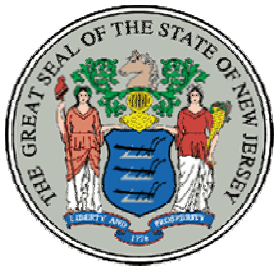

A NEW BEGINNING:

THE FUTURE OF CHILD WELFARE

IN NEW JERSEY

June 9, 2004

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[1] We apologize for any errors of omission.

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■ INTRODUCTION

Today we mark a new beginning for the children, families and communities of New Jersey. The past year has been a tumultuous and tragic one. Faheem Williams' death – and those of too many others whose names did not fill the headlines – brought into stark relief the most basic question for any government: are we keeping the most vulnerable among us safe and well? Clearly and for far too long, the answer has been no.

The past year also brought to a head a broad-based litigation, filed by Children's Rights, Inc., and the Lowenstein Sandler firm, regarding many aspects of our child welfare system. The case had several important benefits: it highlighted the depth of the problems we confront, and resulted in a settlement structured around an expert panel who have been of great assistance.

Out of crisis has come opportunity. For the past seven months, the State of New Jersey has engaged in the most sweeping re-visioning of its child welfare system in several generations. This process has involved hundreds of people including the agency's clients (both children and their families), system employees at all levels, community members, academia, advocates, and others. No issue was off limits, no strategy out of bounds. The essential question was this: what is the best possible child welfare system we can imagine for our state, and how do we get there from here?

This plan is the result. It represents our vision – and more importantly, our commitment – to the children, families and communities of New Jersey. It reinvents child welfare in fundamental ways, from the front lines to the Commissioner's office; from the casework with families to the system's relationship with neighborhoods and communities; from accountability to the provision of resources. We will need, and will be seeking, the assistance of many of you in many different roles to help make this vision a reality. But the buck stops here.

We move forward with great humility, mindful that the task ahead is vast, but with greater resolve, committed to seeing this essential process to its end: a child welfare system responsive to all the families and children who need it. The citizens of New Jersey are owed no less. May we be judged by the outcome of this journey. And may our work be a tribute, albeit inadequate, to Faheem and the others.

■ CORE COMMITMENTS

♦ Children's Safety, Permanency and Well-Being

Our system has three essential obligations to the children of New Jersey: safety, permanency and well-being. We recommit ourselves today to the provision of all three.

All are essential, but the first, child safety, is and must always be foremost. Allegations that children are in danger – including such allegations regarding children already in foster care or under the system's supervision in their own homes – must be investigated quickly and professionally, and all necessary steps taken to remove a child from continuing danger whenever necessary. This will remain our highest priority. We will separate the investigative and ongoing service-provision functions in two different people – renamed child protection workers and permanency workers – so the investigative workers can be trained in skills not universally held by social workers. We will limit child protection workers (including those in the Institutional Abuse Investigation Unit, who handle allegations of abuse or neglect of children in out-of-home care) to eight new investigations per month; will limit their caseloads to no more than 12 open cases at a time;[2] and will insist that they complete all investigations within 60 days. We will employ newly focused and integrated investigative teams for cases involving sexual or severe physical abuse, and will provide real and immediate treatment whenever needed. And we will back-stop all of this with an ongoing program of safety assessments at critical junctures.

Permanency is children's need for families. Even at its best, foster care should be temporary and short-term. Children have a basic need for stable, reliable relationships with caring adults. Almost all children want this relationship with their birth family, even when they have been neglected or abused. Our first obligation in all but the most extreme cases of severe abuse is to do everything possible to help the child's birth family stay together or reunite. This is often difficult work, for both the family and the caseworker, but it remains our obligation, both because the law requires it and because in the vast majority of situations it is the best possible result for the children. Even when it ultimately fails, this work is still critically important, laying the legal groundwork for a quicker path to permanency through adoption and strengthening the child's bonds with adults who will be ongoing supports, potentially even adoptive parents.

For families who cannot come back together after a fair and reasonable period of trying, the child's need for permanency and stability should be met through adoption. In such situations, the system's obligation is to find appropriate adoptive parents (as often as possible, the same

[2] We will staff up the agency to meet this standard statewide by no later than 2007, and will work with the Panel to develop appropriate interim standards to be achieved by December 31, 2005, and December 30, 2006. Note that all caseload standards in this plan are not averages but individual worker targets, and, as the interim and ultimate standards become applicable, strategies will be developed to promptly address any situations in which an individual worker's caseload exceeds the applicable standard. We will develop a system to track and monitor the remediation of any situations in which caseload standards are exceeded. At every stage of our progress toward achieving our final caseload standard, we will overfill the case-carrying positions by 10%, so the workload will be fully covered, without exceeding the then-applicable caseload standard, even allowing for attrition, temporary leaves, unexpected system-wide caseload fluctuations, or other variables.

resource families[3] who already have the child), and to move the legal process through to finality quickly. Children languishing in foster care – unable to return home, not moving toward adoption – is a triple tragedy: the child may maintain false hope of reunification, remains in legal limbo without legal stability, and is getting older (and perhaps less likely to be adopted) with each passing week and month. This aimlessness must stop.

The small group (and it must always be a small group) of older teenagers for whom adoption is not in their best interests must be prepared to live outside the system at age 21. Our obligation is to help them develop the skills and, more importantly, the web of relationships with caring adults essential to their continuing healthy development and success as adults.

Well-being includes everything a child needs to grow into a healthy and productive adult, including physical and psychological health, an education, a sense of security and purpose, healthy relationships with caring adults, and much more. When children come into the realm of the child welfare system, the system must ensure that they have all these things.

Many people argue that these basic responsibilities – particularly safety and permanency – conflict with one another, and that a child welfare system can either adopt a child protective ("when in doubt, pull 'em out") or a reunification ("family preservation no matter what") orientation. These are extreme descriptions, and we reject them both. The goals are not mutually exclusive. Both, responsibly pursued, are essential, and both are core commitments of our system. The key to making both possible is the context in which critical decisions are made. If a child protective service worker has an unreasonable caseload, inadequate training and job knowledge, insufficient support and supervision, and access to an inadequate array of services to keep a child safe and at home, she may err in both directions: removing some children unnecessarily (and anytime a child is removed from his home it is a traumatic experience) while leaving others home and impermissibly vulnerable. Our obligation to both the child and the worker is to ensure that these conditions do not exist, so critical decisions can be made thoughtfully and professionally.

♦ Reinventing Case Practice

To meet all these essential goals for every child, today, we begin a complete overhaul of our system's case practice model.

In the past, too much of child welfare practice has focused on process, on checking off boxes on forms (have I done the necessary home visits? have I tried to refer the mother to the treatment services she needs?). This approach must end.

Under the new model, outcomes, not process, will be paramount. Whatever a child's goal may be (family reunification, adoption, etc.), the caseworker's responsibility will be to do whatever it takes to make it happen as quickly as possible. Important interim steps will be tracked and monitored, but outcomes will be the final measure and expectation.

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[3] The term "resource family" includes all foster and adoptive parents, both those who knew the child before the child's placement ("kin") and those who did not.

To make this approach possible, caseworkers must have reasonable workloads, and they will. No permanency worker – the caseworkers with open cases, including both children at home and in out-of-home placement – will have more than 15 families or 10 children in out-of-home placement at a time. Caseloads will be geographically assigned, allowing caseworkers to learn the strengths and institutions in particular neighborhoods.

Families are different. They have different strengths and needs. Child welfare work must be individualized to respond to family circumstances. There must be standards and goals, but not a rigid or formulaic approach to achieving them. Caseworkers will have the necessary support, resources and authority, and will be expected to act entrepreneurially to achieve permanency for their clients.

A source of operational tension in some systems is having the same caseworker first do the protective investigation and then, if the child must enter foster care, to partner with the family toward reunification. Since the investigative responsibility can lead to acrimony between the family and the caseworker, even with the most experienced and sensitive caseworker, the subsequent partnering can be doomed to fail before it begins. We will avoid this by employing specialist investigative caseworkers, who will responsibly transfer their cases to other "permanency" caseworkers who will continue the engagement with the family if a case is opened.

For too long, caseworkers have made decisions alone, as if in a vacuum. They have not had sufficient professional support from colleagues and supervisors, and have not meaningfully involved the children and families with whom they work. This must stop.

For children under DYFS supervision (whether in-home or out-of-home), caseworkers will be ultimately responsible for their outcomes, but they will not act alone. Instead, they will collaborate with children (of appropriate age), families, service providers, and community partners to help the families build or strengthen their own supportive teams to support them in keeping their children safe and sustaining any necessary changes they must make. Family team meetings – at which the caseworker, the family, and others in the family's network who might provide support – will be an important new element of case practice, and the forum where service plans are developed. These meetings will be held at critical junctures of a case, and will bring together all the available supportive resources for the child and family to strategize as a team about how to keep the child safe and meet her permanency goal, and what resources are needed to achieve these ends. Community representatives will attend to help identify neighborhood resources and open up the decision-making process around initial placement and subsequent moves. If a supervisor's input is necessary to support a less experienced caseworker, the supervisor will attend. If the provider of the mother's drug rehabilitation services, for example, would inform the discussion, that person will attend, too. The caseworker will be a problem-solving partner and facilitator. In this way, service plans will be tailored to the family's individual strengths and needs and will reflect the family's own goals and dreams in their own language, not "government-speak."

Caseworkers will be responsible for driving a case to permanency from day one. Through concurrent planning, workers will be required to work toward family reunification (when that is

the initial goal, as it is in all but the most horrific cases) while at the same time laying the groundwork for other permanency arrangements (usually termination of parental rights and adoption), so these processes move forward quickly if they become necessary. This dual-track approach will be discussed candidly with the family throughout the process, in conversations that will be difficult but essential. Parents will be supported in what they need to do to secure the return of their children, or to keep them at home, and will be clearly informed of the consequences of failure.

This new case practice model will require a massive training effort for both new and current caseworkers and supervisors. We will develop a training academy and implement a comprehensive program of initial and ongoing training.

♦ **Recruiting, Retaining and Supporting Resource Families**

No child welfare system can operate without a dedicated cadre of resource families willing to open their homes and hearts to children in need. New Jersey has thousands of such families, but not nearly enough. This problem is largely of our own making. We have made the licensure and training processes unfriendly and cumbersome; have not provided sufficient ongoing support to resource families; and have paid inadequate board rates. All this must change.

We will approach this effort with a customer service mindset. People willing to consider foster and/or adoptive parenthood should be respected, honored and supported throughout the process. We have not always done this. We will now.

The training and certification process for foster parents has taken up to twelve months. It will be streamlined to 90 days, for the convenience of the resource parents and, more importantly, so we have the range of placements at the ready when children need them. Prospective resource families will work with only one agency from application through licensure to avoid unnecessary delays and provide a more unified study process that is easily understood and navigated by applicants.

We will license families interested in fostering, adopting, or both, in a single, streamlined process, making them "resource parents." We will certify "resource parents" – licensed as both foster and adoptive parents – in a single process. Today, people are first certified as foster parents in a cumbersome process. If they later decide to adopt, they must go through another process. Resource parent certification will end this. Because some of our resource parents will know from the outset that they are interested in adoption, the child placement process will be able to consider possible permanent compatibility from the very beginning, and fewer children needing adoption will have to move to another home to achieve it.

Historically and currently, there is often great antagonism between foster parents and birth parents, hindering visitation and rendering family reunification far less likely. This must change. Resource families will be trained to work in partnership with birth families – when appropriate - modeling good parenting and otherwise supporting them – up to the time the child's permanency goal is changed to adoption. For this to work, children must be placed with resource families from their own neighborhood. This plan commits to a significant recruitment effort in

neighborhoods of high need. We will make a particular effort to recruit resource families willing to care for traditionally hard-to-place children, including adolescents and large sibling groups.

The payments to resource parents have been inadequate and inequitable. We will equalize the board rates paid to resource parents previously unknown to a child and the rates paid to kin serving as resource parents, by raising the rates for kin. This is particularly important because our first goal when placing a child into out-of-home care is to place him with people he already knows. We will also raise rates substantially across the board.

Just as children in the system and their birth families (when the permanency goal is reunification) have a caseworker to support them, resource families also need support. The system has not provided it to date, but will now. Resource family support workers, a new role in the system, will be responsible for home studies and the provision of ongoing support to the resource families in a geographic area.

♦ Partnership and Community Collaboration

New Jersey's child welfare system will work in partnership with the neighborhoods where its children and families live, work, play, attend school, pray, and come together to create meaning and community. This is not a progressive piety, just pure pragmatism: without such partnerships, we cannot succeed. Neither is this an abdication of the child welfare agency's ultimate responsibility, only an acknowledgement that even the finest system – like even the strongest children and families – can only flourish collaboratively.

Children and families do not exist in isolation. They live in overlapping circles of extended family, block associations, neighborhood groups, community organizations, schools, workplaces and businesses, religious and civic institutions, and much more. Collectively, these are enormous assets for families. Indeed, it is difficult to imagine any family succeeding, in a meaningful sense of the term, without the participation of informal supports and institutions like these.

The first assets the child welfare system will draw on in working with any family, are that family's own strengths. Even the most struggling parents have talents and abilities that must be engaged in support of their children and themselves. Working to keep families together, or to reunite them, means drawing on these abilities, even while addressing limitations.

Parents' best sources of support are the people and institutions already around them. The child welfare system will work to nurture, develop and partner with communities statewide, and will deploy community developers who will work with the community on the local level to map assets, build on existing strengths, and create partnerships for child welfare. We will also form more geographically focused child welfare collaboratives in the communities of highest need. The first 12 of these will be started in the next 24 months, in neighborhoods selected based on the prevalence of child welfare cases there. Neighborhood-based steering committees (comprised of community residents and stakeholders, informal local leaders, and state representatives) will be established to run the collaboratives, which will be provided with technical assistance in mapping the community's assets that can support children and families, and will have a primary role in allocating preventive service dollars. The community

collaboratives will be linked to their county's broader effort, with the goal of creating a continuum of programs to prevent child abuse and neglect and support families.

The public system will approach these community partnerships with great respect, mindful of the fact that government generally, and this agency in particular, have not always done so. Localities know their families and institutional supports. The State will enter these relationships as learner and supporter.

The child welfare system will align its work in accordance with this neighborhood-based partnership model. A web of preventive services will be coordinated by the collaborative, which ultimately should enable many more children to remain safe at home by drawing on local services. As noted earlier, resource parents will be recruited from the neighborhoods where the system's clients tend to live, so children who do need to enter out-of-home placement will remain near home (with their own kin whenever possible), able easily to visit their parents and siblings still at home, attend the same school, and stay in touch with their friends. Caseworkers will have neighborhood-based caseloads, permitting them to develop long-term working relationships with local institutions, service providers and resource parents. Through these working relationships, developed in a spirit of humility and co-equality, we hope that trust between the public employees and the community partners will be built and become ever-stronger, so that each becomes a reliable resource for the other in support of the neighborhood's children and families.

♦ Supporting Children and Families with Necessary Services

Vulnerable children and families need a network of supportive services – of various types, of varying intensity, available in their own communities – to avoid becoming involved with the child welfare system or, once they're involved, to receive the help they need to strengthen their families and keep their children safe and well. This network does not exist today with anything like the necessary resources or organization. The services that do exist are not coordinated with the need, are not evaluated for results in a rigorous way, and have seen their budget lines cut over and over again. With this plan, we commit to turn this tide.

In New Jersey now, children and families generally only get help when their situation has significantly deteriorated, and even then we do not provide enough help of the right kinds. More services are needed, and they must be accessible much earlier and all along the continuum of need. We will now devote significant additional resources to a range of preventive services, and will build the infrastructure for their provision throughout the state (with a particular but not exclusive focus on the neediest neighborhoods, through community collaboratives). We will also organize and focus existing spending, working with local planning bodies to focus it on the most pressing needs.

Experience and research tell us that the five main causes of family disruption and disintegration are substance abuse, mental health, domestic violence, lack of housing and poor physical health. So this plan places these five core services at the center of the system's preventive service model, and calls for:

- $10 million for the remainder of FY 2004, and approximately $10 million per year thereafter, for a range of substance abuse services for parents with children at risk
- $1 million in FY 2005 (to purchase and renovate a facility) and $2.3 million annually for five years to add, each year, 25 short-term residential treatment beds and 125 intensive outpatient treatment slots around the state for substance-abusing adolescents – adding a total of 125 residential beds and 625 outpatient treatment slots by FY 2009 (thereby returning the state to 1997 levels of both these essential services)
- approximately $10 million over five years to expand statewide a program of specialized services for children from homes with domestic violence
- addressing, by a variety of means – including a Section 8 voucher bridge fund, expansion of Emergency Assistance housing grants, and $1 million per year to rehabilitate homes of birth or resource families – the needs of hundreds of families at risk of initial or continuing family dissolution owing to their tenuous housing (which is to say, because they are low-income)
- $4.5 million for the remainder of FY 2004, and approximately $12 million per year thereafter, for a range of child behavioral health services including Mobile Response, Youth Case Management, Treatment Homes, Behavioral Assistance and Intensive In-Community supports

We will balance the allocation of services between children with open DYFS cases (now almost 65,000, up 38% in the past year) and those at risk of DYFS involvement. Our goal is that all children and families needing services receive them (with the priority always being abused or neglected children and children at significant risk of abuse or neglect), whatever the door through which they enter the service system: DYFS, the police, the courts, a community-based agency, self-referral, or another.

A child welfare planning council will be created in each county to plan and develop an integrated continuum of necessary services including both existing and new ones. (These planning groups will coordinate, and perhaps ultimately consolidate, with existing county human service planning bodies.) When these plans are complete and the planning groups strong, each of these areas will receive resources to purchase new preventive services needed in its area.

When sufficiently developed, each neighborhood-based community collaborative also will have access to resources for preventive services its steering committee deems most necessary, for collaborative staffing (with staff drawn from the neighborhood itself), and for flexible funds to stabilize families in emergencies.

Both the areas' and collaboratives' spending will be subject to performance-based contracting with rigorous, outcome-based reviews to ensure that all resources are appropriately and efficiently targeted.

♦ Supporting the Workforce

Caseworkers and front-line supervisors in the child welfare system have among the most difficult jobs in New Jersey. Like the "first responders" we so vigorously and rightly support and honor in this era, front line child welfare employees do terribly difficult and sometimes even dangerous work, often with lives in the balance. The decisions caseworkers are called upon to make can be

extremely difficult, and must be made under far less than ideal circumstances. Child welfare case work may not be rocket science or brain surgery – in some cases, it might be harder. The public should appreciate the gravity of the work, and honor those willing to do it. The child welfare agency's management, starting with the Commissioner, must and will lead by example here.

The system must make it possible for workers to meet their serious responsibilities. This starts with structural supports: reasonable caseloads, adequate training, appropriate supervision, support for ongoing professional development and skill-building, access to a requisite range of local services, backup by casework specialists when necessary, and more. None of these things has been consistently available to our caseworkers (the agency's turnover rates – which undermine its ability to meet its mission – reflect this). This plan commits to all of them.

But the necessary support does not end there. There is also a public and political dimension to it. The vision of vastly improved child welfare practice to which our State commits itself in this plan never will be realized unless the agency's management and caseworkers operate as true partners at every stage of the process. Management today commits itself to such a partnership and promises, as a starting place, to support its front lines.

♦ Creating a Culture of Accountability

We will create a culture of accountability throughout the child welfare system, at all levels, starting with the senior management. For too long, all real accountability has flowed only downhill and fallen on the front lines. No more.

Accountability will rely on two basic elements: <u>mutuality</u> and <u>data</u>.

<u>Mutuality</u> means that at every level there will be reciprocal – not unilateral – responsibilities and obligations:

- The State – both the government and the citizenry – must provide the child welfare system with the necessary resources and public support, and the system must provide safety, permanency and well-being for all the children for whom it is responsible.
- The system's management must ensure that its caseworkers and front-line supervisors have the tools and supports necessary to do their difficult jobs, and the front-line personnel must adopt and implement an outcome-oriented, "whatever it takes" approach to meeting the children's needs and goals.
- Caseworkers must partner with, not dictate to, children (of appropriate age) and birth families to determine the appropriate goal, the steps necessary to reach it, and the services necessary to make the steps possible, and the children and families must avail themselves of the services and take the steps.
- The system must provide resource families with the training and supports they need, and the resource families must provide both love for the children in their homes and vigorous partnership in achieving the permanency goal.

- The system must approach communities and neighborhoods with deep respect, openness, a mindfulness of their histories and assets, a desire to partner on a co-equal basis, and adequate resources, and the community must mobilize its resources and institutions to provide the circles of support essential to children's and families' success.

Data means a system that focuses like a laser beam on outcomes, tracking everything necessary for all parties to rigorously determine whether real progress is being made. Like all aspects of accountability, this will start at the top. The system's key benchmarks will be tracked numerically on a quarterly basis, and will be available on the agency's Web site, beginning no later than June 30th. This agency will hold itself accountable, and expects the public to do no less.

Data will be central to the system at all levels. As soon as the necessary computer system can be put in place – SACWIS, the statewide information system, is under active development and will be pushed forward as quickly as possible – managers will be provided routine reports regarding the workers whom they supervise, as an objective tool to determine which cases are moving forward and which are stalled, which areas each worker excels in and which require more training or support. (An interim computer system will generate reports until SACWIS is on line, supplemented by qualitative case record reviews.)

Data will also include qualitative information of the sort available through a system of regular, random case record reviews. Numbers are important, but child welfare is a human endeavor, and its essential aspects cannot all be captured on a spreadsheet.

Data regarding both aggregate case progress and neighborhood assets also will be made available on the neighborhood level, to inform the neighborhood collaboratives at the center of this plan.

We will have a high-level data analysis unit dedicated to analyzing and tracking everything important about the system's work. This information will feed into a program of continuous quality improvement (CQI), through which both achievements and areas needing improvement will be focused on from the front lines to the Commissioner. The CQI process will involve community members, whom we will ask in each county to help us monitor our progress and identify where we can do more.

It is impossible to overstate the degree to which this sort of data-driven accountability represents a sea change in the state's child welfare practices. Creating this system will require enormous efforts in the realms of information technology, quality improvement, and institutional culture. All begin today.

♦ Providing the Necessary Resources

This plan would not be real without the resources to implement it. Over the next two years, the plan calls for:

- 416 new child protection and permanency workers
- 48 new casework supervisors
- 136 new adolescent specialist

- 191 new resource family support workers
- 12 new community collaboratives
- a greatly enhanced array of services, both statewide and with particular emphasis on the highest-need neighborhoods
- a 25% increase in foster care board rates
- and much more

This will not come cheap, but must be paid for. New Jersey has underfunded its child welfare system for the better part of a generation. We now know all too well the human price we pay when we fail to invest in our most vulnerable children and families.

