019-23
Framingham	14	25	100	1	8
Quincy	26	40	96	4	8
Everett	19	40	70	2	5

[153] YRBS data: https://drive.google.com/file/d/1ZF0PyJvEfDdkXab0bjS4tgdyQXfmIfAi/view

Table 41: FRC Visits from Waltham Families[153]					
Boston	13	30	65	1	3

Waltham health related social needs

There are health related social needs in the city that an FRC could address.

According to the Waltham 2023 Youth Risk Behavior Survey:

- Just over 30% of Waltham High School students experienced frequent overwhelming stress, 23.9% experienced frequent overwhelming anxiety, and 27.8% depression during the past year.
- Rates of self-harm were also high, with 12.8% of all students reporting they harmed themselves on purpose and 6.4% having attempted suicide.
- Nearly one-quarter (24.7%) of Waltham Middle School students have seriously considered attempting suicide.
- Rates of stress, anxiety, and depression were even higher rates of non-binary, gender expansive, and questioning, female, and LGBQ+ student report.

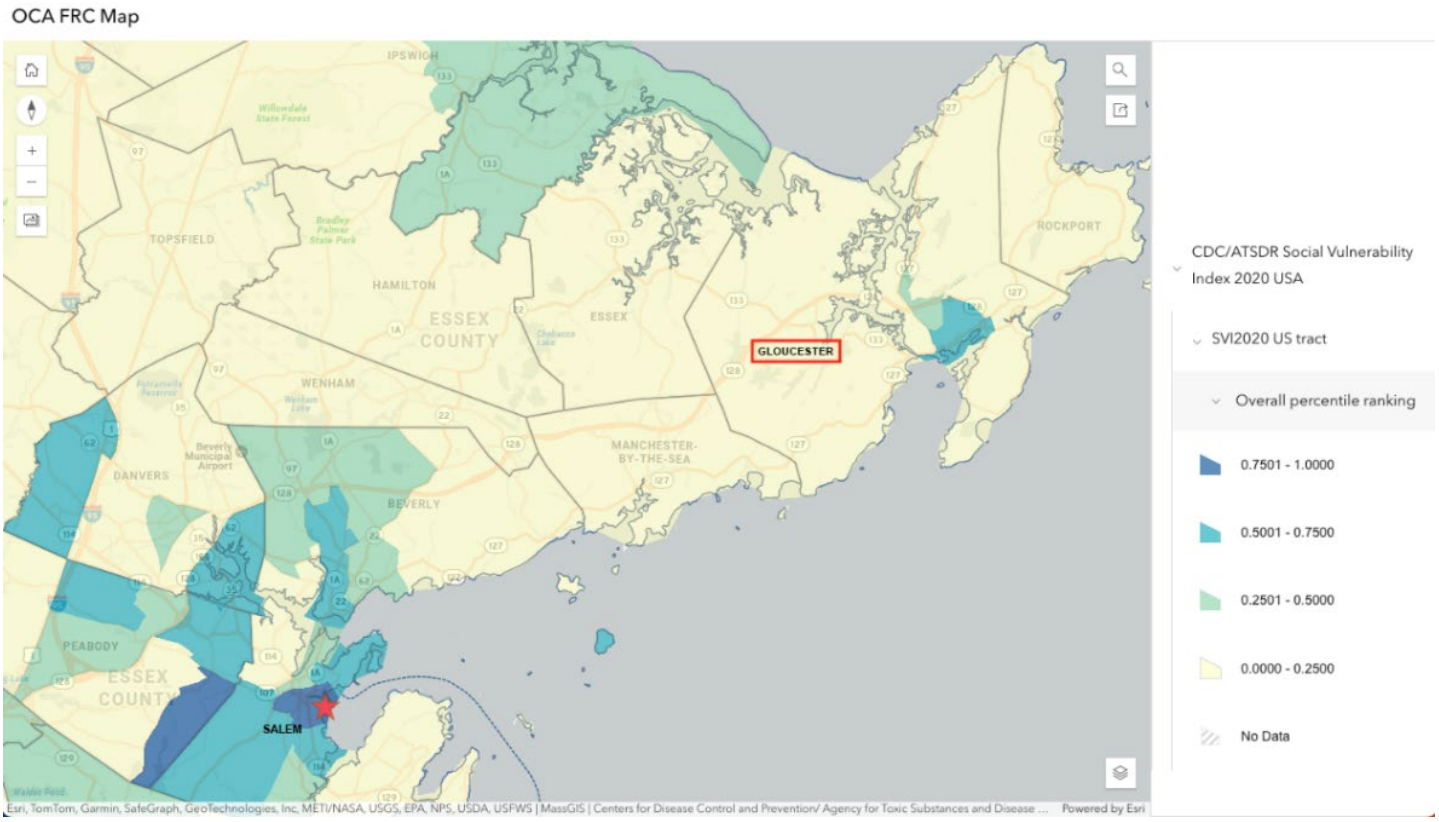
Potential FRC Expansion Community: Gloucester