Those days are over. In the FY 2005 (which begins July 1, 2004), $125,352,000 in new money (that is, in addition to DYFS's existing budget) will be devoted to the implementation of this plan. And $180,228,000 has been projected for year two.

These are significant sums. But they are only the down payment. A system that has itself been neglected for so long will take many years to heal and reform. Providing the child welfare system with the resources necessary to continue improving must become an institutionalized and unwavering part of our political culture.

■ ESSENTIAL PRINCIPLES

1. This plan was developed and will be implemented in accord with the following principles:[4]

   Children in out-of-home care should be protected from harm.

   a. Out-of-home placement should be as temporary an arrangement as possible, with its goal being to provide to children a safe, nurturing, and permanent home quickly.
   b. If at all possible, children in out-of-home placements should be quickly and safely reunified with their biological families. If this cannot be accomplished, children need to be placed with an adoptive family, or in the permanent legal custody of an appropriate kinship family, in a timely fashion.
   c. Families should be provided with the services they need to keep them together or to allow for safe and speedy reunification whenever possible.
   d. In making determinations about plans and services, the child's interests are paramount.
   e. Children in out-of-home placement should be in the least restrictive, most family-like setting appropriate for their needs.
   f. Children in out-of-home placement should be placed in settings that promote the continuity of critical relationships: together with their siblings; with capable relatives whenever possible; and in their own communities.
   g. Children in out-of-home placement should have stable placements that meet their needs, and should be protected from the harm caused by multiple placement moves.
   h. Children in out-of-home placements should have the services necessary to address their medical and psychological needs, including those services needed to address problems arising from the child's removal from his or her biological family.
   i. Children in out-of-home placement must have timely decision-making about where and with whom they will spend their childhood, and timely implementation of whatever decisions have been made.
   j. Children in out-of-home placement should be protected from abuse and neglect and, to this end, investigations of allegations of abuse and neglect in out-of-home placements should be timely, thorough and complete.
   k. Adolescents in out-of-home placements should be provided with the skills, opportunities, housing and permanent connections with caring adults they need to successfully make the transition to adulthood.

2. Decisions about children in out-of-home placement should be made with meaningful participation of their families and of the youth themselves to the extent they are able to participate.

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[4] These principles, which are embodied in the settlement of the litigation, were developed and agreed to because they are manifestly in the best interest of the children and families reliant on the state's child welfare system. Because the litigation focused on children in out-of-home care, so do these principles. But they are without limitation as to the other principles embodied throughout this plan regarding children at home and their families.

3. In order to protect children and support families, New Jersey's child welfare system should operate in partnership with the neighborhoods and communities from which children enter care.
4. New Jersey's child welfare system should be accountable to the public; to other stakeholders; and to communities throughout the state.
5. Services to children in care and their families should be provided with respect for and understanding of their culture. No child or family should be denied a needed service or placement because of race, ethnicity, or special language needs.
6. New Jersey's child welfare system should have the infrastructure, resources, and policies needed to serve the best interests of the children in its care.

■ ACCOMPLISHMENTS TO DATE

Even as this plan was being developed, the Division of Youth and Family Services (DYFS) and other parts of the Department of Human Services (DHS), in partnership with the Governor's Office and other agencies of state government, took the first steps down the long road of reform. These did not come close to resolving the problems, which will take years of diligent effort. They were an initial down payment, and evidenced the state's seriousness of purpose.

We increased the number of DYFS caseload carrying positions, assigned police officers to DYFS District Offices, equipped the field workforce with desperately needed vehicles and equipment, bolstered continuous quality improvement staff, telegraphed an increased emphasis on accountability at the local level, criss-crossed the state to engage the larger community in the reform effort, enhanced staff training, implemented interim web-based case tracking tools for caseworkers, and developed scholarship and employment training opportunities for aging-out youth.

Specifically:

- During the last year, DHS has secured meaningful commitments from other key departments, underscoring the government-wide engagement in this reform process. The Department of Community Affairs has agreed to fund housing assistance programs for foster and adoptive parents, and to provide additional emergency housing for victims of domestic violence. The Department of Labor has piloted an innovative apprenticeship program, focused on children aging out of foster care. And the Department of Law and Public Safety has undertaken a long-needed assessment of structure and capacity within the unit assigned to represent the child welfare system in court, leading to a more efficient operation and expanded supervision for attorneys.
- During the latter part of last year, the Department of Human Services held a series of high-profile public meetings to begin the public discussion of the reform process and emphasize the need for full public engagement and support.
- Between July and December last year, DYFS achieved a net gain of 253 caseload carrying workers[5] and is now at an all-time high, nearing 2,000. The Division recruited aggressively through job fairs where, for the first time, candidates could apply and be interviewed on the spot, and has utilized an over-fill strategy to keep up with attrition.
- The Department assigned more than 30 Human Service Police Officers to DYFS District Offices to help caseworkers find missing children and families, ensure caseworker safety, and improve relations with local police departments.
- The Department transferred 160 underutilized vehicles from other divisions and purchased about 3,000 computers, 2,000 cell phones and 90 digital cameras to fully equip DYFS caseworkers.

[5] Through December, DYFS actually added 390 caseload carrying workers, but lost 137 others to attrition.

- To bolster the Division's ability to evaluate its work, five Quality Assurance Coordinators were hired for the DYFS QA unit, which had been decimated by layoffs and budget cuts in past years.
- Division staff reviewed hundreds of DYFS case files to assess quality issues and developed report cards for field offices to measure performance. These monthly report cards track the progress of each District Office on: the number of children in substitute care; the number of children supervised in-home in open cases; the percentage of children with multiple placements; the number of children placed out of state; the number of children in intake less than 45 days; the number of cases closed in the current month; and the number of new foster homes licensed.

  Internally, the Division is producing quarterly reports on the progress of each office in: the recurrence of abuse or neglect; the percent of children abused or neglected in foster care; the percent of children reunified within 12 months of placement; percent of children reentering care within 12 months of returning home; and the percent of children who have had two or fewer placements. DYFS is using these report cards to chart areas needing improvement in each office.
- DYFS developed management and supervisory training and implemented management changes throughout the organization. The management training, developed through a university consortium, began on January 23 at Rutgers. About 100 people attended. There will be five more training sessions over the next several months.
- The Division continued to develop a Structured Decision Making program (SDM), a set of nine web-based tools to improve the quality and consistency of case practice with children and families, both in-home and out-of-home, from initial screening throughout the life of a case. Training for professional staff began on April 12.
- DYFS and the Department implemented a web-based case recording and tracking tool that allows staff to view management reports that identify and provide location information on all children in placement, both in- and out-of-state.
- A web-based case recording and Minimum Visitation Tracking (MVR) program was developed and is now mandatory. This tool allows staff to record the substance of their interviews with all clients and collateral contacts as well as to record conferences with Deputy Attorneys General and Supervisors. It also documents other administrative conferences about cases. These contacts previously all were done only on paper, so other staff could access the information only by reviewing the physical case record. This software also will be used to track the timeliness of responses to reports of child abuse and neglect.
- The Department of Human Services worked with the Department of Labor to prioritize training and job placement for children aging out of the state's foster care system. The County Workforce Investment Boards (WIBs) and the sub-groups that focus specifically on youth, the Youth Investment Councils (YICs), are being required by DOL to focus spending plans to meet the needs of youth aging out of foster care, child-only TANF cases, and youth under the supervision of the Juvenile Justice Commission.

- The Newark YIC plan will build on efforts DYFS has begun in introducing aging out youth to career opportunities and the training necessary to achieve these goals. This partnership with DOL, the Newark YIC and the federal DOL will be replicated throughout the state.
- In May, Governor James E. McGreevey created the Governor's Cabinet for Children, bringing together senior members of his administration (including the Attorney General, Treasurer, and the Commissioners of Health and Senior Services, Community Affairs and Education) with New Jersey child advocates to work together on a continuous basis in support of New Jersey's children. It is currently chaired by the Commissioner of Human Services.

More Recent Actions

On January 14, Commissioner James Davy announced several immediate actions to address long-festering problems at DYFS. He ordered seven immediate actions, and has been publicly reporting on their status each week. These actions included:

1. Safety re-assessments for out-of-home placements.

   Safety assessments involve a visit to the out-of-home placement, assessment of the surroundings, an interview with the caretakers, and face-to-face interviews with the children. On January 29, training began for DYFS employees who will be conducting safety assessments. Three outside agencies – Youth Consultation Services, Children's Home Society of New Jersey and Family Services of Burlington County – have been contracted to partner with DYFS in this effort.[6]

2. Licensing of resource homes.[7]

   DHS expedited the training and licensure processes, with a goal of adding 100 new resource homes to the system within one month.

   As of February 4th, 107 new resource family and treatment homes had been licensed, and 190 more potential resource families in training had concurrently begun the home study process, reducing the licensing process from months to weeks. These new resource families were expedited through the process, some within 90 days.

3. Providing transportation and programming for children in District Offices.

   Each of the four DYFS regional offices received $250,000 to contract with child care providers and after-school programs so children would not have to spend time in District Offices. DYFS also created 38 case aide positions and redeployed other staff to transport the children to child care, school and after-school programs.

[6] If these safety assessments – which are a new technology – are deemed to be effective (the process is being evaluated by DHS, the Child Welfare Panel, and Children's Rights, Inc.), the agency will consider making them a routine part of its practice.

[7] These were formerly known as foster homes.

4. Increasing the number of medical staff available for children's medical screenings and pre-placement medical examinations.

   As of February 4th, working in conjunction with the American Academy of Pediatrics (AAP) New Jersey Chapter, and the Federally Qualified Health Centers (FQHCs), 100 providers at 114 sites in all 21 counties had been identified to conduct medical screenings. In addition, 10 new nurses will be hired to handle medical screenings. The existing DYFS nursing staff have been issued cell phones and pagers so medical screenings can be conducted as quickly as possible.

5. Reducing the incidence of boarder babies.

   Of the 21 boarder babies (infants medically cleared for release from the hospital after birth, but with nowhere to go) who were in hospitals on January 14, only four remained by February 4th. Two caseworkers – a boarder baby coordinator and a family team conferencing facilitator – were redeployed to work exclusively on this problem in Newark, where it is the most prevalent.

   An additional $300,000 was provided on February 3rd to contract with community agencies to conduct home studies of relatives. This will allow the placement process to be expedited and allow babies to go home with relatives sooner. The funding also will be used to purchase infant supplies such as cribs, car seats or whatever the families may need to bring the baby home.

6. Close cases and reduce worker caseloads.

   Following the death of Faheem Williams in January 2003, there was a dramatic increase in awareness of child abuse and neglect issues, and referrals to DYFS increased dramatically in 2003. At the same time, because Faheem's case was closed without a caseworker having seen him, there was heightened sensitivity to closing cases. Thus, there were more cases entering the system but fewer being closed.

   Overtime was authorized for DYFS supervisors to review cases and close those that can be closed safely. As of February 4th, 356 DYFS supervisory staff had volunteered to review the cases, and 2,000 had been closed by the second week.

7. Increase immediate efforts to recruit foster homes.

   In addition to the 107 new foster and treatment homes added, the Division signed a contract with the Hispanic Information Center to add 10 foster home beds in Passaic and Hudson counties.

8. Finally, in early February 2004, $10 million in additional funding for substance abuse treatment for mothers with children was provided, and the Division of Addiction Services – whose work is so essential to child welfare – was moved from the Department of Health and Senior Services to the Department of Human Services, where it will be able to participate more closely in this reform effort.

■ REFORMING CASE PRACTICE – A NEW WAY OF DOING BUSINESS

♦ Keeping Children Safe

As stated in our core commitments, child safety is, and must always be, foremost. In order to do that job well, we must be accessible to the public, and when the public call us, we must respond swiftly and professionally in order to ensure children are safe.

The public – teachers, police, doctors and nurses, daycare staff and others – are on the frontlines of keeping children safe. They are our eyes and ears in the community. They call us because they are concerned about the safety and well-being of a child. They must be able to reach us quickly and easily – day or night – weekdays and weekends. Our staff answering these calls must know the right information to gather. They must make informed and consistent judgments about when a child might be at risk, triggering the need for an investigation.

When a report[8] requires investigation, that investigation must be conducted professionally and with appropriate urgency – with the knowledge that a child may be in danger. In order to accomplish this goal, we must separate the protective from the permanency functions. Staff assigned as protective workers should have specialized training and low workloads to ensure a laser-like focus on the issue of risk. We propose that our protective staff respond to all reports within strict timelines – initiating the investigation within 24 hours or less of the report – which includes a face-to-face private interview with the child – and concluding the investigations within sixty days. We will need to change our work schedules to make ourselves available evenings and weekends – when our families and children need us. We need to provide these protective staff with sufficient training, support, and supervision to ensure they are able to make accurate, guided, informed, and consistent judgments about how best to keep children safe. Separating the protective and permanency functions will also improve our ability to coordinate with law enforcement and medical providers in cases of severe maltreatment which may require criminal prosecution or immediate medical care.

During the investigation, we expect our protective workers to treat families with respect. When possible, they must try to keep families together, supported by services. When they must separate a child or children from a family, that "removal" will be done as sensitively as possible. And whenever the decision is made that a case must be opened – either for services alone or services and placement – the protective worker, with the permanency worker (and family resource worker where appropriate), will work with the family as a team to create the best alternative plan. In order to keep the protective worker focused on finishing the investigation, once the case is opened, the permanency worker takes over responsibility for case management. The two continue to operate in parallel, as a team, as the protective worker finishes the

[8]Note that we are using very precise nomenclature to distinguish between calls, reports, or investigations, and cases. The Hotline receives calls – and they then determine whether or not a call meets the standard for a report of maltreatment. In turn, they refer the reports to the protective staff, who investigate the reports. If the investigation proves the report is founded THEN they will open a case. In current practice, an open case refers to reports, investigations, and cases opened for services or services and placement.

investigation, and the permanency worker proceeds to work with the family on planning and permanency.

If a subsequent allegation of maltreatment arises after we have opened a case, if the child remains in her own home, our protective staff will investigate the case. However, if the child is in a placement of any kind, allegations of maltreatment while the child is in placement are referred to the Institutional Investigations Abuse Unit (IAIU), which will take over the investigation to guard against any potential conflicts of interest. IAIU staff will employ the same enhanced forensic tools we will provide to our protective staff and will meet the same timeframes and investigative standards – and we will improve communication between IAIU and our child welfare staff.

With open cases, safety is the responsibility of ALL child welfare staff, led by the permanency staff member and her supervisor. On all open cases, whether a child remains at home or in placement, we will conduct safety assessments at least every six months or more often in cases where we deem it necessary.

We make three basic commitments in this area:

1. Creating a Centralized Hotline. We will create a centralized hotline with dedicated staff. That hotline will operate 24 hours a day, 7 days a week. The public and professionals will be able to access the hotline through a single well-publicized telephone number. Calls will be answered swiftly and professionally. We will screen those calls according to strict protocols which ensure consistency. When we accept a report of maltreatment, we will rapidly transmit that report for investigation.
2. Improving Investigations and Safety Assessments. Investigations, whether the child is in the community or in care, will happen swiftly and thoroughly. We will respond to calls from the Hotline within 24 hours and we will conclude investigations within 60 days. We will improve training and coordination on investigations of cases involving children in placement. On all open cases, we will conduct regular safety assessments at both mandated milestones and whenever circumstances warrant them. As with the Hotline, we will train and support staff to respond consistently to issues of risk.
3. Integrating the Child Advocacy Centers (CACs) and Regional Diagnostic Treatment Centers.[9] The cases served by the CACs and Diagnostic Treatment Centers involve the most severe maltreatment where there is the prospect of criminal prosecution. We will work with local law enforcement and medical providers to improve the level of cooperation with DYFS and to connect these Centers to ensure statewide coverage.

[9] CAC's and RDTC's exist to focus on severe cases of maltreatment. These cases require extraordinary levels of coordination between law enforcement, medical staff, and child welfare in order to collect the necessary evidence. These models focus on trying to minimize trauma to the child – by creating child friendly environments, minimizing the need for re-interviewing (so the child does not have to repeat upsetting information over and over again), and encouraging exchange of information among the key players.

The Current Situation

Reporting Maltreatment

Currently in New Jersey, it can be challenging to try to report suspected neglect or abuse. In many states, there is a hotline – with a single well-known and well-publicized number – an "800" number – which everyone knows. In New Jersey, there are more than 30 different telephone numbers to report child abuse/neglect and the "right" number to be used varies by location, day of the week, and time of day—and whether or not the child is already in placement.

If the caller has the right number, there are differences throughout the state in how that call will be handled. At present, calls go to various locations – there is no centralized screening. In some of our offices, staff must handle these calls while juggling other responsibilities. Many District Offices do not have a unique screening function, so the task is shared by many staff with various levels of training and expertise. For cases where a child is in placement, the caller must call a separate number, the Institutional Abuse Investigations Unit (IAIU), which has its own hotline. Most offices do not have screeners available to handle reports from Spanish speaking reporters, or reporters in any other language. That lack of language ability could prevent us from receiving a report. Finally, from office to office, there is no shared set of standards about how to respond. The result is that reports accepted for investigation in one part of the state may not be investigated in other places.

Straining to Conduct Investigations in the Community

In 2003, we received almost 30,000 reports requiring investigation – an average of 2,440 reports per month. Currently, there are great variances in how investigations are conducted and in who conducts them. Some offices have specialized units, while in many others, investigations are handled by staff who also carry client caseloads. Average caseloads consist of 42 children – a number which far exceeds national standards for both investigatory and permanency caseloads. That volume can slow down or compromise a staff member's ability to respond quickly and appropriately during an investigation.

But the issue is more than volume. The mixed workload requires staff to triage among tasks that all require high priority. At any one moment in time, they must juggle responding quickly to an allegation of abuse or neglect along with trying to meet urgent needs among the children and families on their caseloads while also being responsible for reporting to court. In that juggling, safety usually wins – but it wins at the cost of the ability to deal with a crisis for a child in care, with the ability to provide services, with the ability to keep cases moving along to permanency.

In addition to the challenges of high volume and conflicting, important priorities, we ask staff to make critical investigative decisions without enough specialized forensic training and without clear and consistent guidelines to support them in their decision making. Without strong investigatory training, staff may miss issues, placing a child at risk by leaving a child who should have been removed in the home, or may remove a child who could stay in the home, causing enormous disruption to that child and family. And, as with the existing practice in screening calls, our staff conducting investigations apply varying guidelines in determining which cases

warrant opening a case – and among those, which require immediate, emergency removal – which means in practice that families with the same issues are treated very differently from office to office and worker to worker.

Finally, when the investigative and service-providing functions are housed in the same person, we create a trust challenge for the families and children under our supervision. We ask families to accept that the person who decided that something was wrong with the family, so wrong, in some cases, that the family was separated and the child or children removed, is the same person they have to trust in order to help them get back together. Some staff can bridge that tough challenge – but it is hard. And we believe it is asking too much – too much of our families and too much of our staff.

Straining to Conduct Investigations in Placement

Once a child is in placement, there is a separate system for handling allegations of maltreatment. Those investigations are handled by the Institutional Abuse Investigations Unit (IAIU), which is charged not only with investigating individual allegations but also with looking for patterns and practices of abuse or neglect across offices or institutions. In 2003, IAIU investigated 1,945 cases, an 11% increase over 2002. Staffing levels at IAIU have not kept up with the increase in the volume of investigations. The average caseload in IAIU is currently 31.5 cases. IAIU is housed outside of DYFS in the Department of Human Services in order to control for any potential conflict of interest.[10] This separation requires effort to ensure against fragmented communication between the DYFS staff responsible for individual cases and IAIU investigators.

Lack of Coordination and Coverage for Cases of Severe Maltreatment

The State of New Jersey utilizes a forensic system for the investigation of sexual abuse and severe physical abuse and neglect that has evolved over the years without the benefit of statewide planning, goals, and clear delineation of responsibilities. The system suffers from a lack of consistent policy, operational guidelines and leadership. Resources, systems, and responsibilities vary widely from county to county.

Although the investigation of child abuse and neglect is a joint responsibility of child protective services and law enforcement, in many cases the county prosecutor's criminal investigation takes the primary lead over the DYFS civil investigation. Yet county prosecutors lack sufficient staff to respond to reports on a timely basis, and often require DYFS staff to gather information for them. The entire system suffers from a lack of properly trained forensic interviewers and from the lack of uniform protocols for joint investigation and information sharing. The result is that cases are not as well prepared for criminal prosecution as they could be – delays can be common place – and children can remain in limbo as the results of the DYFS investigation are forced to

[10] The concern is that it could be difficult for the DYFS to license and oversee a placement – and then conduct a sufficiently independent investigation of that placement if an allegation of maltreatment is made. The theory is that keeping IAIU separate controls for potential conflict of interest, such as DYFS's potential desire to keep a placement on line or blindness to its own failure to properly supervise. On the other hand, DYFS knowledge about a placement could aid the investigation and any corrective actions and replacements that may result if an allegation is founded will have to be effected by DYFS.

trail the criminal prosecution. And cases where the investigation does not result in a prosecution can be lost to the child welfare system.[11]

Currently, many of these cases are handled through Child Advocacy Centers (CACs). The CACs have been established over the years primarily by county prosecutors based on the availability of funding, community support and interest on the part of the county prosecutor. Each operates independently and practices vary from center to center. DYFS's role varies widely from center to center and is most often dependent on the standards established by the county prosecutor. There is no requirement that the centers operate according to national standards.

In addition to the CACs, the state has established four Regional Diagnostic and Treatment Centers (RDTC) to provide medical and psychological forensic services. These RDTCs are utilized by both law enforcement and DYFS staff. The statute establishing the centers defined some staffing and operational responsibilities. In practice, each of these operates according to its own model and independently established sets of operating guidelines and services. Unfortunately, the location of the four centers makes them difficult to access for much of the state. And the volume of cases that require forensic medical evaluation far exceeds the capacity of the four centers. As a result, counties utilize a variety of other medical/psychological services on a contract/vendor basis to supplement the RDTCs.

All counties have some form of a multi-disciplinary team (MDT)[12] to respond to cases of severe maltreatment. There is no uniform design for the MDT. Some of these teams conduct only investigations – others require members provide case planning as well. Some report to the local county prosecutor while others fall under DYFS's authority.

The bottom line is a fragmented system which suffers from a lack of uniform policy, direction and leadership. In theory, the CACs, RDTCs, and MDTs were established to improve the level of service to children – in practice, the needs of the children can be lost among the demands of the jockeying authorities.

Straining to Monitor Safety on Open Cases

Whether a child is at home or in placement, even as DYFS staff investigate new cases, provide services, run to court, and pursue permanency, they are also supposed to keep a constant eye on the safety of all of the children in their care. All DYFS staff know they are responsible for monitoring safety on their open cases – but high caseloads, juggled priorities, and a lack of consistent support and accountability by management have strained performance of this responsibility. And the result can be that a child or family falls through the cracks with potentially tragic results. Recent tragedies have underlined this duty – but have not given staff the tools to carry it out well or consistently. And over the past year, some of our initial attempts

[11] While the evidence or allegations may not have been sufficient to meet a criminal standard, that does not mean there was not sufficient evidence to meet the standard for neglect or abuse – and these cases may have needed services or even services and placement.

[12] Various other systems – mental health, juvenile and criminal justice – also have constellations of staffing referred to as multi-disciplinary teams. For the purposes of this plan, we are referring specifically to multi-disciplinary teams formed for the purposes of investigating allegations of child maltreatment.

to execute regular safety assessments have not met best practice standards, further undermining the public's confidence in our ability to take care of the children on our caseloads.

Strategies

To turn around our protective services, we will employ four strategies:

1. Create a Centralized Hotline

In our new vision of the system, no suspected abuse or neglect will go unreported simply because a concerned citizen does not know how to call us. So the first step in improving our protective services is creating a centralized hotline with one number which we will publicize everywhere.

Next, we will staff that Hotline with dedicated staff in a centralized location. These specialized staff will receive intensive training and supervision to ensure that calls are being answered quickly and professionally. The increased volume of calls over the past two years also suggests that we need to dedicate more staff to this important task. The creation of a centralized system also will allow a concentration of bi-lingual workers available to handle Spanish-speaking calls, and we will establish access to a language bank of interpreters with skills in over 130 languages. We also will provide TTY access for reporters who are hearing impaired.

And we will support the staff by providing them with the latest in decision making tools – Structured Decision Making (SDM) – to improve consistency of judgment in the initiation of investigations. We have already begun the process of outlining the protocols for response, detailing which types of calls require which precise responses. Centralizing this function will aid our goal of employing a single set of informed standards, will pool the expertise of a dedicated staff, and will allow us to monitor this important "front door" to our system closely. These staff will have access to a centralized database, which will track prior reports – and enable them to identify children or families with previous histories of abuse or neglect. Once staff determine a report meets the threshold for abuse or neglect, that report will be automatically transmitted to the District Office covering that geographic region and to the frontline protective worker and supervisor on-call. In cases involving children in placement, the report will be similarly transmitted to IAIU staff.

2. Conduct Quality Investigations

Best practice suggests we radically overhaul our investigative function.

Competent, timely[13] and thorough investigations will be conducted on all children reported as suspected victims of child abuse/neglect when the information from the reporter meets the criteria established in regulation – whether that child is still at home or in placement.

[13] The question of timeliness raises the issue of the system's days and hours of operation. The need for child welfare services is not confined to traditional weekday business hours. DYFS has traditionally operated on a 24-hour basis, but to a limited extent. The centralized Office of Child Abuse Control (OCAC) and the county-based

In this plan, we commit to separating the investigative function from the casework function. We will dedicate staff – protective workers – to the sole task of investigating allegations and taking appropriate steps to address safety and risk issues. They will not carry a permanency caseload. Instead, once a protective worker decides, with his supervisor, that a case must be opened, there is an immediate hand-off – in most cases, as we discuss, through a family team meeting. After the hand off, the protective worker remains responsible for finishing the investigation while the permanency worker assumes responsibility for providing services and permanency. That change will help us keep protective workloads down – reduce delays in investigations while reducing delays in getting services and starting towards permanency for the children under our supervision. Each protective worker will receive no more than eight new investigations per month, in keeping with the national standards.[14] But in order to reduce workloads to acceptable national standards, we will also seek the resources to hire more protective workers.

With fewer reports and with their training and attention focused on investigation, protective staff can respond to new reports quickly. We commit to initiating our investigation and seeing the child in under 24 hours in every case. And staff will move investigations along more swiftly, without compromising thoroughness. Those changes in practice allow us to set a standard of concluding investigations within 60 days (unless an extension is granted by a protective service supervisor for good cause.) For our most serious investigations, sexual abuse and severe physical injury, joint investigations will be conducted between DYFS, law enforcement, Child Advocacy Centers, and Regional Diagnostic Treatment Centers.

But it will take more than lowering workloads and transferring on-going case management responsibility to improve the protective function. Investigations require skills in specific areas: forensic interviewing, gathering and maintaining evidence, and extensive use of safety and risk assessments. Protective investigators must be able to engage families in a non-hostile manner and establish excellent working relationships with law enforcement and hospital staff. Special qualifications and experiential requirements will be necessary for staff performing this function.

As with the Hotline staff, protective investigators will be equipped with a set of clear protocols and guidelines about how to make decisions. The goal is to have those decisions made more consistently with expert judgment about what levels of risk warrant what levels of system response in order to keep children safe. Structured Decision Making also will improve the consistency of our response from community to community and from case to

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Special Response Units (SPRU) have operated at night and on weekends to address referrals received at times other than during the traditional work week. In addition, to accommodate families that are not available during the day many field staff have historically completed home visits on their cases after hours, but this has always been more of an informal operating procedure. We believe more is required – in areas including but not limited to child protective investigations – and are committed to making our staff available, more formally and routinely, both weekday evenings and weekends as necessary to meet our clients' needs. Achieving this goal raises a series of considerable labor relations, logistical and fiscal issues. A broad-based work group to evaluate these questions and develop a detailed proposal is being formed. A proposal will be developed by August 2004, and it is anticipated that implementation will be begin in January 2005.

[14] Note that this is an individual limit – not an average caseload size.

case, reflecting the expert judgment of the Department, rather than being left to the individual worker.

All of these protocols and guidelines encourage staff to solicit input and insights from children and family members – and to look for strengths and solutions as well as problems and needs. It will take some practice for staff – at all levels – to learn to internalize and value input from families in the decision making process – and to resist treating the protocols and guidelines as checklists of risk. SDM should guide decisions, providing workers valuable information to improve case plans, family team meetings, and services. It is a means to the end of good practice. As with the work of our Permanency staff, we expect to find a tension in the real life application of the Structured Decision Making process with our practice model in which we are committed to consulting with children, family, and community members. Bolstered by outside expertise, we will work closely with our staff – not just in terms of training but in providing on-going support – to help them manage this change.

Investigatory staff will receive close supervision – there will be no more than one supervisor per five staff – and supervisors will go out into the field with each staff member at least once per month.

We commit to responding to the level of risk with the least intrusive response consistent with maintaining the child's safety. If there is a low level of risk, we will not open a DYFS case but will refer the family for community-based services. If there is a moderate risk, we will convene a family team meeting and make a determination as to whether to open a DYFS case or place case management responsibility with a community provider or mental health or TANF caseworker, as appropriate. With high risk, we will open a case for services or where it is necessary to protect the safety of the child, separate the family – conducting what is termed a "removal" – and place the child in an alternate form of care.

As with our permanency staff, the protective staff will be distributed geographically to District Offices. This geographic distribution will help protective staff become knowledgeable about the community in which they work. They will know the schools – and school staff. They will know local law enforcement. And they will know and become known to local community organizations and community members. All of these ties will improve their ability to conduct thorough investigations.

Such knowledge about the community also will help keep our staff safe – and predict when they may need back-up. And we commit to expanding our ability to provide that back-up. We currently have 18 Human Service Police Officers and plan to hire more so that each District Office will have at least one officer. These officers also will assist our staff in locating families we cannot find in doing our investigations. And our geographic focus will help our staff improve coordination with local law enforcement for any additional necessary back-up.

In separating the protective and permanency functions, we know we run the risk of information loss and a break in the relationship between the family and DYFS staff. Therefore, transfer will not take place on paper alone. Instead, the primary mode of transfer

will be a face-to face conference, supplemented by the paper record, involving the protective worker, the permanency worker, and a supervisor. We commit to including families in those transfer meetings, transforming them into family team meetings. Where a case involves the need to separate the child or children from the family (a removal), the family resource worker will also attend. If the family cannot attend this initial meeting, permanency staff assume responsibility for ensuring that a family team meeting takes place as soon as possible after the opening of the case – and we have set a benchmark of achieving that conference in under 72 hours.

In cases involving investigations of children in placement, we will maintain the separate Institutional Abuse Investigations Unit. We commit to providing those investigators with the same enhanced tools we will utilize for our protective staff. We also commit to improved communication and coordination between IAIU staff and protective and permanency staff. We will also build strong relationships between IAIU and Continuous Quality Improvement (CQI) staff to ensure that IAIU expertise and findings inform Quality Assurance oversight. Toward this end, and as part of the process of establishing a robust Office of Children's Services within DHS (discussed elsewhere in this plan), IAIU will be moved to within OCS, into the same organizational unit at OCS CQI function. We also will conduct a comprehensive review of the IAIU's practices, protocols and procedures, including its follow-up with corrective action plans and its communication with related operational units (licensing, foster home units, caseworkers, contracting, and others), and covering alleged abuse and neglect in both congregate and family settings.

3. Improve Victim Services and Coordination Among Law Enforcement, Medical Staff and Our Staff in Cases of Severe Maltreatment

In severe maltreatment cases, we want to integrate the responsibilities and activities of child protective service, law enforcement (including county prosecutors and police), and medical and psychological services, into a new forensic investigation model. This new model would establish uniform guidelines for the investigation of child abuse/neglect by DYFS and law enforcement, and the operations of Child Advocacy Centers, Regional Diagnostic Treatment Centers, and Multi-Disciplinary Teams. The model needs to delineate and establish standards for, and provides resources for:

- When, how, by whom, and where child victims of child sexual and physical abuse and neglect are interviewed;
- When, how, by whom, and where alleged perpetrators of child sexual and physical abuse and neglect are interviewed;
- When and how to access appropriate forensic medical/psychological services.
- Timely and appropriate linkages to treatment.

Principles:

- These systems need to be designed in a manner that first and foremost meets the medical and emotional needs of victims, while providing investigators access to information to protect the child and support the prosecution of perpetrators;

- The investigation of child sexual and severe physical abuse and neglect is an equal partnership between child protective services and law enforcement;
- Children should be interviewed only one time by trained forensic interviewers;
- Information developed during the investigation must be available on a timely basis to both law enforcement and child protective services;
- Every county must have access to trained forensic medical and psychological services to allow investigations to be completed within established time frames and to allow staff to make required decisions concerning child protection and criminal prosecution.

4. Monitor the Safety of the Children Under Our Supervision

Safety is our highest priority not only for Hotline calls reporting allegations of abuse or neglect – but also with respect to the children already under our supervision, whether still at home or in placement. We commit to improving the safety monitoring of these children. Management expectations of our staff on this front will be extremely clear. We will provide the tools and support our staff need to perform this function consistently and well. In turn, we will hold all of our staff – frontline, supervisory and managerial – responsible for making sure this gets done.

Checking on the safety of the children under our supervision should happen every single time any one of us sees a child. We want to work with our staff so they internalize good safety practice – and we will provide them with training so they know the right questions to ask and the right things to look for. But in the end, it is not a checklist – it must be a way of seeing and thinking.

In order to instill this mindset and ensure such safety checks occur, we are mandating that staff document their completion of a comprehensive safety assessment at the beginning of our involvement with the family and at important milestones thereafter. Key junctures for safety assessments include the need to evaluate whether or not to remove a child, before unsupervised visits occur, before a child returns home, before a case is closed, after reunification occurs, and at other points when a major change occurs in the family (e.g. the introduction of a new adult to the household). Anytime a safety factor is identified a specific safety plan must be developed that addresses the safety factor and can be closely monitored by our staff.

To be clear, such assessments will not be conducted on the paper record – but will involve a face-to-face visit with each child. Every child and adult in the household will be interviewed. Staff will visit every room in the home, note the housekeeping standards, check to see that the electricity is on and all appliances are in working order and ensure there is adequate food in the home.

After an initial push to do baseline assessments for all of the children under our supervision, we will build these assessments into home visits (which will occur at least monthly) as a part of our regular on-going practice. Permanency staff will conduct safety assessments of the children on their caseloads at least once every six months. The lowering of caseloads and

geographic concentration of cases should help reduce workload pressures on our staff to ensure improved performance of monthly visits and six-month safety assessments.

But the responsibility of ensuring the safety of the children under our supervision extends well beyond front-line permanency staff. Other staff – resource family support workers, adoption workers, and community resource development specialists – will have regular contact with birth families, resource families and children – and will be trained and expected to monitor safety issues. Supervisory and managerial staff will receive training in how to perform these assessments themselves – they will be responsible for approving the assessments for the staff who report to them and they will need to provide back-up to frontline staff to ensure blanket execution of this policy – but they will also receive tools designed to assist them in monitoring the execution of safety assessments. We will develop tracking systems which will enable managers, supervisors and front line staff to monitor and red flag cases where safety assessments have not happened within the established timelines. We are making these assessments a priority for quality assurance purposes – and the CQI staff will check independently to ensure we are fulfilling this responsibility.

Creating a Centralized Child Abuse Hotline

Implementation Steps

1. By July 2004, establish a single 800 number for calls and identify and equip central Hotline location.
2. By July 2004, design, plan, and implement a community awareness/marketing plan to publicize that number widely to the public.
3. By June 2004, develop Hotline protocols which:
   a) Standardize the criteria for screening and assessing which reports meet the threshold for suspected child abuse or neglect.
   b) Establish the process for referring cases meeting that threshold to protective services or IAIU for investigation.
   c) Refer reports that fall below that threshold to either another state system (Child Behavioral Health Services, or TANF) or directly to community-based agencies for voluntary service engagement, or provide the caller with the necessary information and referral – depending on the reported need.
4. By July 2004, staff trained and in place. Identify and train staff for Hotline to provide 24/7 coverage. Review and resolve personnel issues regarding transfer of current frontline and supervisory staff. Institute hiring process to add additional staff, as necessary. Train on all protocols.
5. By July 2004, develop an information system to allow for the automated transmission of reports to District Offices, IAIU, and the OCA (as appropriate). This automated system should also track calls, investigation time frames, and referrals and allow for analysis of data over time, including identifying patterns of calls.

6. By July 2004, open Hotline for business.

Forensic Investigations

Implementation Steps

1. By March 2005, hire 20 additional field investigators and four additional supervisors for IAIU.
2. Begin hiring by April 2004 and assign a Human Services Police Officer to each District Office and IAIU unit to assist with criminal investigations and coordinate the process of receiving police reports in a more timely manner.
3. By November 2004, develop comprehensive investigative standards that include:
    - Screening for prior history of abuse or neglect
    - Private interviewing of all alleged child victims within 24 hours of the report
    - Contacting all mandated collaterals
    - Completing all investigations within 60 days, unless a formal extension request for good cause is granted;
    - Involving Child Advocacy Centers or Regional Diagnostic Treatment Centers in designated cases.
    - Requiring a comprehensive review of the family and home environment, family dynamics and relationships, and the identification of risk and safety factors that need to be addressed immediately.
4. By September 2004, establish standards for Substantiating or Unfounding a report. Eliminate the Unsubstantiated category on all protocols and reports.
5. By September 2004, institute policy requiring supervisory sign-off on all investigations prior to a finding.
6. Develop and implement specialized forensics (October 2004 in accordance with phase-in) and screening training (July 2004). For implementation – refer to training section.
7. By July 2004, develop an automated capacity that provides supervisory and management staff with a daily report of any case where a child was not seen within 24 hours or an investigation was not completed within 60 days.
8. Begin implementation in July 2004, and complete by June 2005: develop database and reporting system for supervisors to track and monitor each worker's compliance with investigative mandates.
9. Begin implementation in April 2004, and complete by January 2005: finish development of Safe Measures[15], a web-based child welfare quality assurance reporting tool that can provide

[15] In May, 2003, DHS approved $1,435,566 in funding both for the National Council on Crime and Delinquency's (NCCD) installation, maintenance, and training services for "Safe Measures," a web-based child welfare quality assurance reporting tool, and for the associated purchase of CRC's services in developing, installing, and maintaining the databases to support the Structured Decision Making Tools. These funds include support for training staff in SDM and analyzing implementation.

managers and supervisors at the state, area, district, and unit levels with data captured from existing files, linking those data elements to key performance standards. Implement weekly, monthly, and quarterly reports from Safe Measures to track compliance with federal standards on subsequent maltreatment and length of time to achieve permanency.

10. Begin implementation in November 2004 to create units in each District Office whose sole responsibility is to conduct investigations of new reports of child abuse/neglect. Develop and implement staffing policies and protocols to ensure trained investigators can respond to reports 24 hours a day, seven days a week. Develop case assignment protocol for supervisors to apply to ensure caseload levels are not exceeded.

Improving Support to Child Victims and Coordination Among Law Enforcement, Medical and Child Protection Staff in Cases of Severe Maltreatment

Implementation Steps

The Office of the Special Deputy Commissioner for Children's Services will work with the Attorney General's Office to establish a committee charged with developing a uniform model for forensic investigations of child sexual and severe physical abuse and neglect, to be implemented throughout New Jersey. This model will clearly describe the partnership between Children's Services and law enforcement in the investigation process and the supporting role played by forensic medical/psychological services. This committee should be co-chaired by a County Prosecutor and the DYFS Deputy Director and include broad representation from the CACs and RDTCs. Technical assistance can be obtained from the Regional Child Advocacy Center Resource Center.

The committee should:

- Require joint investigations of alleged child abuse and neglect in cases which law enforcement will be involved.
- Require coordination of interviewing, so that interviews of child victims of sexual abuse will be conducted only one time and only by trained forensic interviewers. These interviewers may be law enforcement, Children's Services staff or staff of a CAC.
- Establish uniform statewide standards for Child Advocacy Centers, consistent with national standards. Encourage the co-location of Child Advocacy Centers – the preferred model (used in Essex County) in which Children's Services, law enforcement and other supporting services are housed in one location.
- Establish uniform statewide standards for the Regional Diagnostic Centers, to address intake, standards for assessment, report preparation, and time frames. Clarify that the role of the Regional Diagnostic Centers and other medical personnel is to provide forensic medical/psychological assessments to assist Children's Services and law enforcement in making the appropriate case findings and the development of an appropriate case plan. Provide uniform funding for the centers to assure that each center can fulfill its mission. Require the development of a quality review process. Build linkage to Federally-Qualified Health Centers (FQHC), especially in high need neighborhoods.

- Establish a training program for all staff involved in the forensic investigation of child abuse/neglect, which requires a minimum number of training hours.
- Provide access to forensically-trained medical personnel in counties, even if that county is distant from a Regional Diagnostic Center.
- Require the development of county protocol between the DYFS District Office, IAIU and the County Prosecutor's Office consistent with the statewide protocol. The county protocol will describe the investigation process in each county and establish appropriate liaisons.

To implement the model, the statewide committee should establish county work groups co-chaired by law enforcement and child protection. Each work group should inventory existing resources relative to the standard noted in the model and develop a county plan to meet those needs. And the work group should identify the Multi-Disciplinary Team for the county whose responsibilities include monitoring case investigations, assuring communication and coordination among the stakeholders, and preparing reports identifying issues and concerns dealing with any aspect of the investigation process.

Finally, the statewide committee should designate a state body to coordinate and if appropriate, provide oversight to the county-based teams, each of which will be required to submit a yearly plan updating the committee on implementation of the statewide protocol and requesting additional state support. This statewide body will review and endorse the county plans and request the necessary budgetary support.

Timeline

By July 2004, designate the statewide committee.

By July 2005, produce a final plan that describes New Jersey's model for forensic investigations and addresses major implementation issues, including funding, training, and staffing.

By January 2006, develop county protocols for forensic investigations.

By July 2006, submit county plan to state, with timeframes for implementation and resource needs for FY '06 and FY 07, including development of county co-location Child Advocacy Centers.

Safety Assessments

Begin implementation in July 2004 to institute safety assessments as part of practice.

- at the beginning of the investigation
- minimum review every six months
- review at key change points
- opening of case
- unsupervised visitation
- change in household composition
- change in placement
- return home

By November 2005, develop baseline for safety assessments.

By November 2005, develop database to track administration of safety assessments and flag cases which go beyond six months.

By November 2004, develop quality assurance protocol to review safety assessment practice.

♦ Placing Children Who Need Out-of-Home Settings

Placement outside of the home should occur only when absolutely necessary – where providing services in the home will not be enough to keep a child safe. But when placement is necessary, it carries its own challenges, including the need to handle the separation sensitively and matching a child to the best placement. Separate sections of the plan – Resource Families and Congregate Care – address our need to improve the quality and quantity of the placements available.

The decision to separate a family and take a child into out-of-home care is a serious one. Virtually all children prefer to remain with their birth families, in their own home. Because we know this, we commit to a policy which strives to maintain children safely in their own homes. We are providing more training and support to our staff – both protective and permanency – to guide and support them in making appropriate and consistent decisions about safety and minimize separating children and families. We prefer measures such as in-home services or emergency services which can alleviate safety concerns and keep families together – and this plan expands the availability of such services. But when that home is not safe, and cannot be made safe with in-home or emergency services, we have no choice but to separate the child from her birth family. At that point, what we can do is handle that separation as sensitively as possible and work with the birth family to identify the best possible – and least restrictive placement – for that child.

When a child is separated from her family, we will help that child through that process. We will employ a "buddy" staffing system to ensure one staff member stays with the child throughout the process. We will make every effort to bring that child's familiar objects – clothes, toys, and other material items important to that child – along with us when we leave the home. We will bring existing medical and school records. We are increasing our medical staffing in our District Offices so that children will no longer have to wait for long hours in emergency rooms. We are

increasing our placement options so children no longer have to wait in chairs for their new home. And finally, we are expanding the best practice by some of our own staff of staying with a child at the placement to introduce them to their new home and their new resource family (or congregate care staff). And the lowering of caseloads should help staff have the time to spend helping children adjust – and as supervisors and managers, we will value our staff spending that time.

With regard to the placement process, when a child must be placed outside the home, the placement should be planned, determined with the family's input (utilizing a family team meeting), and closely monitored. We should talk to the child and the family about what is happening and why – soliciting their advice and keeping them informed. Our first resource for placement will be extended family and friends. We will have a clear preference for placing children with their "own," people whom they know and who are known to them, who may already have ties of affection and interest to that particular child or family. And where a child has special needs which must be addressed in order to make that extended family placement possible, we will provide services to make it possible for the extended family to provide for that child.