Table 42: Gloucester[154]		
Census Data	**Gloucester**	**State of MA**
Population	29,836	6,982,740
% Population under 18	15.4%	19.20%
County	Essex	
% Poverty	10.8%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Gloucester**	**State of MA**
2023-24 Student Enrollment	2,862	2,293
First Language Not English (%)	13.90%	26.0%
High Needs (%)	59.20%	55.8%
Low Income (%)	44.20%	42.2%
African American	1.70%	9.6%
Asian	1.40%	7.4%
Hispanic	15.20%	25.1%
White	77%	53.0%
2022-23 Absent 10 or More Days	56.40%	49.5%
2022-23 Unexcused > 9 Days Rate	55.10%	25.9%

[154] https://www.census.gov/quickfacts/fact/table/MA, https://profiles.doe.mass.edu/, Red text= higher than state average

The Social Vulnerability Index map shows that two Gloucester census tracks have medium to high level of vulnerability.

Figure 34:
Gloucester Map



Map produced by DMA Health Strategies for the OCA.

FRC visits from Gloucester Families

- Despite the percentage of high needs students enrolled in the Gloucester public school district, only 22 families from Gloucester visited an FRC from 2019-2023.
- In 2023, 13 families from Gloucester visited the newly opened Salem FRC, accounting for 10% of families served by the Salem FRC.
- Although a 32-minute drive, average public transportation time from Gloucester to the Salem FRC is one hour.

Table 43: FRC Visits from Gloucester Families

Nearest/ Visited FRCs	Miles from FRC	Avg. Driving Minutes	Avg. Public Transport Minutes	# visits to an FRC 2023	# visits to an FRC 2019-23
Salem	17	32	60	13	13
Lowell	47	68	165	2	5

Table 43: FRC Visits from Gloucester Families					
Boston	40	69	112	1	1
Lynn	29	47	60		2
Lawrence	45	62	204		1

Gloucester health related social needs

There are health related social needs in the city that an additional FRC could address.

According to the 2023 Gloucester Youth Substance Use Prevention report[155]:

- Among respondents, 37% of high school students and 33% of middle school students reported experiencing depression, and 16% of high school students and 22% of middle school students reported considering attempting suicide.
- YRBS data found 22% of high schoolers and 20% of middle schoolers worry 'fairly often' or 'very often' about family issues. Parental separation and being placed in the care of another relative or the foster system were mentioned as particular stressors.
- Parental or siblings' poor mental health and substance use were also identified as stressors, with 11% of high schoolers reporting someone in their household "drinks too much alcohol."