But if extended families are not available, we have to know what resource families and (where appropriate) congregate facilities are available, and we should have a variety of placements to choose from so we can match a child to the right placement. Placements should be close to home, and children should continue to attend their home school. Siblings should be placed together. The resource family or congregate care staff should speak the same language as the child. And our staff should have the ability to identify children with special needs – and match them with placements best suited to meet those needs. Finally, placement should be truly temporary – lasting for only the minimum amount of time necessary to secure the child a permanent home, whether that is a brisk return to her own family or identification of an adoptive family.

Obviously, we cannot achieve all of those goals in every case – emergencies happen and the resources may not be available the moment we need them. But we want to move to a system in which the majority of placements do take place according to those principles. And when an emergency placement is made and we must compromise on one or another of these principles, we will utilize the family team meeting in the majority of cases in order to make the initial placement decision. But if we cannot meet that standard (and we may not in a removal which takes place at 3 am), we may have to place and then utilize the family team meeting to revisit that placement decision and ensure that a child is not left adrift in an inappropriate placement. As discussed in our Resource Family and Congregate sections, we want to know our placements – and our staff, resource family staff and permanency workers will visit regularly to ensure the child is being treated well. We will respond briskly if we suspect or learn that there is a problem with that placement. We will place a high value on stability and so strive not to punish a child by moving them from place to place. If a child has to be moved, we will pay attention to the timing and manner of that move – and if the child is not at imminent risk of harm, we will let him finish the semester or school year where he is and we will make sure he has the time and support necessary to say good-bye to his friends, teachers, and family members.

Commitments

1. We will remove a child from home only when absolutely necessary. We will expand the availability of in home and emergency services so that we can keep more children safely in their homes.
2. When we must separate a child from her family, we will do everything possible to reduce the trauma of the placement experience.
3. We will place the child in the least restrictive placement available.
4. We commit to placing siblings together whenever possible.
5. We prefer placements with extended family.
6. We will make placements in consultation with the child and her family utilizing family team meetings.
7. We will place the majority of children in their home neighborhoods, the exception being children whose kin live elsewhere or who have special needs which cannot be met with services in a neighborhood home.
8. We will make arrangements to ensure that in the majority of cases the child continues to attend her home school, even if that requires developing special transportation arrangements.
9. We will visit our placements regularly.
10. We commit to reducing re-placements.
11. We will provide support to our caregivers and extend in-home and support services to stabilize placements.
12. When a re-placement is necessary, we will strive to do that in as planned a manner as possible, so as to minimize school disruptions and with appropriate support to the child to manage the transition.
13. We will analyze our placement needs and develop sufficient placement resources to meet those needs.

Current Situation:

At present, New Jersey's placement system operates in crisis mode. We rarely plan a placement in advance. Instead, whether it is an investigation which results in a removal or an incident which happens in the current placement, we usually delay acting until we have to and then we end up placing or re-placing the child on an emergency basis. Emergency placements are bad for several reasons. Finding the right placement for a child generally takes time. At present, we do not have a wide variety of placements and so, on an emergency basis, we find we have to place children in placements we know or suspect are not appropriate. We end up splitting up family groups. We don't have time to find or license potential extended family homes. We end up moving children out of their own neighborhoods, in some cases, placing them very far away and making visitation with their parents virtually impossible. Acting on an emergency basis also limits our ability to minimize the trauma for the child, including minimizing school disruptions.

We take the child away from home – and we may not tell the parent or the child where they are going – often because we do not know.[16] We do not ask their advice about what placement

[16] There are a few cases in which safety suggests we affirmatively should not tell the alleged abuser where the child is going. But because the overwhelming majority of our cases involve neglect – and not abuse – normally we can safely tell the parent or guardian where the child is.

might be best – and we are not as good as we should be about asking about available extended family resources, particularly paternal relatives. Too often, we act as if they have no say about what happens to them or their children. We forget that we will need to work with them as we explore the possibility of reunification. In the process, we can get off on the wrong foot – which sets the family and us back in achieving permanency. And it leads us to ignore potential resources which might minimize the trauma of placement. As discussed in the Resource Family section, current practice does not encourage us to treat our resource families as part of the decision making process either. At present, neither birth families nor resource families are involved in the placement process, and we do not currently consider them as partners in providing for the safety, permanency and well being of children.

The "removal" process itself needs work. At present, we bring the child back to the office to sit on a chair, or sit in an emergency room, while we send in a request to the Regional Office to identify a placement. In the meantime, our staff run around getting the paperwork together – the clothing voucher, etc. Once a placement is found, some staff can be so rushed that they go and drop the child off. The child needs time to adjust – to be introduced to the resource parent or congregate care staff or even to the kin family member if it is a distant relative. They need to know where the bathroom is, what the rules are about meals, and some information about the neighborhood. Some of our staff are sensitive to the need for this transition and spend time with the child getting settled. We need to spread that practice among all staff and provide them with the support necessary to help that happen.

Our process of identifying the best placement for the child also needs work. Our frontline staff have received very little assessment training and so may not collect all the information necessary from the child or family to identify the best placement. We ask them to fill out a form which tells the little they know about the child and family – and send that form into the Regional Office. In theory, the Regional Office is supposed to send back a few options for placement so we can decide which placement might work best. In reality, there is usually one placement – and one placement alone – available and so it does not matter if that placement is already over-crowded or if that child has special needs or if the placement is far from the home neighborhood. The current goal appears to be to achieve A placement not the RIGHT placement. We do not have an adequate tracking system which lets us know which resource families or congregate care settings have a bed available. Instead, our staff must get on the telephone and start calling the placements they know. They wheedle and beg and try to come up with the best home they can find in the time available. Our frontline staff generally have no special training in the types of placements. Recruitment and identification of placements happens in a Regional Office far from the local office. The staff in that Regional Office do not necessarily know much about the neighborhood where that child lives – and so may not know about potential resources in that neighborhood.

The end results are not good. Too many – twenty-five percent – of New Jersey children are initially placed in congregate care settings without any attempt to try to place the child in a more homelike setting. Too many children are placed outside of their communities – and too far away to stay in their home school. For example, the data indicates that 44% of New Jersey's children in 2003 were placed ten or more miles away from home. The data also suggests that too many are placed in available beds with little or no consideration of the appropriateness to the child's

needs. The result is that almost two out of five are moved one or more times.[17] Our failure to deliver an appropriate and neighborhood based placement has an impact on outcomes. Children generally do not have immediate and regular contact with their families. Only 42% of children entering placement for the first time will be reunified within one year.

And we do not always monitor our placements the way we should. Children in placement are not always regularly visited by caseworkers. Children and resource families are not provided needed resources – which means that either the child does not get what he needs and so falls behind developmentally or the placement implodes – which starts the whole process of identifying a new placement over again and the child must adjust to a whole new situation, including, often, a new school.

And as is discussed in our Resource Family section, we do not encourage – in fact, often, discourage contact between birth families and resource families. The result is that birth families and resource families communicate rarely and generally do not work together toward permanency for the child. And if the child is in congregate care, we seem to forget that the child has a birth family at all – so we can forget to arrange visitation or place the child in a setting very, very far from home.

Strategies

Strategy 1: Better Distinguish between Necessary and Unnecessary Removals and Provide Enhanced In-Home and Emergency Services: We know that some removals are necessary because they are the only way to ensure the safety of the child – but we are committed to safely and consistently reserving placement as the last resort. We know that we have not always been consistent about which children are removed and under which circumstances. And we know that recent tragedies may have encouraged some of our staff to err on the side of removing – while lack of access to services forced us to utilize placement in some cases where in-home services or access to emergency services might have kept that family safely together.

We have been working hard to develop protocols which clearly delineate our standards for assessing risk – and we will begin training and supervising our staff to ensure those protocols are applied routinely and consistently. Our first response to safety issues will be to develop a safety plan which enables us to keep the child safely in the home. We have committed to providing improved and expanded in-home and support services as our first line of support in keeping children safe. Improvement in our investigations and commitment to a set of standardized protocols for when to remove a child will reduce unnecessary removals. We need to reduce unnecessary removals not only to spare the child the trauma of the separation – the most important reason – but also because our placement resources are precious and need to be allocated wisely.

Strategy 2: Improve the Handling of "Removals." We know that child welfare systems in other parts of the country have developed techniques we can use to improve our removal process. In cases in which removal is necessary, we will provide our protective staff with the necessary

[17] Chapin Hall – 39% of children in resource family cohort were moved at least once as were 30% of the children in congregate care.

training and support to improve their engagement and assessment skills. We know we have a big task before us – with the challenge of a cultural shift from one in which we see ourselves as dictating to or judging the parent to one in which we understand that the parent is our most important initial resource. Our clear goal – the goal we will convey to our staff – will be to reduce trauma to the child and family during the removal and placement process.

We have already begun employing a "buddy" or "team" approach to removal so as to allow one staff person to focus solely on the needs of the child. We will instill in our protective staff the need to collect all of the child's necessary personal belongings and medical and school records. Improved engagement skills should help us begin the process of working together with the parent from the start. We will tell the parent where we are taking the child (except when it is not safe to do so) and we will establish a time for the initial family team meeting. We will work with the parent to identify resources within the family for a potential kinship placement.

Once we take the child away from the home, we will utilize other staff to get any necessary paperwork while we keep our protective staff focused on staying with the child. To accomplish this, we will increase the level of staffing and refocus the jobs of the aides on the support tasks, rather than leaving children with them. We will have a new practice for obtaining medical check-ups for our children. We will turn first to the child's own primary pediatrician. If she is unavailable, we will next turn to one of the pediatricians who has agreed to be on call for our area and finally to a Federally Qualified Health Center (FQHC). We will utilize emergency rooms only when the child's medical condition requires it or no other service is available.

And by lowering the caseloads and focusing protective staff on the initial process, we will free them up to provide a proper introduction to the new home. We will train them on how to introduce the child to the new home – and our improved relationship with our resource families will also help support us in making this transition go more smoothly. Finally, unless the child is too young or too traumatized, we will include her in the family team meeting, and we will solicit her input about how best to take care of her needs.

***Strategy 3*:** We will encourage planned, rather than emergency, placements. Reducing caseloads for both protective and permanency staff should assist staff in responding to a family's needs before there is an imminent risk – or if after placement, before the placement breaks down. We will support staff in achieving goals which reduce unnecessary placements and reward them for maintaining stable and appropriate placements.

***Strategy 4*:** We will involve birth families in the placement process. We will train our protective staff to engage birth families right from the start, with a particular emphasis on the need to identify extended family in the event placement becomes necessary. We will train protective and permanency staff and supervisors in how to conduct Family Team Meetings.[18] We commit to holding the first Family Team Meeting within 72 hours of the child's removal from the home.

[18] Family Team Meetings have been used successfully in other jurisdictions to better engage families, improve planning, minimize placement, and achieve permanency as rapidly as possible. See the Permanency Section for further discussion of Family Team Meetings.

***Strategy 5*:** We will utilize Structured Decision Making and other assessment tools to collect more information about children to better inform placement decisions.

Strategy 6: We will build a coordinated data tracking and analysis system for staff to facilitate a "matching process" and monitor placement data.

Strategy 7: We will provide resource family support staff in each District Office to assist case managers in finding the appropriate placement setting, preferably in the child's community.[19] This requires that communities have a pool of Resource Homes available. (See Resource Family section).

***Strategy 8*:** Develop policy, practice manual, and training curricula to assure clear and uniform understanding of values, roles, responsibilities, standards and criteria for both placement process and supervising placements.

The mechanics of the placement process[20]

Children have a right to live with their families wherever possible. When children cannot safely remain with their families, decisions regarding placement should be made with the children themselves (unless they are too young) and their families whenever possible. Out-of-home care should be as temporary as possible, with a goal of family reunification whenever possible.

We will strive to create a system in which children receive the most appropriate placement in a seamless manner, regardless of the system through which they enter. The need for either DYFS or the Division of Children's Behavioral Health Services to identify the placement should be invisible to the family.

A placement unit within the DYFS local offices will be created to manage and support caseworkers in the placement process. The placement support unit will include a resource family recruiter, a resource family trainer, resource family support workers, and a resource family placement facilitator.

When placement is necessary and a resource family needs to be identified (after the family team meeting), the permanency worker will provide information to the placement facilitator regarding the needs of the child. (A tool will be developed that will identify the critical areas to be considered when "matching" the needs of the child and the preferences, skills and competencies of the resource family). A database of all available resource families – both those developed by DYFS and those developed by private agencies – will also need to be developed for this purpose.

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[19] Licensing regulations will be revised to comport with Child Welfare League of America capacity standards, which hold that no resource family may have more than four foster children, more than two foster children under the age of two, or more than six total children (including biological, foster and adopted) in their home at a time, except in the case of larger groups of sibling foster children, who may be kept together. The revised regulations will not affect existing placements, and will apply to new placements made on or after June 1, 2005.

[20] A more refined implementation plan regarding child placement will be developed by July 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

The database will be accessed by the placement facilitator, who will search for families that may meet the child's needs, considering criteria including geographic proximity to the child's home and school, ability to accept siblings (if applicable), ability to meet the critical needs of the child, etc. They will then work with the resource family support worker(s) who know the identified families best and who will help to determine the most appropriate family for the child. Placement facilitators, who will be DYFS caseworkers, will work with resource family support workers, and when possible attend family team meetings and collaborate with child's permanency worker around placement issues.

The resource family support worker will contact the resource family and arrange for any supports and services the family may need to accept the child for placement. Flexible funding will be available for this purpose. The resource family support worker will be available to the family to assist with any service needs throughout the child's placement.

Child Behavioral Health Services will have a Team Leader in each area office. They will work closely with the DYFS placement staff to facilitate the timely and appropriate placements of children who need therapeutic placements.[21]

Child Behavioral Health Services has created the capacity for 24-hour mobile crisis response to families in the community. These services will be available to resource families as well as birth families when children are placed with them, whether on an emergency or planned basis. These services will include assessment and behavioral health services for children as well as support services for resource families.

Recognizing that it is not always possible to have a family team meeting prior to placement, it may not be possible to gain sufficient information to match a child to a specific family. Emergency resource family and treatment homes will be developed for this purpose. These homes will be able to accept children in crisis situations, to keep them safe while the family team meeting is arranged and their needs assessed. Children will remain in these placements on a very short-term basis (48 to 72 hours), after which they will either return home (if they can do so safely) or be placed with a well matched resource family. These emergency homes will also be useful when a child's relatives or kin have been identified as an appropriate placement resource but are not able immediately to accept the child.

Deciding Who Must be Placed – Removal of a Child Due to Abuse or Neglect; Integration of Structured Decision Making (SDM) and Family Team Meetings (FTM)

Whenever it is consistent with child safety, children and their families will be involved in the decision-making process regarding the need for placement and the identification of placement resources. We will do this through the use of family team meetings, which will be employed first in the child placement context; we will phase this in as our new practice model rolls out to the various area offices, starting with the first four areas in January 2005. Until staff are trained

[21] Currently, DYFS and Behavioral Health use different assessment tools to inform the placement process. A unified tool will be developed, in consultation with the Child Welfare Panel and other relevant experts.

and competent in conducting family team meetings, each local office will train specialist FTM facilitators to conduct the meetings and coach and mentor staff on doing so.

- Use of SDM Safety Assessment tool to guide decision about whether the child is safe.
  - If the child needs to be removed immediately in order to be safe, the placement process delineated below is implemented.
  - If safety factors are identified that can be remedied immediately, a safety protection plan will be developed by the worker, supervisor and family (e.g., environmental issues such as replacing a missing window).
  - The Division will provide flexible funding to address emergent issues.

- Use of Family Team Meetings
  - When immediate remediation as described above is not possible to keep a child safe but the child does not need to be removed immediately, the worker will contact the supervisor to have the FTM facilitator arrange a family team meeting to develop a safety protection plan. The caseworker and supervisor will be responsible for notifying the participants.
  - The Division will provide flexible funding for services to aid in the implementation of safety protection plans.
  - If placement becomes necessary, the family team will identify placement resources for the child, looking first to relatives and kin.
  - Family team meetings will include the child when age and developmentally appropriate. If not, we will ensure that the child is in a comfortable, safe environment during the meeting.
  - Resource Family Support Workers may attend FTMs when appropriate.

Deciding Who Must be Placed – Meeting the Needs of Status Offenders and Juvenile Delinquents

- Family Court Judges will order the Office of Children's Services to develop a 14-day plan for status offenders or juvenile delinquents.
  - The DYFS Court Liaison will determine if the child needs protective/permanency services or behavioral health services.
  - If child needs protective/permanency services, DYFS will serve the child and access behavioral health services as needed.
  - If it is not a protective/permanency case, it will be referred directly to Youth Case Management (YCM, a case management entity within Child Behavioral Health Services), which exists in each county.

- YCM or DYFS will have 14 days to develop a plan to present to court, and will have the ability to access to wrap-around services for the child during those 14 days.
- YCM or DYFS will have the ability to get child behavioral health evaluations and assessments as needed.
- If a child is in detention awaiting an out-of-home treatment setting, YCM will plan for the child's expedited placement.

- CBHS's newly created liaison to Family Court will work with judges so they will better understand and will utilize the new system.
- CBHS's newly created liaison to juvenile justice system will work to coordinate services for children involved with that system.

The Placement Process – When a Child Must be Placed – Additional Policies and Issues

- A buddy system will be used (two DYFS workers) to effect children's removal, so one person can attend exclusively to the child(ren)'s needs during the process.
- The family will be involved in identifying and securing the child's possessions, to ease the transition to placement.
- Workers will spend time with the resource family and the child and will utilize the DYFS Placement Kit as a guide to address all the issues important to the child and family. The Placement Kit outlines various questions and issues a worker should address while placing a child with the resource family.
- Medical exams will be completed whenever possible by the child's pediatrician. DYFS has also developed a statewide network of physicians available 24/7 and willing to examine children. Emergency rooms will only be utilized when medically necessary, or in the limited circumstances when no other service is available.
- The suitability of potential relative/kin placement resource will be determined expeditiously (CARI and CHRI checks, initial home inspection, PROMIS GAVEL, etc.).
- When necessary, Mobile Response will be accessed to help immediately assess the behavioral health needs of the child and to provide services for the child and resource family or determine the appropriate level of care.
- An integrated assessment tool will be used to determine a child's behavioral health, medical, social and educational needs.
- Placement of children after hours is an issue OCS needs to address further. Flexible office hours will need to be developed to ensure that the placement model can be effectively implemented regardless of the day or time a placement is needed. (Preliminary data indicate that most removals and placements occur between 9:00 a.m. and 10:00 p.m.)
- Connections with contract agencies that develop placement will need to be strengthened.
- An integrated information system with real-time data will need to be created to effectively roll out this system.
- A continuous quality improvement (CQI) program focusing on the placement process will need to be developed through OCS's new office of CQI/IAIU.

Implementation Steps and Timelines

<u>Establishing Placement Values, Training, Protocols and Technical Support</u>

By November 2004, develop and begin to implement procedures to better distinguish between necessary and unnecessary placements and reduce unnecessary placements. Provide staff with protocols and training to support them in delineating between levels of risk and development of safety plans that can keep children safely in their homes. Implement policy, practice manual and

training for use of Structured Decision Making in placement decisions and process, and supervision of placements.

By October 2005, develop policy, practice manual and training materials for caseworkers on engaging birth and resource families to work together to better meet the child's needs during the placement.

Beginning July 2004, expand in-home and emergency support services available to our children and families and develop a process to inform staff about the services available in their community.
Beginning January 2005, develop and begin to implement placement procedures to better inform and reduce trauma to the child and family, including at a minimum:

- strengthening efforts to place children in their community,
- allowing children to attend the same school,
- ensuring that children can transport their belongings in a respectful manner to the placement,
- facilitating immediate contact and visitation with parents and siblings,
- ensuring that the placement process allows children to move directly from one home to another home, or from one home to a safe and child-friendly place and then to another home,
- creating a placement handbook for children (age appropriate versions) and birth families, and
- providing accurate information promptly to the child and parents.

By January 2005, articulate in policy, practice manuals, and training materials the criteria staff are to utilize when selecting placements that can lead to permanency, and guidelines about how to balance competing interests (for example, out-of-state kin placement and need to maintain child close to family of origin and in their community).

Develop training materials for resource families on how to work together with birth families to better meet the child's needs during the placement. Institute "Ice Breaker" meetings to engage birth and resource families to work together to better address the child's needs.[22]
[For timeline, see Resource Family Section.]

By November 2004, develop policy, practice manual and training materials to establish the procedure for managing placement disruptions and replacement with as little trauma to the child as possible.

By January 2005, revise both policy regarding removal and placement, and caseworker coverage plans to ensure that every removal uses the buddy system to provide that one caseworker is solely responsible for meeting the needs of and reducing trauma to the child.

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[22] As discussed in the section on resource families, not all cases will warrant resource family/birth family contact. When such contact is deemed desirable, resource families' addresses and phone numbers will not be provided to birth families without consent.

Placement Data and Matching Tools

By June 2004, develop an annual placement report detailing the number of children by type of placement broken down by age, race, ethnicity, gender, and special needs.

By November 2004, design and begin implementation of protocols and tools for collecting necessary placement-related information about children at initial contact and throughout need for placement. This information begins with neighborhood and home school but also includes the SDM strengths and needs assessment as well as information about the child's religion, race, community location, sibling(s), etc.

By November 2004, design and begin implementation of expanded placement tracking tool. The database should contain consistent information (including criteria) about the needs that can be met by resource families and other available placement resources. It should also track bed availability. At present, the only provider availability tracked on a system-wide basis are those placements with the therapeutic component through Value Options. The tool should provide "real time" information but also create the capacity to analyze and report on placement availability and patterns over time.

By December 2004, develop an automated data system that can integrate with SACWIS and will "match" the characteristics, information and criteria from the completed automated placement tools to find available placement resources for children.

♦ Achieving Permanency for Children

All children need a home and by home, we are not referring to a physical location but rather to a family. Children need a family that can raise and nurture them, tend to their well being, and give them the skills and support they need to become productive and independent adults. It takes some baby birds a matter of months to grow up and go out on their own – people take a very long time, usually eighteen years or more. Children come to our attention because their own homes may have become unsafe. Our job is to help ameliorate the risks to ensure children can stay in their own homes safely or when we must place, that placement is brief and we secure a permanent home for that child as quickly as possible.

This section covers all of our work with children and families under our supervision. They have come into our supervision because of child abuse or neglect, or because of an identified risk of maltreatment. In some cases, we can provide services that keep the child safe in her home. In other cases, we have to separate the child from the family and provide out-of-home placement. The work in this section covers our case practice for both because our permanency staff will serve both.