Potential FRC Expansion Community: Norwood

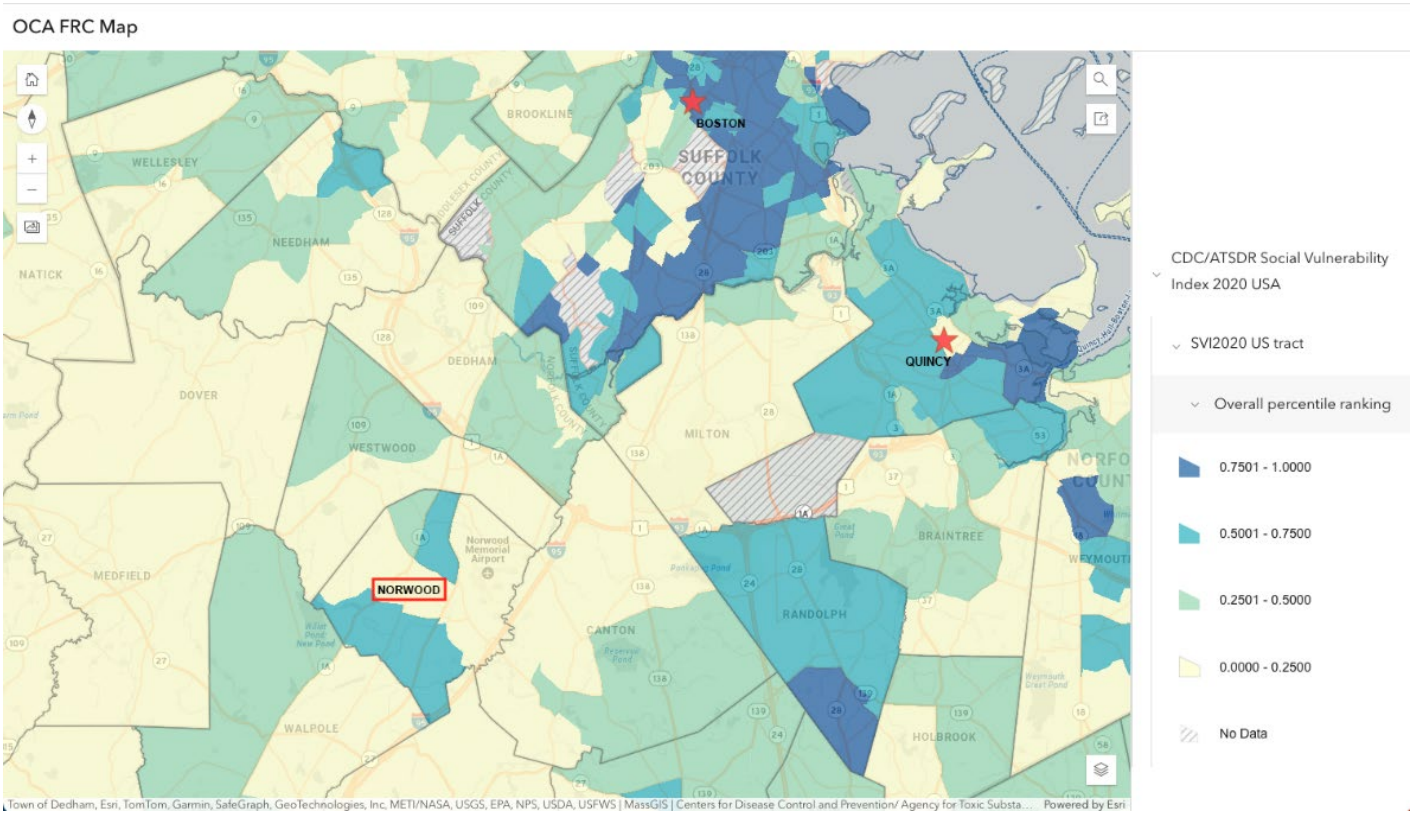
Table 44: Norwood[156]		
Census Data	**Norwood**	**State of MA**
Population	31,317	6,982,740
% Population under 18	19.6%	19.20%
County	Norfolk	
% Poverty	7.6%	10.40%
MA Dept. of Elementary and Secondary Education Data	**Norwood**	**State of MA**
2023-24 Student Enrollment	3,545	2,293
First Language Not English (%)	29.7%	26.0%
High Needs (%)	58.8%	55.8%
Low Income (%)	40.7%	42.2%
African American	13.1%	9.6%
Asian	7.5%	7.4%
Hispanic	20.1%	25.1%
White	54.5%	53.0%
2022-23 Absent 10 or More Days	48.9%	49.5%
2022-23 Unexcused > 9 Days Rate	40.9%	25.9%

[155] https://gloucester-ma.gov/DocumentCenter/View/9254/Gloucester-SOR-PEC-Report?bidId=

[156] https://www.census.gov/quickfacts/fact/table/MA, https://profiles.doe.mass.edu/, Red text= higher than state average

The Social Vulnerability Index map shows that three census tracts have medium to high levels of social vulnerability.