Through our case practice, we can create a system which values families. In order to do that, we need to learn to approach families respectfully, to make them the centerpiece of the process of creating the solution. We need to have services which reflect the needs of our families – and not try to make our families fit the available services. We need to make those services convenient – easy to use, approachable, and culturally and linguistically appropriate. We need to shift to providing more services in the home – go to our families, instead of making them come to us.

Providing services in the home gives us an opportunity to understand the context in which the family operates and provides a better opportunity to assess on-going risks, strengths and needs. It also saves the family valuable time and transportation money, and it provides the opportunity to make our advice and support concrete and real.

But when flexible and good services are not enough, sometimes we will need to separate a family and take a child into placement. When that happens, we must do it in such a way as to minimize the unintended consequences. So when we do remove a child, as we discuss in the Placement section of this plan, we must pay attention to that child throughout the process and help ease the worry and hurt, and sometimes anger, that comes with that removal. And we must conduct ourselves during the removal in such a way that we do not break the relationship with the birth family – because that child still needs them and we need them as well in order to accomplish our permanency goals.

And from the minute we touch that family, we must remember that our goal is permanency – achieving a permanent home for that child. Our hope is that in most cases, the birth family can provide that home – and so we must work very hard to either preserve that family with services or reunite them as soon as it is possible to ensure the safety of the child. Placement in care is supposed to be <u>temporary</u>, for the shortest possible time. In our vision of a new system for New Jersey, we will strive to reduce the length of time most children spend in placement. From the start of the placement, we will engage in concurrent planning to identify an alternative permanent family resource even as we vigorously pursue reunification, so if reunification fails the child does not have to remain in care for years.

We need to preserve families and children from the strain of adjusting to our staff turnover and role specialization. We are adopting a One Family, One Worker model. To do that, we must make our caseworker jobs doable. We must lower caseloads, increase supervision, provide increased training and decision making tools – in short, make this a job that a staff person can do well over a longer period of time. And we must make our staff available to our families – available when they need us – on nights, weekends, and holidays. And we must also eliminate a structure which makes families or children move from caseworker to specialists in order to get necessary expertise. We propose a system in which the caseworker remains the same and specialists help support that caseworker.

And we must provide the resources necessary to make this all possible. It will take resources to expand our staffing – to lower caseloads and increase supervision. It will take resources and some adjustments to our contracting processes to supply the level and type of services we need to preserve or reunite families, support a child's well being, and achieve permanency. It will require commitment to train and support our staff to approach their work in a completely different way – family centered, neighborhood centered, and with a consistency grounded in best practices. But as we accomplish this, we should see better outcomes for the children and families in our care.

Commitments

To accomplish this vision of a system which can support and provide permanency for the children in its care, we make the following commitments:

1. Create a family-focused culture for casework staff.
2. Introduce the One Family, One Worker model of service delivery.
3. Provide and expand family-friendly services.
4. Support concurrent permanency planning.

The Current Situation

At present, in New Jersey, our families and children are in the system for too long. And we do not deliver the quality or quantity of services they need. Our service delivery systems operate in silos – with gaps, overlap, and contradictions. Sometimes we dictate to our families, rather than utilizing them as the main architects of their own destinies. Our inability to deliver too often forces us to compromise between leaving a child in a home where we cannot provide services to ensure safety or taking that child away because we cannot provide services to ensure safety. When we separate children from their families, it takes us too long to get them back together. Delay also costs us opportunities to reunify families – as we allow parents and children to drift. Where reunification is not possible, we take too long to achieve adoptions – and we fail to provide children who need them with adoptive homes. We have too many children who age out of our system.

Even as we bemoan our own lack of services, we have a system of last resort for service delivery for families who need services from other systems. As a consequence, we open voluntary cases in an attempt to help those families – and then spread ourselves too thin, distracting resources and attention from our primary mission, keeping children safe. In some cases, we utilize voluntary placements to avoid the hard question of whether or not there really was abuse or neglect – which short-changes the critical scrutiny provided by the courts.

We expect our caseworkers to operate virtually on their own – and the consequences of that decision fall squarely on the children and families they are supposed to serve. All of the strains we discussed in the protective section also apply to permanency. We saddle them with caseloads that <u>average</u> 42 children, exceeding national standards of no more than 15 families per worker for casework. We do not have enough supervisors to provide them with the level of support that they need.

We scatter the children and families on their caseloads all over the state – making it a challenge for caseworkers to maintain the level of contact we expect them to have and that families and children need in order to achieve permanency. We locate our caseworkers in offices far from the communities where most of the children and the families on their caseloads live. We do not encourage them to seek out local resources – but instead, want them to rely on centralized service and placement recommendations, which may or may not meet the needs of their families. The volume and conflicting priorities on our caseworkers' caseloads encourage delay and discourage the acquisition of the specialized knowledge they need to do the permanency part of

their job well. We do not have well established protocols or decision-making processes that guide our frontline staff. As a consequence, too often the type of services, the decision to place, the type of placement, the goals, and all the other important decision making points in the handling of a case are shaped more by the subjective experience and best efforts of our staff than they are by our Department's policies and commitment to best practices.

And even more importantly, those decisions are usually made without much input by the family. We do not encourage or support our staff in being family friendly. Instead, we often tell our families and children what they need to do, without listening to them about what their needs are or what they might propose as solutions. We look for shortcomings and pathologies in our families – we do not look for strengths.

We have created a system which effectively blames families for the delays and barriers we inadvertently erect which keep them apart. As a system, we place children far from their home neighborhoods, making visitation difficult and expensive. We require most visitations to be supervised and take place in our offices – our goal is currently to initiate visitation (once every two weeks) which is not effective for accomplishing reunification, and we know we often fall short. We utilize visitation as a "reward" – failing to see its importance as a tool to achieving speedy reunification. We also do not maximize use of unsupervised visitation to promote gradual reunification, letting children and families spend evenings and weekends together. We have, in recent years, become better about ensuring sibling visitation, when siblings live apart – but we could do better.

We require so many types of services at different and conflicting times and places as to make it difficult for parents to be compliant.

We have established a system in which it takes a crisis to get the attention of one of our caseworkers – sometimes, maybe even often, a crisis which could have been averted if the caseworker had been able to pay attention sooner. For example, a family that might have been kept together with services (may have even asked over and over again for services) falls apart, and the child comes into placement. Or a child or a resource family struggling with a placement cannot get help, and the placement disrupts. And running from crisis to crisis keeps attention away from achieving permanency – and keeps children lingering in placement.

Our current casework positions require extraordinary people to fill them – and we have some extraordinary people on our staff. But you cannot run a system that requires that all staff be extraordinary. You need to make the job one that is doable by ordinary people. And by requiring that staff be extraordinary, we burn out too many of those who try to achieve that goal or we turn the other way and accept an unacceptable level of mediocrity in provision of our services.

We ask our children and families to adjust over and over again to new staff. Sometimes, they are assigned a new caseworker because the previous one left – or has been assigned new responsibilities. But we have also made structural decisions in our current system, which requires children and families to move from caseworker to caseworker. Specialized roles exist for Permanency, Adolescent Services, and Residential Care, as well as Adoptions Services

(Adoption Resource Centers - ARCs). Each change risks a loss of information – and certainly risks a loss of a critical relationship between that original staff member and the child and family.

Too often, we have inadvertently encouraged a system of accountability which focuses more on which forms are filed or which boxes are checked off rather than on measures of well-being or permanency outcomes. Our current forms and practices suggest single-track goal setting – reunification OR adoption OR independent living.

We do not pay enough attention to our children's well being while they are under our care. And many of the children in our care do not do well on measures of well-being – even when compared to other children who come from equally disadvantaged neighborhoods and circumstances. National data suggests that our children are more likely to suffer from medical ills; less likely to receive good medical or dental care; more likely to be behind a grade or more in school; more likely to be in special education services; less likely to have their special needs addressed; less likely to graduate from high school; less likely to be able to get and maintain a job to support themselves; and more likely to have a child early – and more likely to have that child, in turn, taken away from them and placed in the child welfare system.

Finally, we run a system that is severely under-resourced and you can see its most egregious effects when you look for our performance on achieving goals related to permanency. We lack enough services, enough placements, enough caseworkers. It is true that money is not the only answer, but under-resourcing the front-end of the system ends up costing the state and its taxpayers enormous amounts of money on the back-end. It costs because children and families linger in the system; it costs because our failure to address a crisis at home or in a lower level of placement escalates into more and more expensive forms of placement; but most importantly it costs because these children, who were originally victims, do not flourish in our care – and so some do not grow up to be the capable citizens our society needs.

Strategies

We begin by focusing DYFS on its core mission – serving children who have been maltreated. We believe that if we focus on that core mission, we can achieve better outcomes, including permanency, for the children and families in our care. As described in the Structure and Services sections of this plan, we have restructured our relationships with other government agencies and within the Department of Human Services so as to maximize our focus on that core mission – and maximize our ability to deliver the services our families want and need. To that end, we will phase out the practice of opening voluntary cases within DYFS. We will refer families with non-safety related service needs to our partners within our own agency and in the community who will meet those needs. And we will not utilize voluntary placements as an "out" in cases where there is abuse or neglect.

We will change our case practice – and support our permanency staff in making that change. In our new model, our case practice rests on two core beliefs that will guide all our interactions with and services to families: (1) families will be partners in decision-making and (2) families will be able to identify their strengths and needs – and then access effective informal and formal supportive services in their own communities.

Families and children will have one assigned case manager who will help them individualize results-focused service plans based on their strengths and needs in order to ameliorate the safety issues that brought that family to our attention. Children and families will be served in their homes when it can be done safely. And they will be provided with an array of service options to better enable their opportunity to make choices among providers, timing of services, format of services, as well as type of services. We will expand our providers and community resources to deliver more and different kinds of services but we will also build the capacity of our staff to be more than case managers – and sources of referrals – but also service deliverers.
We will consider safety, permanency, and well-being simultaneously throughout a family and child's involvement in the child welfare system. If a child needs to be removed from her home because it is no longer safe to remain there, we will meet with the family to identify the best alternate placement, and the child will be placed in the most appropriate setting that meets the child's needs and leads to timely permanency.

There are several strategies we will pursue in building our new vision of case practice. We will describe each separately for ease of understanding. But in the end, these strategies all weave together to form the whole of a single model of case practice. And we believe this model of case practice will produce better outcomes for the children and families in our care.

Strategies:

1. Develop a neighborhood-based focus.

2. Institute a One Worker/One Family policy.

3. Rely on Family Team Meetings for decision making.

4. Provide individualized, coordinated and family-friendly case planning

5. Expand flexible and home-based services.

6. Implement Concurrent Planning.

Overall Implementation Steps
(Case practice implementation steps are contained in the sections below.)

Phase out voluntary admissions to DYFS.
Begin: October 2004.

Develop a Community-Based Focus

Child welfare services are best delivered through a community-based model. To function within that model, DYFS caseworkers must be part of the community. As discussed in the Organizational Structure of the plan, we are creating a structure which places our District Offices in the communities we serve. Even as those offices are established, we will begin the process of assigning caseloads geographically so that each staff member serves children and families in the

same community. Geographically assigning cases allows DYFS staff to work regularly with the same schools, same providers, same informal networks, and same group of resource families.

In this model, we will not sit apart from the community – but we will be a member of that community. This position represents a radical shift. We have heard from our community partners during this planning process that our staff are sometimes seen as interlopers. To do our work well, we must be out and about participating respectfully in the communities where we work. Supervisors will value the time our staff spend developing community ties and participating in neighborhood relationship building.

Our new model requires caseworkers to become extensively involved with their families and with community partners. For families to experience success, caseloads must allow sufficient time for caseworkers to perform these tasks. Permanency staff will carry blended caseloads of families requiring services only and families with children in placement. But we will limit individual caseloads to 15 family cases per caseworker – with no more than 10 children on each caseload being in placement at any one time.[23] We have based this caseload standard on those promulgated by the Child Welfare League of America, combining two separate standards – for services alone and for placement alone.

Caseload Reduction

Our workforce cannot possibly do its job, and this plan cannot possibly be implemented, unless caseloads are reasonable. We have a very long way to go to achieve this. Because reforming case practice depends on caseload reduction, we present here our detailed plans to achieve this:

- Beginning in April 2004 there were 72 caseload carrying staff[24] hired throughout the Division. These staff will impact caseloads by October 2004 (most new staff are trainees and unable to assume full caseloads for six months).
- The next hiring will be in July 2004. This hiring (of 160 people) will be targeted to the four high-need counties that have been selected to begin the reform (Essex, Camden, Mercer, and Passaic). An additional 50 positions will be hired to staff a Statewide Support Team that will target case closings and exceedingly high caseloads both within these four counties and throughout the state. This hiring will impact caseloads by January 2005.
- Staff from the regional offices, DYFS central office and DHS central office will be identified to provide additional support with case closings and intake relief.
- Overtime will continue to be offered as a 3rd level of support to reduce the burden of current caseloads.
- Retirees will continue to be utilized to assist front line staff with case closings.
- October 2004 hiring will add another 100 positions. This hiring will provide relief to areas other than the four initial areas. The impact on caseloads will begin by April 2005.

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[23] We will develop a system to track and monitor the remediation of any situations in which caseload standards are exceeded. At every stage of our progress toward achieving our final caseload standard, we will overfill the case-carrying positions by 10%, so the workload will be fully covered, without exceeding the then-applicable caseload standard, even allowing for attrition, temporary leaves, unexpected system-wide caseload fluctuations, or other variables.

[24] All references to the hiring of front-line staff imply the hiring of additional supervisors at a ratio of 5:1.

- Another 69 caseworkers will be hired in March 2005, and will be deployed to areas with the highest caseloads.
- June 2005 will complete the FY05 staffing initiatives, with 52 additional hires, also deployed to the highest caseload areas. The impact on caseloads will begin by Dec 2005.
- 150 caseworkers will be hired in Sept 2005, impacting caseloads by March 2006.
- By March 2006, at least 95% of workers statewide will have caseloads of no more than 15 families with no more than 10 children in out-of home care (for permanency workers).[25]
- By August 2005, no more than 12 open investigations with no more than 8 new investigations per month (for Child Investigative Workers).
- These staffing projections build in an assumption that five percent of our workforce will be on leave at any given time, and include maintaining a statewide support team until the caseload reaches our ultimate goals of 15/10 (permanency) and 12/8 (investigative).

Additional caseload-related strategies

- Statewide Centralized Screening will be implemented to standardize screening protocols (based on other states' experiences and our current caseload, this may reduce our current caseload by up to 10%).
- Accelerate the contract expansion for Youth Case Managers to begin to take responsibility for community case management of adolescents who are experiencing behavioral health issues but are not in need of services for abuse, neglect or permanency (this may reduce our current caseload by 5%).

- [25] When the caseload of 15 families has 10 children in out-of-home care, the total number of children in that caseload will not exceed 25.
- We will conduct a time study relative to the time parameters concerning good case practice. The union will be invited to participate in the development, data collection function, and evaluation of that study. The time study and recommendations will be completed by July 2006 and are subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.
- A monthly report will be provided to CWA identifying workers with caseloads in excess of twenty-five (25) children. The report will contain the following information:
    - For each caseworker, the worker's identification number, title, office, and unit;
    - The identification number and title of the caseworker's immediate supervisor;
    - For caseworkers in on-going units, the number of families assigned to the worker, the number of children in out-of-home placements and the total number of children assigned;
    - For caseworkers in intake units, the number of open investigations;
    - The reason(s) the limitation was exceeded; and
    - The steps that were and/or will be taken to bring the worker's caseload within the limitations within fourteen (14) days from the date the limitation was exceeded.
- Effective July 1, 2007, when any caseworkers in local offices are assigned more than twenty-five (25) children, union representatives and management will meet monthly to review caseloads that exceed twenty-five (25) children during the course of the preceding month. When parties agree that a caseworker cannot fulfill the case practice requirements, the following options are available: (a) establish a caseload reduction plan; (b) temporarily suspend new caseload assignments; or (c) reassignment of the case(s)
- Results of the time study may influence any of these provisions.

- Continue our strategy of expanding preventive services – i.e., substance abuse, housing, school-based youth services, domestic violence – statewide, which should reduce the incidence of abuse and neglect and lower the number of new cases.
- Implement the first six community collaboratives in highest need areas within the first year to begin to address community needs.
- Develop and implement management training to prepare managers to appropriately implement the reform statewide within the first year.
- Utilize Family Team Meetings with SDM as the cornerstone of the reform, targeting first the counties (preferably the identified phase-in counties first) that have at least 95% of their caseload at no more than 17 families per worker.

Phase-in schedule

Over the past several months we have exceeded our prediction of closing 6,000 cases. We have closed in excess of 12,000 cases, but 12,000 more have taken their places. We must get control of our caseloads. The strategies just listed should help us start, but we will maintain vigilant attention to this issue, and add new approaches if necessary.

It will be the supervisor's job to ensure that unique factors are considered when assigning cases. These include: number of children in non-placement families;[26] complexity of cases on each worker's caseload; level of risk and frequency of contacts required on other cases on the worker's caseload; and specialized skills that a worker may have. Our supervisors and staff also will work closely together to determine when cases can safely and appropriately be closed, a critical element if we are to keep workloads manageable and our focus sharply on the families and children who need us.[27]

We will need to make ourselves available on the rhythms of when our families and children need us – and so we will need to provide flexible scheduling that allows for coverage on evenings and weekends.

Our community focus supports a richer and more coherent level of service provision for all of the families on our caseload. When we operate with a geographic focus, we can help our families

[26] By January 2005, guidelines will be developed for supervisors to prevent any permanency worker from having an unmanageable number of children on her caseload, and to promptly remedy any such situation that may occur. While our caseload standard limits the total number of children in out-of-home care, it does not – we believe appropriately – limit the number of children with open cases living in their own homes. These guidelines will address the circumstance of a worker being concurrently assigned a number of in-home cases each of which includes many children.

[27] In acknowledgment of the immediate caseload crisis facing the system, we recently took several immediate steps, even as this plan was being finalized, to provide some initial relief. On April 19, 2004, 72 new caseworkers, and 40 new case aides (who provide various types of support to the front-line caseworkers), were hired. On the same date, the process of promoting eight additional front-line supervisors, drawn from our caseworker ranks, to supervise the 72 new caseworkers, began. Also, we now have a process by which potential new caseworkers complete many stages of the hiring process – including application, interview, reference checks and background checks; basically everything but fingerprint checks, which go stale in 30 days – in advance, so that when funding becomes available for new positions we can confirm their ongoing availability and interest and get them into the training process forthwith. There are now more than 700 such "pre-processed" applicants.

identify services which are convenient to their home – and which operate in a manner and at times which make them user-friendly.

Our community focus also supports our commitment to improved visitation for cases involving out of home placement. The research shows that robust visitation is the number one predictor of successful reunification. And yet the realities of our old practice led us to set a very low standard of practice for visitation. We are today adopting the following visitation standards for children in out-of-home placement:

- To begin, DYFS will modify its visitation schedule (called the minimum visitation requirement, or MVR) to require that all children in placement, regardless of placement type, be visited no less than once per month.
- We will phase in an increase in that minimum requirement so that when we have fully reached our targeted caseload standards the MVR for children in placement will be once every two weeks. The phase-in will be designed so the more frequent visitation standard applies sooner for children newly placed or moved to a new placement.
- We will revise policy and training to clarify that the minimums are just that, and that workers are expected to visit with both children and parents as frequently as feasible and necessary to implement all elements of case plans and achieve permanency.

When children's permanency goal is family reunification, it is also essential that their parent(s) be visited regularly, to ensure that they receive the services and supports necessary to effect reunification as quickly as possible, consistent with child safety. To that end, we adopt this standard:

- DYFS will phase in an increase in the MVR for parents of children in out-of-home placement with a goal of reunification so that when we have fully reached our targeted caseload size standards, these families will be visited no less than once every two weeks.[28]
- Here, too, we will emphasize that visitation in excess of the minimum should be conducted if feasible and necessary to comply with case plans and achieve permanency.

Moving our offices to the community and assigning caseloads geographically has several advantages for visitation. Our lowered caseloads, firm commitment to family team meetings, and improved safety assessments should help us know our families much better and so reduce our reliance on supervised visitation as the only "safe" option. All of this should also bolster our ability to reassure a judge of the soundness of our decision making in recommending unsupervised visits.

We are also going to know our resource families better – and our re-training of resource families will support collaboration and partnership with birth families, rather than separation. Consequently, where fully unsupervised visitation is not the best option, the next option should be visitation with the resource family in attendance.

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[28] All Structured Decision Making tools and curricula will be adjusted to comport with the aforementioned visitation standards.

Finally, when we must provide supervised visitation, our connection to the community should allow us to develop options for supervised visitation outside of DYFS offices. A few models already exist in New Jersey – those models (and best practices from other places) should be imported to other communities and expanded where necessary. Visitation in a community setting is much preferable in terms of environment and convenience for our families and children. And where we must resort to visitation in the office, the relocation of our offices to the localities where our families live, and the geographic distribution of our caseloads, should enable us to support visitation on a much more frequent basis.

Regular visitation – whether supervised or unsupervised – will also be supported by our commitment to neighborhood-based placement, eliminating one of the most substantial barriers to regular visitation – distance (and the consequent expense and time).

And the lowering of those barriers will help us achieve our goals of increasing family and sibling visitation.

Our community focus will also aid our commitment to caseworkers regularly visiting our families and children. Geographically assigned caseloads will make it much easier for staff to see their clients regularly. With out of home cases, we have set a standard of requiring a minimum of one visit per month – that is one visit for each birth family and one visit for each child or sibling group out-of-placement. That number is not an average – it refers to each individually. It also is a minimum as we want to cultivate a culture in which staff spends most of their time with their families and children. With visitation to the intact families who comprise the overwhelming majority of our caseloads, we will also set a minimum standard of once per month – but we will mandate increased levels of visitation by staff at the beginning of those cases, when risk has just been identified and we do not know the family as well. And there will be other milestones through cases – presented by safety concerns, changes in family composition, and changes in services – when we will mandate increased levels of visitation. These schedules will be informed by Structured Decision Making, which will help gauge the potential risk, if any, of visitation. In sum, we expect to build a system in which caseworkers see children and families all the time.

To aid that goal, as described in the section of this plan on pursuing permanency for children in the courts, senior management will work closely with the court system to consolidate scheduling so as to free staff up from spending as much time as they currently do in court – and more time where we all, especially the judges, want them to be – with their families and clients.

And our other policies will underline the necessity of regular and frequent face-to-face contact between our staff and the children and families on their caseloads. Our commitment to family team meetings, described in a later section, requires frequent face-to-face contact.

Implementation Steps and Timeline

Geographic distribution of caseloads
- Begin October 2004
- Finish by January 2006

Redistribute caseloads in accordance with new standards (phase-in)
Implement by October 2004
Complete by January 2006

Develop and implement new visitation protocols for families with children in out-of-home placement
Implement by April 2004
Complete by January 2006

One Family, One Worker

Establishing a One Family, One Worker case practice model fosters trust and engagement between the family and the worker. It also enhances continuity of planning and service delivery. This principle holds true for all cases – cases involving services where children and families remain together and cases involving placement.

One of the common complaints we have heard from families and children is that their caseworker changes all the time – they do not know their caseworker and their caseworker "does not know me." One family, one worker is a concrete, important step we can take to signal that we take our relationships with the children and families in our care very seriously.

Where there is worker continuity, families referred for services are more likely to receive and complete those services – and have their cases closed successfully. And where the child is in placement, research shows that permanency is achieved more quickly and is more likely to result in reunification where there is worker continuity. One family, one worker is also good practice for staff – it improves staff attachment and morale and it increases accountability because it makes that staff member the single case manager and facilitator for that child and family.

New Jersey commits to implementing a One Family, One Worker policy and practice. And we can implement this policy in the overwhelming majority of our cases quickly in conjunction with our separation of the investigative and permanency functions and the assignment of geographic caseloads.

In our new model, once the investigation phase is completed and the decision to open a case is made, each family will have one primary caseworker assigned throughout the life of the case, and all efforts will be made to maintain that relationship. When a staff member leaves or is promoted, we recognize the potential for disruption in planning and disruption in trust – and so will provide for planned and thoughtful case transitions. These case transitions will be managed through family team meetings which will be held in a time and location convenient for the family and will be attended by both the transferring and receiving casework staff. Lowering caseloads and improving the support we provide to our frontline staff should reduce burnout and turnover – and the impact that turnover has on our children and families.

On placement cases, we will eliminate specialist case manager roles – in which we require children and families to switch caseworkers in order to receive new or different services or

because the "status" of their case changed. Historically, these categories include adolescent specialists, residential (congregate care) specialists, and adoption specialists (housed in the Adoption Resource Centers or ARCs.) We know that we will continue to need much of the expertise that currently resides in these specialist case manager positions. But we want to distinguish between case management responsibility and specialist expertise – and we want to move toward a uniform One Family, One Worker case management model. Instead of our current practice of making children and families switch case managers, in our new model, the expert support will be supplied to the permanency worker in a team approach, with the permanency worker remaining the case manager throughout.

We are mindful that the historical specialist roles were often created because the existing generalist staff had struggled to address the needs and services these specialists represent – and in many cases, specialist practice has brought some improvements. But it has also come at a cost – loss of information in the transfer and sometimes even a loss of cases, setting families and children back months from permanency. Keeping the case with a single worker guards against information transfer loss, focuses accountability for case management on a single individual, supported by a team – and underlines the importance we place on our relationship with the families and children we serve.

We will monitor this change closely to ensure service delivery on the specialist focused areas. We will integrate adolescent and residential case manager caseloads into the one family, one worker model from the beginning, rooting that expertise in the adolescent specialists and permanency staff members in our District Offices.

The area of adoption warrants particular attention. As discussed in a later section on adoption, adoption specialists play a uniquely important role in our system, and their work has led to large numbers of adoptions in recent years. Today, when a child receives a goal of adoption her case is transferred from the worker with whom she may have a longstanding relationship to another worker (an adoption specialist) in another office (an ARC). Our goal is to maintain the child's relationship with her existing caseworker (and thereby eliminating the possibility that her case "falls through the cracks" during the physical transfer of the file from one office to another) while bringing to bear the invaluable expertise necessary to process adoption cases (and thereby reducing the chance that the child's case languishes because she may be in a stable pre-adoptive placement and receive less attention than the more vulnerable children on her worker's caseload[29]). We will do this by bringing the adoption expertise into the district offices, and assigning adoption specialists whenever a child receives the goal of adoption[30], with case management responsibility remaining with the permanency worker. This will take careful implementation, and we will work with the statewide Adoption Services Advisory Committee and other adoption advocate partners to seek to meet these goals in the best possible manner.

No child whose case is now managed by an adoption specialist will lose that case manager (these children have already had their case manager change at least once, and we will not impose another such change). Practice changes will be implemented only prospectively. The training all existing and new permanency workers will receive over the next year, and thereafter, will

[29] Permanency worker and front-line supervisor training also will seek to diminish this possibility.
[30] That is, when the decision is made to pursue termination of parental rights.

include an important emphasis on concurrent planning, so permanency workers are trained to do early pre-adoptive work even as they pursue reunification for a child. When this training takes root, children receiving a goal of adoption should by that point already have received some of the pre-adoptive work now done later, in the ARCs.[31] The DYFS central office program of adoption support (which does important work in areas including interstate adoptions) will be maintained. By February 2005, adoption specialists will be assigned to the district offices. By December 2004, we will cease transferring case management to the ARCs when the goal becomes adoption. Instead, case management will remain with the existing permanency worker, and an adoption specialist will be assigned to the case to provide expert support. By the end of 2005, the ARCs will be phased out,[32] and our children needing adoption will have the best of both worlds: an uninterrupted relationship with a permanency worker until permanency is achieved, and an adoption specialist with essential expertise.[33]

With the overwhelming majority of our cases oriented to the one family, one worker model by the end of next year, our families and children should start experiencing – and reporting – a difference in their customer service experience with DYFS.

Implementation Steps

Create new positions:

Adolescent Specialist
- Create by July 2005
- Begin implementation by September 2005
- Finish December 2006

Resource Family Support Worker
- Create by August 2004
- Begin implementation by October 2004
- Finish July 2007
- Other

By December 2005, protocols and policies incorporate One Family, One Worker

Incorporate one worker/one family commitment into staff training on new case practice model.

Train supervisors and managers.
- Begin training: January 2005
- Finish training: March 2005

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[31] Carefully analyzing the steps necessary to adoption, allocating responsibility for them between the permanency worker and the adoption specialist, and developing a detailed model for the operational partnership between these two people will be important aspects of the planning in conjunction with the Adoption Services Advisory Committee. The adoption specialists will certainly be responsible for developing a child-specific recruitment plan for any child receiving the goal of adoption who does not have an identified adoptive family.

[32] Working with staff, we will develop a transitional support program for ARC employees to assist them through this change process.

[33] A more refined implementation plan regarding adoption will be developed by October 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

Train all permanency staff and team members.
Begin training: January 2005
Finish training: March 2005

In assigning cases geographically, incorporate specialists (except for cases with existing ARC case manager) so that caseloads reflect one worker, one case model.
Begin December 2004
Finish December 2005

Develop protocols and policies to be used in those situations such as attrition, where case transfer cannot be avoided. These policies should include:

- Assigning a new caseworker at least two weeks prior to a worker's departure.
- Conducting a Family Team Meeting that includes the family, the current caseworker and new caseworker, service providers and others representatives working in support of the family.
- Increasing the frequency of visits with the family before case transfer and during the first few months of new caseworker assignment.

By September 2004, develop protocol and policy
Train: in conjunction with case model (and one family, one worker) training
Begin implementation: March 2005
Monitor client satisfaction through consumer survey
Develop survey July 2005
Pilot by September 2005
Finalize
Develop Administration Schedule
Administer December 2005

Family Team Meetings

"A family-centered and strength-based approach to planning and implementation results in approaches that will best enhance the safety, permanency, and well-being of individual children, youth, and their families."[34]

We are re-orienting our case practice around families. We want to support families as the architects of their own destinies. We know this will take something of a revolution from current practice. The Hornby-Zeller and Associates Preliminary Child and Family Services Review (2003) reported:

> " overall there was limited family involvement in the case plan process. In fact, this is the item on which DYFS showed the lowest performance in the entire review….In general, case plans appeared to have been prepared by the caseworkers and then presented to the parents with a request for their input and feedback….A parental signature was found on only one of

[34] Children's Bureau publication, Rethinking Child Welfare Practice Under ASFA, Nov 2000

38 cases….When asked about the case plan process, parents often reported that their caseworker did little to encourage their involvement."

While we want a family-friendly orientation throughout our process, the primary tool we will utilize to embed this orientation into our practice will be regular use of family team meetings. The family team meeting is designed to effectively engage the family and the family's relatives, friends, neighbors and others in the process of addressing the issues which brought the family into the DYFS system – and constructing solutions in order to achieve successful closure of a case. These meetings bring together the wisdom, resources, and expertise of family, friends, informal supports (neighbors, clergy, etc.) and formal supports (counselors, health professionals, etc.) to:

- Focus on solutions to meet the family's needs and to ensure the child's safety;
- Learn what the family hopes to accomplish;
- Set reasonable and meaningful goals;
- Recognize and affirm the family's strengths;
- Assess the family's needs;
- Design individualized support systems and services that match the family's needs and build on its strengths;
- Achieve clarity about who is responsible for agreed-upon tasks; and
- Agree on the next steps.

The only current example of joint decision making or the family team approach in DYFS is Family Group Conferencing, which is used in each region in a limited number of cases after the decision to place the child has been made. This model has proven successful at keeping families safely together. This positive experience suggests that with appropriate endorsement, support and accountability, expansion into consistent Family Team Meetings will improve our interim measures of well-being and permanency outcomes for the children in our care.

We will utilize family team meetings for both in-home and placement cases. Convening a family team meeting will be the first thing a permanency worker does upon being assigned to a case – and it will be the vehicle to develop the plan and make every decision throughout the life of the case. Family team meetings must be held at the start of a case – to develop a case plan, and where there is a possibility of placement, to design either a plan to keep the child safely at home or a plan for an alternative placement. Family team meetings must also be held whenever a family member requests one. We will use family team meetings to track progress on case plans and to suggest any changes or adjustments. These meetings must also be used to make all permanency decisions, including returning home, guardianship, independent living, termination of parental rights, and adoption.

We want family team meetings to be inclusive of a wide range of family, including paternal relatives, and friends, neighbors, ministers – any and all who can provide support and help to that family in need. We want to emphasize in particular our need to engage fathers and fathers' families from the very beginning. Too often we have overlooked paternal rights and responsibilities in our process. Incorporating paternal family members not only increases the wisdom and resources around the table – it increases the options for temporary placement and it is a necessary pre-requisite to accomplish concurrent planning.

We know that the process of changing our culture will not be easy. We also know that there is considerable expertise involved in learning to convene and facilitate family team meetings. We will need help and outside expertise to develop this capacity. We will also need to develop internal expertise – and then leverage that expertise to spread this practice throughout our agency. In the end, we are committed to securing the support we need to develop this practice – and move families to the center of the planning for their own futures.

Implementation Steps[35]

By May 2004, identify and select consultant to plan, manage, and support implementation of family team conferences and shared decision-making.

By August 2004, meet with selected consultant, determine training package to be used, and enter into contract.

By July 2004, establish a design team of to work with consultant in tailoring training and implementation to the needs of New Jersey families and child welfare system, including the integration of family team conferencing with Structured Decision Making.
By December 2004, develop training plan.

By December 2004, develop family team community and staff education plan, training, and implementation plans.

By December 2004, develop policy, practice manual and training materials to implement family team conferences.

By February 2005, begin training for staff in offices within the first four high-need areas: Passaic, Essex, Mercer, and Camden. After training, implementation will begin with family team conferences for children entering placement in these areas. To be done in conjunction with training and preparing Resource Families in those areas to participate in family team conference model.

By July 2005, begin training staff in the offices in the next five phase-in areas. After training, implementation will begin with family team conferences for children entering placement in these areas (again, in conjunction with training and preparing Resource Families to participate in family team conference model).

By September 2005, develop Web-based data and tracking system to integrate with SACWIS and will monitor the scheduling, completion, and results (case plans) of family team meetings.

By December 2005, develop a community awareness campaign for staff, consumers, and stakeholders related to the concept of family team conferences.

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[35] A more detailed implementation plan regarding the use of family team meetings in other contexts will be developed, in partnership with consultant Paul Vincent, by August 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

By January 2006, begin training staff in final six phase-in areas. After training, implementation will begin with family team conferences for children entering placement (again, in conjunction with training and preparing Resource Families in those areas to participate in family team conference model).

By January 2006, family team conferences will be held for children entering placement and all service cases in offices in first four phased-in areas.

By July 2006, family team conferences will be held for children entering placement and all services cases in offices in next five phased–in areas.

By July 2006, all staff, Resource Families, and identified community partners will be trained on family team conferencing in accordance with roll-out plan.

By January 2007, family team conferences will be held for children entering placement and for all services cases in offices in final six phased-in areas.

Individualized, Family-Friendly, and Coordinated Case Planning

Writing the case plan isn't the hard part of our work – formulating the case plan is. In our new model, that hard work will take place in family team meetings described in the previous section – hard work we will want to capture in a revised version of a case plan. Here, we talk about the new revised case plan – revised as to both form and substance.

In our new model, we want our families and children to be the primary authors of the plan. We want to write these plans in a form and language accessible to the lay reader. The audience will include the family and children who are the subject of that plan. It will not be an "insider" document. We believe we can write plans that meet all federal, state, and other legal mandates – but still write those plans in such a way that the people those plans are written about will understand and recognize what we are saying.[36]

The case plan captures the process in the family team meeting by which the family, children, friends, formal and informal supports and the caseworker have:

- analyzed a family and child's needs and strengths
- identified existing risks and safety concerns
- developed the strategy to address those concerns
- identified the services that the family members and child need, including those the agency will either deliver (directly or by referral) and
- set the goals and timeframes for successful completion and closing of the DYFS case.

[36] The format for the plan will be one that allows the work of the family team meetings to be included and submitted to the courts for approval.

Written case plans can be extremely useful documents. Writing down a case plan provides:

- family, children, friends, caseworkers – and anyone else who was involved in the family team meeting or who will be providing services – with a written summary of the meeting, allowing each to check to make sure there is an accurate statement of the issues that need to be addressed and the proposed solutions;
- a record to help all of the participants remember what each person promised to deliver and do;
- a yardstick to mark progress – or lack of progress through the life of a case; and
- a useful monitoring and accountability tool for family, staff, supervisors, managers and others, including the courts.

In our model, the end result provides families with a single comprehensive service plan that is individualized. That plan is based on that family's strengths and responds to individual family needs rather than just offering services that are available. In the next section and beyond, we talk about the revised range of services we plan to offer. But even with these new services, the case plan should not devolve into a checklist – albeit one with new boxes. We want the family and their supports to suggest the services and solutions that will meet their needs – some of which we may have readily available, others of which they will identify from the community or we will have to work with the community to identify. An individualized service plan is yet another tool to make it clear that we are committed to being family-focused in our agency – and manifests our belief that engaging families throughout the process will produce better outcomes for the children in our care.

Before facilitating family team meetings to develop and revise case plans, staff will have learned safety, permanency and well being protocols. These will help staff identify the range of issues they should be sure are covered in the family team meeting, and remind them what not to do – e.g., not to write their own version of the case plan and not to impose a definition of the problems or to unilaterally construct solutions. Our revised protocols will help prompt permanency workers to such practice changes as identifying fathers and paternal relatives at the very beginning of a case. They will help them remember to collect all the information they need to begin concurrent planning – and because we want them to get better and better at addressing safety issues and concurrent planning[37], those protocols will help them embed good practice into their day to day work.

We also want to have families operate utilizing a single case plan. A coordinated plan must exist for all agencies or providers involved with the family. Individual service plans should be brought together into a coherent whole so that the array of services is clear – and to ensure against overlap and gaps and unreasonable scheduling. We will work with agencies and service providers to help them develop service plans which reflect these values – especially those of family input and tailoring to individual needs. We will also include service providers in family team meetings as much as possible.

[37] We are designing those protocols to help them to remember to explore viable options for permanency that previously were little used or employed only months or years into a case – for example, voluntary surrenders for adoption.

Implementation Steps

By July 2004, revise current plan format to be more "family friendly" allowing family strengths, concerns, goals, and tasks to be more in the family's own words, behaviorally focused, and incorporating the family's team meetings over time. Develop a new format utilizing a workgroup with representatives from 1) parents and youth who are currently receiving services, 2) resource parents, 3) the court, 4) other key provider stakeholders, 5) front-line and mid-level supervisory staff to revise the case plan format and design a unified case plan document. Incorporate case plan goals into new service plan development.

Roll out new case plan format in conjunction with roll out of team meetings.
See schedule for family team meetings above.

Meet with existing primary providers to construct a protocol for producing comprehensive, cooperative case plans.

Conduct file review to check sample of case plans.

Delivering Family-Friendly Services

The goal of the New Jersey child welfare system's intervention and delivery of services is to restore the family system to the point where parents can assume full responsibility for the care of their children without DYFS involvement. Currently, there are several issues with the range, type, and timing of services available to meet this goal:

- Services are often delayed or unavailable.
- There is a desperate need for more resources in all areas and some areas are particularly under-resourced.
- There is no continuum of services.
- If a family needs more than one service, they often have to juggle several service providers – who sometimes have conflicting requirements and scheduling.
- Services, as implemented, do not necessarily meet the needs of the family.
- Services are designed to the convenience of the system rather than to meet the needs of children and families.
- Many services are available only during work hours, forcing families to choose between working and complying with service requirements.
- Services are often not located in the community, making it difficult and challenging for our families to access those services.

When a family is in crisis and needs DYFS assistance and we go to the cupboard for services, too often now that cupboard is nearly bare. This situation is frustrating and debilitating for our families and children and disheartening to our frontline staff. It also can be costly. If we cannot help deliver the services our families need to keep their children safe, we may need to take those children into placement – and if we cannot deliver them to the family when a child is in placement, then that child will linger. One of our biggest commitments in this plan is to substantial increases in the services we will provide and improvements in how we will provide

them. We will expand our providers and community resources to deliver more and different kinds of services but we will also build the capacity of our staff to be more than case managers – and sources of referrals – but also service deliverers.

There are several principles that we will follow in reforming and building our service delivery system:

- Ensuring a child is safe throughout the service delivery process.
- Work with community members, birth families, children and resource families to map the Communities of greatest need, to define the types of services people need, and to define service delivery models which are family-friendly.
- Utilize family team meetings for plan development, service monitoring, and case transfers.
- Deliver services in the communities where our families and children live and expand our notion of service delivery to include existing community providers and informal supports identified by the children and families in our care.
- Develop a full array of supportive services in each community to ensure compliance with best practice.
- Ensure that services to children and families focus on strengths of the family and empower families.
- Ensure that the child welfare service systems operate in a way that is compatible with the customs, behaviors, and beliefs of the diverse range of the people in our care. Understand that assessment, planning, decision making and delivery of services must occur within the cultural context of the family.
- Increase delivery of in-home services based on research which shows that those models are most effective and efficient.
- Operate with urgency – reduce delays in accessing services and frontload service delivery.
- Provide sufficient flexible funding to address the service needs of individual children and families on a timely basis, without restrictions from particular funding sources.
- Increase the capacity of community-based, culturally competent, linguistically appropriate services
- Work with our partner service providers to contract for and support services which reflect the values set forth in this plan – including our focus on making services family-friendly, family-directed, individualized, community-based, and in home.
- Develop clear guidelines for assessing and monitoring diagnostic and treatment services.
- Introduce the flexibility to redesign services in response to measured outcomes and to better meet the needs of the children and families served.
- Establish a close, cooperative working relationship with other agencies to ensure local school districts and local mental health centers help support service delivery.
- Ensure that children and families have continuity of services even when case managers change.
- Develop comprehensive strength and needs assessments on all life domains.
- Understand that assessments of strengths and needs must be on-going and not “one-time only.”

- Utilize one family/one worker to insure continuity.
- Support building our knowledge of community resources by geographic caseload assignment.

Following those principles, we are substantially expanding the core services our families need. As described in the Service section which follows in this plan, these are: substance abuse, domestic violence, behavioral health, medical, and housing. We know right now, for example, that there can be long waits for a parent seeking substance abuse treatment and that very few in-patient slots allow people to bring their children, forcing families to separate. We have incorporated the Division of Addiction Services into the Department of Human Services so that we can coordinate that service delivery with the needs of our families. We have committed $3 million a year in additional funds to expand those services – and to help our families achieve their goals within the timelines set by ASFA.

We have committed to expanding mental health and health assistance to our families across the board: for families with children at home, for our children in care, and to help support our resource families so that a child in their home can stay in that home and not need to be moved to a higher level of care in order to receive the services he needs. We also commit to adding treatment homes so we can reduce the numbers of children in congregate care.

We have added more home visiting services for new mothers and families with young children. We emphasize our commitment to providing high quality, in-home services to families and children. In home services will allow children to attend the same schools, maintain family and community relationships, and stay involved in community activities. And we have committed resources and have built relationships with other agencies in state government to address the housing needs of our families.

In addition to all these specified services, effective child welfare work also requires that front line workers have access to flexible funding to meet the unique needs of children, birth families and resource families. Such funding can be used, within appropriate guidelines, for whatever a family needs to meet its immediate needs, from transportation for visitation to a new refrigerator to an essential plumbing repair. By January 2005, we will conduct an analysis of both (1) the ease of access for our staff to flexible funding (are the procedures for accessing it unduly restrictive or cumbersome?), and (2) the adequacy of our flexible funding resources. We will fix any problems identified regarding ease of access by January 2005, and will seek to address any insufficiency of funds identified, beginning in year two of this reform effort and continuously thereafter.

These are just a sampling of the range of new and expanded services that we plan to deliver – but we know we cannot possibly meet the range of needs of our families all on our own. We need help from community providers and from informal helpers in the community. And our families benefit when they can receive services right in their own communities.

We want to work in partnership with local communities, provider agencies, child advocates, and community- and faith-based organizations and leaders to complete community-based asset mapping to identify services resources, needs and gaps. We want to help build local community

capacity to provide services which meet the needs and gaps identified during the assessment mapping, by strengthening existing assets, making existing funding streams more flexible, and identifying new funding. We must increase the availability of services within the community and develop our capacity to support families in accessing community resources. We must reform contracting procedures to require service delivery is tailored to the individual needs of the child and family.

In our new model, we will work systematically to link families to resources in their communities that provide them necessary support. We will encourage and support staff in becoming familiar with resources available in the different communities across the state in which the families they serve reside. We will work hard to locate and access community supports and regularly integrate community supports into case plans.

To develop community linkages that support families, DYFS will assign workers case loads that are clustered in the same community. These workers will utilize the one family/one worker model to ensure that each family has one worker continually tracking their case the entire time they are in the system. These practices will help caseworkers become more familiar with local resources and encourage them to work closely with local service providers to assure continuity in service delivery. These strategies will also allow case workers to follow up to make certain that families connect with community-based resources and that services provided were beneficial. Finally, through the use of family team meetings, caseworkers will be able to identify additional appropriate community supports for families beyond those with which the worker is already familiar.