Figure 35:
Norwood Map



Map produced by DMA Health Strategies for the OCA

FRC visits from Norwood Families

- From 2019-23, 44 families from Norwood visited the Quincy FRC (16 in 2023), accounting for 1.2% of families visiting the Quincy FRC between 2019-2023. Four families also visited the Framingham FRC and Taunton FRC, two visited Brockton, and one visited Boston.
- Although a 30-minute drive, average public transportation time from Norwood to Quincy FRC is over one hour and fifteen minutes.
- Given the percentage of high needs students enrolled in the Norwood public school district, accounting for nearly 2,100 families for 2023-2024, there is likely significant unmet need beyond the 18 families that sought FRC services and supports in 2023.

Table 45: FRC Visits from Norwood Families					
Nearest/ Visited FRCs	**Miles from FRC**	**Avg. Driving Minutes**	**Avg. Public Transport Minutes**	**# visits to an FRC 2023**	**# visits to an FRC 2019-23**
Quincy	14	30	77	16	44
Framingham	24	35	94	1	4
Taunton	28	35	n/a	0	4
Brockton	18	35	136	0	2
Boston	12	30	51	1	1

Appendix D: Examples of Cross-Agency Coordination Infrastructure from Other States

This appendix provides examples of structures established in other states **to support strategic planning, policy alignment, and/or funding alignment across child-serving agencies.** This non-exhaustive list demonstrate different approaches Massachusetts should consider to improve integration and effectiveness of services to support children and families.

New York Office of Children and Family Services (OCFS)

The New York State Office of Children and Family Services (OCFS) is charged with improving the integration of services for New York's children, youth, and families and vulnerable populations, promoting their development and protecting them from violence, neglect, abuse, and abandonment.

New York is different from Massachusetts as it has a county-administered system for many services, including child welfare and other social services.[157] However, the OCFS operates at the state level to provide a "system of family support" as well as being responsible for juvenile justice, youth development, child care, and child welfare services. The OCFS also works closely with municipal and county-based social service providers, such as local departments of social services, to ensure that adequate youth development services and programs are available at the local level. The Commissioner of OCFS reports directly to the Governor.[158]

Functions under OCFS include:

- **An Office of Strategic Planning and Policy Development** to manage policy implementation of federal and state laws, issue administrative directives to local agencies, guide development of policy and data tools, and serve as liaison to federal agencies.
- **A Council on Children and Families** to provide a comprehensive, cross-systems perspective critical for the development and implementation of strategies impacting the availability, accessibility, and quality of services for children and families. A wide variety of state agencies that impact children and families are members of the Council, which has a staff of 18. Positioned as a neutral body, the Council provides coordination between New York's health, education, and human services systems and facilitates the development of state and local service systems that are coordinated, strength-based, prevention-oriented, and responsive to the needs of children and families. Some of the Council's initiatives and programs include:

[157] Children's Bureau. (2018). State vs. County Administration of Child Welfare Services. https://cwig-prod-prod-drupal-s3fs-us-east-1.s3.amazonaws.com/public/documents/services.pdf?VersionId=sCIFPdVWvKGX_HymH2hK53tlMda3d101

[158] See: https://www.nysenate.gov/legislation/laws/EXC/500

- The Kids' Well-being Indicators Clearinghouse, which is a tool to gather, plot and monitor New York State children's health, education, and well-being indicator data in order to improve outcomes for children and families.
- An Interagency Resolution Unit, which works to solve interagency issues and jurisdictional disputes that hinder access to services for children with complex needs.
- A Multiple Systems Navigator Website, which provides families with information on how to navigate the state's various health, education, human service and disability programs.
- The Early Childhood Advisory Council, which provides strategic direction and advice to the state on early childhood issues as well as monitors the implementation of these strategies.
- The Coordinating Council on Children with Incarcerated Parents which provides data on the state's children affected by this issue and advocates on behalf of children of incarcerated parent.

New York City Administration for Children's Services (ACS)

As noted above, New York state administers many programs at the county and local level. Although New York City is a city rather than a state, its size and relative autonomy means it can still serve as a relevant comparison for Massachusetts.