Implementation Steps

Work in partnership with local communities, provider agencies, child advocates, and community- and faith-based organization/leaders to complete community-based asset mapping to identify service resources, needs and gaps.

Begin in August 2004

Help to build local community capacity to provide services which meet the needs and gaps identified during the assessment mapping, by strengthening existing assets, making existing funding streams more flexible and identifying new funding.

Begin in September 2004, complete in February 2006

By November 2004, revise policy, practice manual and training materials on supervising children in placement to address timely service provision.

By November 2004, develop policy and protocol for every family team to access flexible funding for services and resources per fiscal year.

By September 2005, identify the process and criteria by which children and families will be referred to the community for prevention, family preservation and support services. Outline procedures for formal communication and coordination with the child welfare agency for families under supervision.

The state must initiate new contracts for family-focused, culturally sensitive preservation services designed to meet family needs.

Initiate: December 2004

Beginning July 2006, use performance-based contracts to hold providers accountable to meet the service priorities and outcomes.

Beginning July 2004, increase capacity and availability of service providers in the community to meet the needs of children and families.

Beginning July 2004, pursue potential for Medicaid reimbursement for those services that are eligible under the Medicaid State Plan.

Integrate a "Locating, Linking to, and Using Community Supports" section into caseworker and supervisor trainings.

Integrate by April 2006. Implement through training schedule.

Evaluate caseworkers on their ability to locate and establish linkages to local community-based service providers and supports, to include community linkages in their case plans, and to follow up with families and community-based service providers to make certain that the family received the community supports offered and that they were beneficial.

Implement: June 2006

Monitor service delivery on a regular basis to ensure that the planned services being provided are meeting the needs of children and families.

- By June 2006, and every six months thereafter, DYFS will study a random sample of cases in which community supports were used to see if the supports contributed to reunifications, the avoidance of removals, or placement disruptions.
- By December 2006, and every six months thereafter, DYFS will compare a random sample of cases in which community supports were used to a random sample of cases in which community services were not used to see if there was a difference in the number and timeliness of reunifications, the number of removals, and the number of placement disruptions.
- By December 2006, and every six months thereafter, DYFS will interview or survey a random sample of families who have received community-based supports to determine whether they were satisfied with the referral process and the supports or services provided. Based on the results, DYFS will revise its use of community supports as necessary.

Based on all of this information, DYFS will revise its use of community supports as necessary.

Concurrent Planning

As the above sections emphasize, we are going to work as hard as we can to keep children in their own homes by employing new tools (family team meetings, one family/one worker) and new services. We believe that the sum of all of those practices will amount to more children

remaining safely at home and fewer children coming into placement. But even with those reforms – and as we are on the road to those reforms – we will continue to need to separate children from their homes for their safety. And in those cases, we need to be working as hard as we can to achieve permanency as quickly as we can.

Impatience with our failure – indeed the failure of many child welfare systems – to deliver permanent homes for the children in out-of-home care has grown. The institution of the Adoption and Safe Families Act (ASFA) is just one important manifestation of public dismay at the length of time children spend in "temporary" care. The timelines imposed by ASFA are strict – children should spend no more than 15 out of 22 months in out-of-home care.[38] We know that 15 months is a very long time in the life of a child -- but it can pass in an eye blink in a system that does not conduct its business with the urgency and efficiency that our children and families need.

We also know that a lethargic system produces bad outcomes. It stifles and reduces reunifications. It "graduates" too many adolescents into "independence" at 18 without families or resources to provide necessary back-up. It creates destructive tensions and unnecessary fragility in temporary family systems, where children and adults remain uneasy because they lack stability. And it inhumanely delays permanency for children whose best or only option is adoption.

Concurrent planning is a tool which focuses our case practice on achieving permanency for children in out-of-home care. Although the preferred goal for most children who go into out-of-home placements is reunification, planning for alternative permanency arrangements must begin immediately when placement occurs. Waiting to begin alternative permanency planning until it becomes clear that reunification will not be possible greatly delays achieving a long term living arrangement for a child.

Surveys of our staff indicate that they clearly understand and are committed to promoting reunification as the preferred goal for our children in out-of-home placement.[39] But where a family was willing or able to achieve reunification initially, sometimes we have not been able to help them achieve it. It is not that we do not think it is important in most cases – but rather we have not had the right tools, services, or sometimes, the right sense of urgency, to help make it happen. We have also not used some of the tools at our disposal. We have treated visitation as a reward for compliance – rather than utilizing it as a tool to achieve reunification.

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[38] The federal Child and Family Service Review outcome specific to adoption requires that at least 32% or more of all children who exit foster care to adoption do so within 24 months from their latest removal from home. New Jersey is required to meet the ASFA and CFSR outcome of decreasing the length of time to adoption.

[39] Data from the Hornby Zeller report suggest that the Division is in substantial conformity with the federal standards around reunification as a permanency goal. Our caseworkers by and large appreciate the family's and the children's desire to be together as a positive goal to work toward. Hornby Zeller also states, however, that the Division is currently so deficient in engaging families to assess their strengths and needs, in establishing goals and clearly understandable plans to achieve the goals, and in identifying and establishing the proper services and supports, that many reunifications are inordinately delayed or never achieved at all, no matter how much we may desire it.

In our new model, we will facilitate frequent visitation and make better use of those visits to help equip parents and children to achieve reunification. We will also use visitation as an opportunity to promote gradual reunification – extending visitation to evenings and weekends. That way, our families will have time to adjust to living back together – and we will have the opportunity to help them learn to do that. Visitation is only one of the elements of the case practice model described above which will help us match our commitment to reunification with our ability to help our families achieve it.

But when it comes to adoption, in our current practice, we operate differently. Our process has encouraged our case work staff to focus first on reunification – and only when that has evidently and absolutely failed, to move to pursuing adoption. That serial way of operating has high costs for the children in our care. It means that fewer children are adopted than could be – and it means that when children are adopted, those adoptions occur only after months and years of delay.

We believe our staff can pursue both options throughout the life of a case – and the tool for doing so is concurrent planning. Concurrent planning starts at the very first moment of placement. In making placement decisions in family team meetings, staff should promote options which are most likely to hold the possibility of permanency if reunification does not happen. In choosing among placement options, we should prefer relatives or friends or resource families who have the capacity and the willingness to adopt. We should steer away from congregate care settings as initial placements – which we currently use at too high a rate in New Jersey (25%) – because they do not hold the promise of permanency.[40] These principles hold even when that placement happens under emergency circumstances. Child protective staff conducting investigations, their permanency colleagues, and all supervisors must consider long-term permanency even when they immediately place a child. Laying the groundwork for alternative permanency is particularly crucial when the abuse/neglect is severe and the possibility of an expedited termination of parental rights must be explored.

We have introduced the idea of concurrent planning into some parts of our system in the past – but we have not done so as comprehensively and as deeply as we need to in order to improve permanency outcomes for our children. Consequently, we have created some skeptics among the public and the advocacy community about our ability to achieve this goal. Some have questioned whether the same staff can plan well in two directions at the same time – and promote reunification while pursuing adoption. But there are examples from other systems where staff have successfully incorporated this dual orientation into their practice – and we have some staff already who are committed to and want to incorporate this tool into their practice. We believe with expert support and a commitment of resources and focus, our staff can deliver on concurrent planning. And we will produce better and faster permanency for children in New Jersey.

[40] In a very small number of cases, a congregate care setting such as a hospital may be necessary in order to stabilize and heal a child – but even as that placement is made, our permanency staff must be working to identify a home which meets our potential permanency criteria.

Adoption

In order to deliver sound concurrent planning, we need to improve our existing adoption practice and incorporate it into our permanency practice from the very beginning of a case. As discussed above in the One Family, One Worker section of this plan, we are going to increase our capacity in our District Offices to deliver adoption services. And we will work closely with the ARCs to promote practices in our local offices to provide a better foundation for adoption. We believe the obligation to deliver sound and rapid adoption services is not the ARC staff's alone – but is shared in all of our permanency work and throughout how we construct our new model of practice. And we know we want to improve the quality and rapidity of adoptions in New Jersey.

To that end, New Jersey commits to developing an adoption program that is child-centered and supports potential adoptive parents. All elements of a state-of-the-art special needs adoption program will be incorporated into New Jersey's adoption program. For children with a permanency goal of adoption, the length of time to adoption finalization will decrease as a result of system change. New Jersey also commits to increasing adoptions of older children. New Jersey further commits to establishing and strengthening practice as it relates to identifying kin resources early in the life of a case in order to promote kin adoptions.

New Jersey currently provides adoption services for special needs children through the direct administration of six regional Adoption Resource Centers. Children who have spent considerable time in foster care (typically 12-15 months) are transferred from county based DYFS District Offices to regional Adoption Resource Centers (ARC) for adoption planning. While cases are managed at the District Offices they may have multiple workers (intake, in-home supervision, permanency) that lead to delays in achieving case goals.
New Jersey's adoption program has been successful in increasing the number of children adopted since ASFA implementation. From 1998-2002 there were 4,719 children who had their adoptions finalized by the Adoption Resource Centers. New Jersey met the federal mandate to double the number of children who were adopted during this time and was awarded $4.5 million in Federal Adoption Incentive bonuses for outcomes achieved in the federal Adoption 2002 initiative.

There is one Federal Child and Family Service Review outcome for adoption. It is: for children exiting foster care to adoption, 32% of children exit within 24 months of their most recent removal from their homes. New Jersey Child and Family Service data documents that 16.8% of children who exited foster care to adoption in 2002 met the federal standard. This documents that while many more children are being adopted from the foster care system, it is taking too long to achieve the adoption finalization.

But improving adoption practice is not simply a matter of increasing speed. We must also make sound decisions about which families are able to adopt and provide support and services to them throughout the process to decrease disruptions and ensure the safety and well-being of the children who are adopted. Recent tragedies underline the need to not see the moment of

adoption as the time after which we no longer pay attention to the children who have been in our care.[41]

Strategies: The following strategies address improvements we will make in processing adoptions for children:

a. **Concurrent Planning:** A case practice which requires reunification efforts and alternative permanency planning simultaneously. The primary goal always is reunification, but a back-up plan is developed in case permanency with the birth family cannot be achieved within the legally prescribed timeframes.

b. **Create Uniform Licensing Standards for Prospective Adoptive Parents:** New Jersey currently recruits and manages foster and adoptive parents in two separate programs. We will move to a single resource family system with one set of standards that provides for dual licensure. This will add flexibility to the system and allow parents interested in fostering or adopting to move among programs as they wish, without having to navigate different requirements. It will also reduce administrative delays in processing adoptions.

c. **Develop a Family-Child Match Program:** For a child entering substitute care, the needs of that child and the strengths of the prospective resource family should be matched. Matching will address the issue of the first placement being the best placement for children, ensuring that children are placed with families who can meet their identified needs, minimize multiple moves and match children with families who can provide for them on a short-term or permanent basis.
d. **Improve Resource Family and Adoption Support Services:** Resource family and adoption support services must be available to all families in New Jersey. Providing improved services and support to resource families (whether kin or non-kin) will improve stability and encourage adoption. Support services also must carry over to adoptive homes to support those families and children and discourage adoption disruptions.[42]

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[41] In light of the recent Jackson tragedy, as a condition of receiving the adoption subsidy, New Jersey would like to require adoptive parents to produce proof of medical care. We have been told that federal law bars the imposition of such a condition. Senator Corzine's office is working with our staff to resolve this issue and allow medical certification.

[42] Post-adoption services can be essential to preventing adoptions from disrupting – a disastrous outcome for children – particularly adoptions of children with special needs. New Jersey already offers a number of post-adoption services (all are available to all New Jersey families who have legally adopted children, without regard to whether the adoptive placement was made by the state or privately):

The New Jersey Adoption Resources Clearing House (NJ*ARCH), funded by DYFS and operated by Children's Aid and Family Services, offers a range of services regarding the adoption process including an on-line resource directory, a phone line for adoption information and support, a buddy/mentoring program to provide support through the adoption process, and on-line adoption chat rooms monitored by professional staff.

More individualized post-adoptive clinical support services are available through Post Adoption Counseling agencies throughout the state. PAC clinicians have expertise in addressing the needs of this client group; most have completed the 45-hour post-graduate Adoption Certificate program at Rutgers University School of Social Work. The service is primarily individual or family counseling, and may be office- or home-based.

We are committed to supporting adoptive families throughout the process, including the post-adoptive period, and to that end will evaluate whether the existing service array is adequate and, if not, will expand and/or enhance the program to address the need.

e. **Adoption Subsidy:** The New Jersey Adoption subsidy program needs to be enhanced to include entitlement for special services such as day care, respite, medical and mental health services. Special services are rarely approved in the current system and this creates delays for waiting children.

f. **Older Child Adoption:** National data documents that children over the age of eight are the most difficult to place with permanent families. The recently revised Federal Adoption Incentive Program rewards states with fiscal incentives for achieving older child adoptions. New Jersey must develop a specialized model for older child adoption that involves the child as an active participant in the plan and provides enhanced supports for families. A program to provide free tuition to state and county colleges for families who adopt older children is an example of this type of support.

g. **Child-Specific Recruitment:** Children in foster care for whom reunification is impossible or appears unlikely, but who are not in pre-adoptive homes, require targeted, child-specific adoptive-home recruitment efforts, beginning with people already known to the child (for example, a teacher or coach). Under the concurrent planning model adopted herein, such children should be identified earlier than they have been to date. Adoption specialists will be responsible for child-specific recruitment for all children with a permanency goal of adoption who lack a pre-adoptive resource.

h. **Interstate Compact on Adoption Medical Assistance (ICAMA):** New Jersey is one of three states that have yet to join ICAMA. New Jersey's delay in executing joinder in ICAMA has caused delays in facilitating interstate adoptions for waiting New Jersey children. New Jersey should immediately become an ICAMA member.

i. **Interstate Placements:** The Division needs to address the issue of delays in interstate adoption placements. The Interstate Compact on the Placement of Children creates delays both in New Jersey and in other states. Adequate resources need to be allocated to the New Jersey Interstate Services Unit. Additionally, funds need to be allocated for New Jersey to contract with private adoption agencies to expedite home studies and supervise adoption placements when interstate delays are identified.

Implementation Steps

Develop policies, practice guides, ongoing training and management reports that implement concurrent permanency planning in DYFS. Require case reviews of children in placement to include an evaluation of the concurrent plan for the child.

By December 2004

A web-based template will be developed so that family-tree information can be entered at intake.

By October 2004

Adoption Operations will work with the DYFS budget office and Medicaid to explore the possibility of including adoption support and subsidy services in the Rehab. Option of the

Medicaid State Plan. Doing so would enable the state to increase the level of services to families while utilizing state funds more efficiently.

By September 2004

Create a concurrent planning curriculum for New Jersey. Pilot, revise, and then implement.

By December 2004

A contractor will review 100 randomly selected case files statewide to determine whether concurrent planning is being accurately and appropriately implemented.

By March 2005

Update and implement revised provisions for Adoption Subsidy.

By July 2005

Design and incorporate into the practice model strategies for encouraging older child adoptions that includes youth involvement and family support will be developed and implemented.

By May 2005

New Jersey will take all necessary steps to become a member of Interstate Compact on Adoption Medical Assistance (ICAMA).

By October 2004

DYFS will allocate an additional staff position to the Interstate Services Unit and will allocate funds to purchase adoption services by out-of-state licensed private agencies.

By July 2004

■ RECRUITING, RETAINING & SUPPORTING RESOURCE FAMILIES

Children need families that are loving, stable and safe. When their own families are unable to provide these things, the state must. But the government cannot do this directly. You can't legislate love. Only devoted and generous private citizens – with the active support of the state – can fulfill this essential role. These are resource families.

This plan calls them resource families because that's what they are: resources to keep the child safe and help her achieve her permanency goal. We will no longer divide these families depending on the child's permanency goal ("foster family" when the goal is family reunification v. "pre-adoptive family") or position in a legal process ("pre-adoptive family" v. "adoptive family"), or on whether the child knew them prior to placement ("kinship families" or "relative care" v. "foster families"). All are resource families.

Without resource families – in large numbers, from the same the neighborhoods and communities as our children, willing to work with even our most challenging cases – much of this plan would be impossible.

We make two basic **commitments** in this area:

1. We must have an appropriate resource family for every child who needs one, with the necessary skills and training, preferably in the child's own neighborhood, and whenever possible already known to the child, and to this end will recruit at least 1,000 new resource families by June 2005, and more thereafter; and
2. Resource families must be bridges to permanency, willing to work actively with the birth family while the goal is reunification and prepared to adopt if reunification proves impossible.[43]

When children need resource families, they need them right away, not in two weeks. We must be ready. Children should be placed in their own neighborhoods whenever possible, to reduce the trauma inherent in being removed from their home, and so they can stay in the same school, play with their friends, easily visit their parents and any siblings still at home (greatly facilitating reunification), continue with any community activities (sports, clubs, etc.). Being placed with people they already know (kin) reduces the trauma further.

Resource families can and should be not merely safe havens for the children, but also resources to the birth parents, modeling good parenting, supporting the maintenance of the parent-child

[43] The resource family system will be an inclusive system. It will accommodate families who wish only to foster, and those who wish only to adopt. However, it is hoped that many families will come to the system open to the possibility of either role, depending upon their strengths and the needs of the child(ren) placed with them. The willingness to consider adoption, as many current foster parents do, provides critical stability and well-being to children who ultimately need adoptive families. Placement decisions will be made aware and respectful of the preferences of the resource family and the likely permanency goal for the child at the time of placement. Thus, for example, resource families who only wish to foster will be more likely to be considered placement resources for children for whom reunification appears extremely likely, rather than for an abandoned newborn likely to need adoption.

relationship, and encouraging all parties to do whatever is necessary to reunify the family.[44] At the same time, they should be prepared to adopt if reunification is impossible. We realize that asking families actively to support reunification while being prepared to adopt is asking a great deal. The system will recruit and support families willing and able to fulfill both roles. But it will also recognize, recruit and support families interested in only fostering or adopting. Children come to the system will various needs, and will be paired with resource families best able to meet them.

The **current situation** is tremendously far from this ideal. Our recruitment process is haphazard and disorganized. We do not have nearly enough resource families. As the chart below shows, the system has suffered a continuing decline in resource family applications. In 2003 we certified the fewest homes in the past four years and, considering the number of homes closed as a result of more rigorous licensing enforcement, suffered a net loss of 130 resource homes.

	2000	2001	2002	2003
Applications	1,948	1,576	1,416	1,356
# new homes	675	730	887	623
# homes closed	•	•	673	753

• Data not collected for this time period

This decline occurred at a time of steeply increasing need:

	2001•	2002	2003	2004
Children in Foster Care	9,528	10,607	11,209	13,085

• All data as of the first Friday of the year

As a result of these trends, children entering foster care continue to spend long days in offices, their meager belongings in plastic bags, listening to caseworkers begging resource families to take them even for one night, traumatized by the removal from their own homes and provided neither a new home nor stability.

As bad as the overall situation is, it is worse for several sub-groups, including teenagers (who must be placed in far less home-like congregate settings), sibling groups (who must be split up), children with special needs (who are placed with families lacking the skills to meet their needs, and bounce from home to home as resource families get overwhelmed), and "boarder babies" left in hospitals after birth beyond medical clearance for release (who languish in hospitals). We do

[44] We realize that there are some cases in which contact between the resource family and their foster child's birth family would be inappropriate, and in such cases contact will not be pursued. Even in the more routine situation, in which such contact is both appropriate and in the child's best interest, personal information about the resource family, including last name, address, and phone number, will not be disclosed to the birth family without resource family's consent.

not have sufficient Spanish-speaking resource families, and have too many children placed out of state.[45].

When families do express interest in working with us, we make it very difficult. The training and licensure processes are cumbersome, and can take as long as 12 months. Instead of expressing gratitude and supporting them throughout the process, we treat them as if we're doing them a favor by letting them in. Contract providers are also involved in developing resource families. The way they carry out this role is different from provider to provider. The result is that resource families encounter a system that can include many different organizations and units, resulting in confusion and inconsistency. It is difficult to tell resource families what to expect as they move through the homestudy process.

We sometimes demonize birth families to foster families, undermining the very possibility of resource families supporting birth families' reunification.

When a child's permanency goal changes to adoption, if the resource family is unwilling to adopt (the best outcome is adoption by the same family, so the child need not suffer another traumatic loss), another resource family must be found and licensed to adopt, delaying the achievement of permanency for the child.

Once resource families have children placed in their homes, we do not support them in any organized way. Instead of celebrating their commitment and doing everything we can to support their success and draw upon their expertise, we take them for granted. Many understandably give up and leave the system.

To turn this around, we will employ six **strategies**:

1. Hiring Resource Family Support Workers

We will employ a new group of workers statewide, resource family support workers (RFSWs), who will work out of the District Offices and will be responsible for some recruitment, training support, home studies, and providing ongoing support to up to 35 resource families from the same geographic area. Each RFSW will be responsible for working with resource families in a particular geographic area, and will be tasked to work in partnership with the caseworkers and supervisors responsible for the same area. Just as children with open DYFS cases have assigned workers responsible for their needs, so our resource families should and will have the continuing support necessary to ensure their success.[46]

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[45] As of January 2, 2004, there were 382 children in non-kin DYFS foster homes out of state. This excludes children in congregate settings, who are discussed in a later section of this plan; children placed by DYFS with relatives; and children in "para foster homes," which are situations in which the child's caregiver, not DYFS, makes the placement, and the new caregiver subsequently comes to DYFS seeking support (there were 128 such children on January 2nd). Bringing these children back to New Jersey will be a very high-order priority as new in-state resource families are developed.

[46] The private agencies that manage resource homes under contract to DYFS will be contractually mandated also to adopt the resource family support worker model.

RFSWs will have no more than 15 families in their initial caseloads. Thereafter, they will be responsible for guiding no more than five additional families per month through the home study and licensing process.[47] The first-trained RFSWs will be assigned to the areas with the greatest need for new resource families, which will also be the areas targeted for particular recruitment efforts.

2. Organizing and Invigorating Recruitment

We will employ a focused and ongoing recruitment effort, involving the neighborhoods and cultural communities where our children tend to enter care, and devoting special attention to the needs of groups for whom the system has particular difficulty recruiting sufficient homes (teens, siblings, children with special needs, and children from non-English-speaking homes, LGBTQ youth, and children under six who would otherwise be in congregate care settings). We must recruit more resource families than we need on a purely numerical basis, so children will have immediate access to homes and families that match their precise needs.[48] Each local office will have a Resource Family Recruiter dedicated exclusively to recruitment, with specific goals based on the area's need, and responsible for following up on all inquires from interested families in their area. In addition, we will continue to contract for targeted, community-based recruitment assistance in areas of greatest need, employing performance-based contracts to assure positive results.