The NYC Administration for Children's Services provides child welfare, juvenile justice, and early care and education services. In the past decade, the ACS has been committed to offering more services to prevent maltreatment and promote family preservation and well-being, which has translated into a significant decrease in the number of children in foster care.[159] The ACS oversees 14 divisions providing services across child-serving sectors, including:

- **The Division of Child Welfare Programs**, which serves as an umbrella structure that integrates and aligns work across the Divisions of Child Protection, Family Permanency Services, and Preventive Services. Of note, this office oversees and develops policy and practice across the ACS in the areas of mental health, substance use, domestic violence, and education.
- **The Division of Preventive Services**, which oversees and monitors community-based preventive services for children and their caregivers at high risk of involvement with the child welfare system (e.g., team conferencing, crisis intervention)
- **The Division of Child and Family Well-Being**, which monitors and provides early care and education services as well as manages the city's Community Partnership Program,

[159] New York City Administration for Children's Services. (2021). 8 Years of Progress. https://www.nyc.gov/assets/acs/pdf/about/2021/8YearsofProgress.pdf

which funds community coalitions that function as local hubs to coordinate services and resources, and Family Enrichment Centers, which are similar to our Family Resource Centers.

- **The Division of Policy Planning and Measurement**, which collaborates with every division within ACS to strategically develop and implement policies and programs for children and families. This division also produces data, reports and analyses for the entire agency, oversight agencies, the public, and elected officials. Finally, this division provides training and workforce development to staff working in child welfare and juvenile justice divisions.

Vermont Department for Children and Families (DCF)

Vermont's Agency of Human Services, the state's health and human services governing structure, strives to integrate and coordinate family supports services by co-locating child- and family-focused programs under one umbrella agency, the Department for Children and Families (DCF). Vermont's DCF houses a variety of family supports programs across six divisions. [160]

Of particular note, Vermont has also consolidated over 30 state and federal funding streams into one unified case rate (i.e. bundled payment model) to promote preventative efforts and spend funding more efficiently since 2008.[161] The agencies included in this Integrating Family Services initiative are Vermont's Department of Mental Health, Department of Children and Families, Department of Disabilities Aging and Independent Living, Department of Health, and Department of Vermont Health Access (Medicaid agency). Through this initiative, state agencies and their providers are able to:

- Provide flexible funding for family support services.
- Strengthen the continuum of family services.
- Offer services based on need rather than program eligibility.
- Shift the focus from counting clients and service units to measuring the impact of those services.

New Jersey Department of Children and Families

The New Jersey Department of Children and Families is a Cabinet-level agency that focuses on serving and supporting at-risk children and families. In addition to a Division focused on Child Protection and Permanency and an Office of Licensing (which licenses child care centers, and youth/residential programs), New Jersey's DCF has grown to include the following divisions and offices that serve families beyond those involved in the child protective system:

[160] Vermont Agency of Human Services Department of Children and Families. (n.d.) Guide to Our Divisions. https://dcf.vermont.gov/divisions

[161] Vermont Agency of Human Services. (n.d.) Integrating Family Services. https://ifs.vermont.gov/

- **Division of Children's System of Care**, which serves children and adolescents with emotional and behavioral health care challenges, children with developmental and intellectual disabilities, and youth with substance use issues.
- **Division of Family and Community Partnerships**, which includes an office of Early Childhood Services, an Office of Family Support Services, and an Office of School-Linked Services. These offices work across state government and with state and local advocates to ensure coordination of services, particularly for families of children birth to five.
- **Office of Education**, which provides intensive 12-month educational services and supports to children and young adults ages 3 through 21 who have severe cognitive, physical, behavioral, and emotional disabilities, are at risk of failing school, and/or are pregnant/parenting teens.
- **Office of Family Voice**, which works to ensure that policy, operations, and practice throughout the Department are infused with the voices of individuals with lived experience.
- **Office of Strategic Development**, which serves as the Department's hub for the development, adaptation, and implementation of evidence-based programs. Created in 2015, this office ensures area offices implement state-wide strategies and monitors the quality of services offered by the state's 56 Family Success Centers.

Commonwealth of Massachusetts

Office of the Child Advocate

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

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

Website

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

Contact

Melissa Threadgill, Senior Director of Policy and Implementation
Melissa.threadgill@mass.gov