3. Improving Training

The training process will be made much more respectful and user-friendly, and will focus on the values we are now adopting (particularly, active support of whatever is the permanency goal). We will require 24 hours of pre-service training to become a licensed resource family. There will be ongoing training, beyond the pre-licensure portion, so resource families will always have the skills they need. Starting July 1, 2005, each resource family will be required to complete 10 hours of in-service training annually; on July 1, 2006, this requirement will become 15 hours annually. We will make available sufficient training for our resource families to meet these standards, and to avail themselves of more should they wish. Each area will have its own Resource Family Trainers. Resource families, birth families, and children in out-of-home care will all participate in the training process, providing their perspectives and experiences to the new resource families.

4. Streamlining the Process

The process of becoming a resource family will be streamlined, and will occur simultaneous to – rather than following, as has been the practice – the training.[49] The training and

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[47] Though RFSWs will be available to consult with those responsible for the placement process, they will not be responsible for finding placements for individual children.

[48] This recruitment effort will focus on resource families not known to the children ultimately placed with them. Kin – the preferred resource family whenever available – can only be recruited once a child becomes known to the system. In investigating a report of suspected abuse or neglect, part of the Child Protection Worker's responsibility will be to identify all the kin in the birth family's life, for the dual purposes of obtaining their perspective on the alleged abuse or neglect and identifying possible resource families should foster care become necessary.

[49] As noted earlier, licensing regulations will be revised to comport with Child Welfare League of America capacity standards, which hold that no resource family may have more than four foster children, more than two foster children under the age of two, or more than six total children (including biological, foster and adopted) in their home

licensing processes will license resource parents to both foster and adopt children.[50] Each new resource family will have a single, local point of contact and support through the entire process – their resource family support worker. Resource parent applicants will be required to demonstrate their competency and preparedness, via qualitative assessments, before they are licensed.[51] From application through training and licensure, the process will be easy to complete within 90 days.[52]

Resource families will deal with only one agency, be it DYFS or a contracted agency in the community, who will work with them from application through licensure. This means that the family will receive their training and have their homestudy conducted by one organizational unit. Families will no longer find themselves receiving training from one organization, a homestudy from another, and so on. The Office of Licensing will remain responsible for licensure of resource family homes. Employing a carefully designed schedule that overlaps multiple elements of the approval process – training, background checks, references, medical exams, and homestudy – the Resource Family Support Worker will complete the process of preparing the home for licensing review within 60 days of the resource family's application. The OOL inspector will then conduct a joint inspection of the home with the RFSW within the next 20 days (days 60-80) to ensure that the home meets licensing requirements, enabling the OOL to generate and issue the license to the home in the final ten days of the 90-day timeline. OOL staff will also be available to provide technical assistance to the RFSW and the resource family during the initial 60-day phase of the process if necessary to facilitate the licensure of the home.

5. Equalizing and Raising Payment Rates

The rates paid to resource families are both inequitable and inadequate. We will raise the rates paid to kin serving as resource families to the same amount received by resource families previously unknown to the children, then raise all resource families' rates across the board to more accurately reflect the cost of raising a child in New Jersey. These steps will help us recruit and retain more resource families.

The base rate (there is a scale, depending mainly on the child's age) now paid to non-kin resource families to foster the youngest children is $420 per month per child,[53] while kin (now called "relative care") receive a flat rate of $250/month. We will equalize these rates

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at a time, except in the case of larger groups of sibling foster children, who may be kept together. The revised regulations will not affect existing placements, and will apply to new placements made on or after June 1, 2005.

[50] The home licensure regulations will be revised to accommodate the different circumstances of kin and non-kin resource families.

[51] Regulations will be modified so the licensure process, while unitary, will allow appropriate flexibility (as regards minimum space requirements, for example) to permit licensure of appropriate relative caregivers.

[52] It cannot be guaranteed that the 90-day target will be achieved in all cases because resource families must complete pre-service training before being licensed and the families control the pace at which they complete this training.

[53] There are four base rates each applicable to children of particular ages. The calculations in this document based on the $420/month rate are thus exemplary and will not apply precisely as written for all children. All increases will apply proportionately to all rates.

by July 2004, placing kin resource families on the same scale and increasing their rates by an average of 68%.[54]

Equalizing the rates of those resource families who are kin to those who are not will require that the homes of kin be licensed as full resource family homes, rather than the separate category of "relative care." Children removed from their homes on an emergency basis will still be able to be placed immediately in the homes of their kin.[55] The home study, training and licensure will follow shortly thereafter, in accordance with a process particular to the situation of resource families already known to the children. In addition to making kinship resource homes safer and better prepared, the licensure of these homes will also render them eligible for an important federal contribution to the board payments.

The United States Department of Agriculture analyzes how much families of various incomes pay to raise their children in each region of the country. We will use the USDA analysis of middle-income, two-parent families in the urban Northeast, and will increase our board rates incrementally until we reach 100% of this rate in July 2008.[56] These rate increases should help the system to attract a larger group of potential resource families, enabling it to accept only those families well-suited to the multiple challenges and rewards of resource parenting.

6. Supporting and Valuing Resource Parents

Resource family support workers will meet resource families as soon as they submit their applications and will develop strong relationships with them. Just as permanency workers are responsible for attending to the needs and outcome goals of the children, RFSWs will be responsible for attending to the needs of the resource families.

RFSWs will counsel and guide resource families through the application, training and licensure process, and will help build bridges from the resource families to community supports. They will remain involved with their resource families as long as the families have

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[54] DYFS kinship guardianship (now also at a flat rate of $250/month) and adoption subsidy rates (which have equaled foster care rates for many years) will both parallel the new unitary resource family board rates prospectively as the rates increase, avoiding any fiscal disincentive to permanency. Both these rates will be permanent for individual families as of the date a kinship guardianship or adoption is finalized. Current policy is that for children still in high school or an equivalent secondary education program subsidies for adoptions may continue beyond a child's eighteenth birthday until the child either graduates or turns 21, but the subsidy drops by 20% when the child turns 18; we will change this as of July 2004, and will maintain both adoption and DYFS kinship guardianship subsidies for these children at 100%.

[55] Before a child is placed with kin, the child protection worker must grant a preliminary approval of the home following a physical inspection of the home and, through a call to the new 24-hour, 365-day statewide Child Abuse Hotline, a check of the child abuse history and criminal background (via the Promis-Gavel database, accessible via the Hotline) of the people in the home.

[56] This USDA rate, now $792.50 per month per child, is adjusted annually. We will attain the USDA rate in the following five steps: on January 1, 2005, we will close the gap between our current rates and the USDA rate by 10%; on July 1, 2005, we will close the gap by 15%; (to total a closing of the gap by 25% in 2005); on July 1, 2006, we will close the gap an additional 25% of the difference between our rates and the USDA rate; on July 1, 2007, we will close the gap by an additional 25% of the difference between our rates and the USDA rate; and on July 1, 2008, we will reach 100% of the USDA rate.

children placed in their homes,[57] and will visit them as often as the families need their help, and not less than monthly. RFSWs also will provide resource families with access to child care if desired for children of appropriate age; respite care for emergencies or short breaks from the stress and pressure of substitute parenting. There will be a new pool of $2 million per year for resource family supports such as these.[58] A program will be developed to provide crisis support for resource families on a 24-hour basis.

Some of the support services mentioned above are presently available to resource parents, but not uniformly across the state. Some, such as respite, are rare. Resource parents are not always aware of what supportive services are available or how to access them. In addition to a menu of particular services, we also intend to provide flexible funding to meet resource families' individual needs.

The provision of necessary support services for resource families will involve several steps. Early on, clear, simple protocols for accessing flexible funding will be established. RFSWs will be responsible for informing resource families of what supports are available. As the system's IT capacity develops, resource families will have access to databases identifying available services. Contracts for services to birth families will, as appropriate, be modified to include resource families. The quality of services for resource families will be monitored by the Office of Children's Services' Office of Continuous Quality Improvement. Service contracts will be outcome-based, with renewal dependent on performance.

We will provide $1 million annually for home repairs necessary for resource families with incomes below eighty percent of the county median to obtain or maintain their licenses (supporting both retention and recruitment).

We will support community-based resource family support organizations, where resource families can meet with and learn from their peers. Resource Family Support Organizations

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[57] If a resource family adopts a child, the adoption has been finalized, and resource family has stated its desire not to accept any more children into its home, after six months the family will be removed from the RFSW's caseload (though informal contact and support may continue to occur).

[58] The child placement process, discussed in more detail elsewhere in this plan, is worth noting here to focus on the RFSW's role. When a Child Protection Worker or Permanency Worker needs to place a child into foster care, she will work with the RFSW from her Community Support Team, who will be knowledgeable about the resource families available in the area. (Because many child removals happen after hours and on weekends, RFSWs will need to have beepers and be on call.) The RFSW will first determine whether her colleague has done a thorough search for possible appropriate resource families among the child's kin. If such a resource family has been identified, the child protection worker will do a preliminary approval of this family and the RFSW will get them into the training and licensure processes. If there has not been an exhaustive search for a kinship resource family, the caseworker, the RFSW, and perhaps a resource family recruiter from the District Office will all mobilize a quick child-specific recruitment effort among the child's kin (a category that includes both relatives and others the child knows, like teachers and coaches). If no available kinship resource can be found, the RFSW and the child's caseworker will work together with the birth family to identify the most appropriate resource family for the child. As soon thereafter as possible and within three days of the child's removal, the child's Permanency Worker will convene a Family Team Meeting, at which both caseworkers (the child's Permanency Worker and the resource family's RFSW), both families (birth and resource), and all the birth family's available natural resources (clergy, extended family, friends, community members, service providers) will come together to provide the resource family any information they don't already have (school schedule, medical records, activities, etc.) and develop a plan to achieve the child's permanency goal.

will be inclusive of existing foster and adoptive parent groups on both a statewide and local level. In addition, as the system undergoes change, it may be reasonable to integrate resource family support organizations with other family support organizations working with the Office of Children's Services. The intent is to bring together parents – birth, resource or other - who are navigating the system on behalf of children, and to provide them with the opportunity to build mutually supportive networks at the neighborhood level.

More important than these material and other supports, the system needs to draw on the experience and expertise of resource parents. They have uniquely well-informed perspectives on the developmental and other needs of the children placed with them. For too long, this invaluable resource has gone largely untapped. No more. Resource families will be full partners in family team meetings, helping to chart children's courses toward permanency. And their voices, individually and collectively, will be taken seriously by management at all levels of the agency.

While the RFSWs will have primary responsibility for the support and retention of resource families, they will not be the only ones. Resource families are one of the system's most precious resources. The entire system must and will be committed to keeping them, from central management's allocating sufficient resources for respite care and other supports to caseworkers' answering their messages promptly to everyone treating them with the respect their commitment to children so warrants.

Implementation Steps

<u>Hiring Resource Family Support Workers</u>

1. By January 2005, develop curriculum and capacity to train Resource Family Support Workers to:
   - conduct home studies;
   - understand the licensing and inspection process;
   - visit new resource families bi-weekly for the first six months;
   - attend family team meetings when a resource family receives a child;
   - make monthly visits to the home to ensure that any issues or concerns are immediately identified and addressed;
   - assist child protection and permanency workers to match children to the most appropriate placements;
   - attend additional family team meetings as warranted by the child's permanency worker;
   - identify and address resource families' ongoing training and support needs and guide new resource families through training; and
   - interface regularly with permanency workers to continually assess resource families' competencies in caring for the children in their home.
2. Keep the RFSW training pipeline full until the position is fully staffed statewide, at a ratio of 35 resource families per RFSW. Assign first-trained RFSWs to areas with the greatest need for new resource families. Assure that all new resource families are assigned an RFSW; add existing resource families as sufficient RFSWs are available.

Organizing and Invigorating Recruitment

1. By July 2004, hire a system-wide Director of Resource Family Recruitment, Retention and Support, a high-level position in the Office of Children's Services who will be ultimately responsible for the development and implementation of a state-wide resource family plan.
2. By October 2004, a state-wide resource family plan will be developed, with an opportunity for public comment. As regards recruitment, the plan will include:
   - Numerical recruitment goals and timeframes;
   - Targeted recruitment in high needs neighborhoods (Newark, Camden, Patterson & Trenton) and for special populations: adolescents, children with special needs, Spanish-speaking youth, large sibling groups, "boarder babies," LBGTQ youth, and young children who may otherwise be placed in congregate settings;
   - Partnership with organizations including houses of worship, existing resource family associations, labor unions (including a thoughtful recruitment plan submitted by the Communications Workers of America, which represents much of the system's staff[59]) and corporations (to solicit their employees);
   - Development of culturally competent and linguistically appropriate recruitment materials in multiple media;
   - An analysis of care placement trends (by geography and child-group), gaps in capacity, and national best recruitment practice;
   - Determination of data elements to be incorporated into SACWIS to support future recruitment efforts; and
   - An analysis of how currently funded resource family agencies can serve as partners in recruitment, retention and support.[60]
3. By October 2004, the Director of Resource Family Recruitment, Retention and Support will assign all components of the plan to internal recruiters or external partners.
4. By January 2005, tie measurable recruitment outcomes and performance indicators to DYFS Resource Family Recruiters' job performance ratings, and to private partners' performance-based contracts.
5. Beginning January 2005, track recruitment in District Office report cards with the Director of Resource Family Recruitment, Retention and Support responsible for any necessary corrective action.
6. By July 2005, and every July thereafter, update the statewide recruitment plan to reflect current needs.

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[59] The CWA has proposed a partnership including (1) an incentive program to recruit resource families from within the state workforce; (2) a program to recruit resource families from organized labor outside the state workforce in partnership with the State Federation of Labor, focusing on placing DYFS clients eligible for apprenticeship and pre-apprenticeship programs with resource families in the unions sponsoring those programs; and (3) recruitment of resource families from large employers in high need areas using existing relationships among business, labor and community organizing groups.

[60] A more refined resource family recruitment plan in support of the implementation of this plan will be developed by October 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

Improving Training

1. By January 2005, develop and test new curricula to train Resource Family Recruiters, Resource Family Trainers, Resource Family Support Workers, Casework Supervisors.
2. By April 2005, develop and test a new resource family training curriculum that incorporates the system's new values and performance expectations (e.g., partnering with birth parents). The curriculum will include compensated participation by children currently or formerly in care, resource families and birth families.
3. Beginning July 2005, train all existing resource families and appropriate staff with new curricula, through local team training networks.
4. By July 2005, implement a program of rolling training for resource families and appropriate staff, at intervals calculated to address each Area Office's population and need.

Streamlining the Process

1. By December 2004, reengineer the process so resource parents can easily go from application to licensure within 90 days, in accordance with this timeline:

Action	Process	Time to Complete
Application	Completed application submitted by prospective resource parent	Starting point
Training	24 hours required for initial license, followed by qualitative evaluation	1 – 12 weeks
Background checks	FBI & State Police fingerprint checks (CHRI) Child abuse checks (CARI) For all adults in household	3 – 6 weeks
References checks	Personal, medical, employment, school/ day care, optional local police check	4 – 6 weeks
Home study	Interviews, family history, verify medical info Supervisory review	2 – 4 weeks
Inspection	Home inspection -- checklist of standards	2 weeks
Licensed	Contingent upon timely completion, satisfactory results and continued interest by prospective resource parent	90 days total

2. By June 2004, submit to the Legislature the proposed statutory modification necessary to license all resource families under the new unitary paradigm. Begin licensing all resource families this way within 60 days of the law's passage. Beginning January 2005, license all existing resource families under the new standards.
3. By July 2004, develop a protocol for resource families to access funds for rehabilitation necessary to maintain their licenses.
4. As part of the analysis of how currently funded resource family agencies can serve as partners in recruitment, retention, and support, insure that the streamlined system results in resource families working with only one organization for all parts of the process, from application through licensure.

Equalizing and Raising Payment Rates

1. By July 2004, equalize kinship provider rates (relative and kinship legal guardianship) with the rates of other resource families.
2. Raise resource family board rates to 100% of the USDA rate for middle-income, two-parent families in the urban Northeast, by closing 10% of the gap in January 2005, 15% in July 2005, and 25% of the gap in July of 2006, 2007 and 2008.
3. Beginning 2009, adjust board rate periodically to reflect USDA rate for middle-income, two-parent families in the urban Northeast.

Supporting and Valuing Resource Parents[61]

1. By November 2004, establish protocols for resource families to access, through their RFSWs, a $1 million annual capital fund for repairs necessary to obtain or maintain their licenses and a $2 million annual fund for appropriate respite and child care, after-school, child enrichment and other support services.

2. By October 2004, establish a $2 million annual fund for flexible support services, provided by the state or contracted providers, to provide a broad array of individualized support services to resource families. Expand appropriate existing contracts for services to birth parents to encompass resource families.

3. In conjunction with the development of community collaboratives, targeted resource family recruitment, and RFSW deployment, provide seed money for community-based resource family support organizations.
4. By January 2005, create a reporting system to learn why resource families leave the system, and adjust retention strategies accordingly.
5. By August 2004, the Director of Resource Family Recruitment, Retention and Support will develop and implement an ongoing program to regularly inform and remind all DYFS employees how they can support the goal of retaining resource families, and an institutionally supported way for resource families' input on matters of practice and policy to be routinely solicited and considered, and for system shortcomings they raise to be addressed.

[61] A more refined implementation plan regarding the development of supports, including peer supports, for resource families will be developed by October 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

■ ADOLESCENTS & YOUTH TRANSITIONING OUT OF THE SYSTEM

To adolescents in the child welfare system we make two core commitments:

1. We will attend to the safety, permanency and well-being of adolescents no less than those of younger children; and
2. We will prepare adolescents to live as healthy, productive adults with strong relationships with other supportive adults.

There is a tension in child welfare systems' treatment of teens, and it is evident in the two core commitments themselves. On the one hand, the systems should not place adolescents in their own category, declining to accept them into the system when they've been neglected; assuming that nobody would be willing to adopt them; essentially giving up on them and consigning them to a "permanency" goal of "long term foster care" – an official category that should be an oxymoron. Our first commitment is designed to address this.[62]

On the other hand, the second commitment acknowledges that adolescents are different in an important way: they are closer to adulthood and the need to live, if not truly independently (who among us really does this?), at least less dependently. In short, adolescents in out-of-home care need the same help all adolescents need: support in making a successful transition from childhood to healthy adulthood.

New Jersey currently meets neither of these core commitments consistently:

There are approximately 4,000 adolescents, ages 13 to 21, in out-of-home custody in New Jersey, and each year about 300 of them leave the system to live independently.

Like many other child welfare systems[63], New Jersey's is reluctant to acknowledge adolescents' abuse and neglect, and to permit them to enter the system even when they desperately need to – thus consigning them to situations that can include homelessness, drug and alcohol addiction or dealing, and prostitution. There are many reasons for this:

- Most child welfare workers enter the field with a vision of helping young children, not adolescents.
- Adolescents are more assertive, even oppositional, than younger children.
- The system has not recruited and supported sufficient resource family homes for adolescents, so finding a home for them is extremely time-consuming and frustrating.
- Adolescents in foster care tend to have had more checkered school experiences than other adolescents, adding another aspect to caseworkers' difficult jobs.
- Adolescents are often considered unadoptable, even when that is the appropriate permanency goal, so taking them into the system is assumed to mean that they would

[62] Focusing a section of this plan on adolescents runs the risk of exacerbating this very problem, and is not our intent. We include this as a separate section, not without ambivalence, because the system's treatment of teenagers has been so unacceptable that there must be a particular focus on improving it.

[63] We note this only as context, not excuse.

remain for many years, driving up the system's average length of stay in care (a statistic on which systems are routinely evaluated).
- Adolescents in care are far more likely to run away.

Adolescents are frequently placed in congregate care settings inappropriately, because the system has not developed appropriate resources to meet their placement needs. When young people "age out" of the system, they do so woefully unprepared to meet the challenges of adulthood. Caseworkers routinely close adolescents' cases when they reach 18, without any consultation or transition plan, although young people in care at age 18 are entitled, under certain circumstances, to remain in the system longer. Adolescents leaving the system often lack the most basic elements of safe and successful early adulthood: housing, high school diplomas or graduate equivalency degrees, employment or job skills, basic life skills and, perhaps most importantly, relationships with a network of adults ready and able to provide ongoing support.

To turn this around, we will employ the following strategies:

There will be two overarching strategies:

1. We will have Adolescent Specialists in every office. These will be workers with particular training and affinity for dealing with adolescents' needs, and will work in partnership with adolescents and their permanency workers (who will maintain primary responsibility, in accordance with the commitment to the ideal of "one family/one worker") to pursue permanency and prepare for adulthood. They also will be tasked to get any adolescents from their geographic area and inappropriately in congregate care settings to local resource family homes. Adolescent Specialists will be assigned to no more than 30 children, and will be expected to see each of their clients not less than bimonthly. Every child age 13 or more with an open case will be assigned one, in addition to her permanency worker. Many of the problems facing adolescents in our system result from their being forgotten or ignored. Adolescent Specialists will ensure that this does not happen, and will have expertise in the issues particular to this population.[64]
2. We will train all casework employees[65] on the principles and practices of youth development, training them to: build trusting relationships with adolescents of all backgrounds and cultures; work with adolescents to identify and build upon their strengths and interests; give adolescents real input in setting their goals (for permanency and for their future generally); know and be sensitive to adolescents' various developmental stages, so service and care plans are appropriate; understand that being tough and vulnerable are not mutually exclusive, and that many adolescents are both; give adolescents a voice in the selection of where they will live; and work with adolescents to help them better to formulate and articulate their own goals and desires – to help them to take up both their authority and responsibility for their own lives.

[64] There will also be a central office within the Office of Children's Services with planning responsibility for adolescents in both the child welfare and children's behavioral health systems.

[65] These will include, at minimum, child protection workers, child protection supervisors, permanency workers, permanency supervisors, casework supervisors, adolescent specialists, adoption specialists, resource family support workers.

To ensure adolescents' safety:[66]

1. We will accept adolescents into our system – into foster care or in-home cases as appropriate – when they have been abused or neglected. We will train the people answering child abuse hotline, and the child protection workers who do the investigations, to understand adolescents' vulnerabilities and to make their decisions – whether to accept an allegation for investigation, whether the situation warrants opening a case, and whether an adolescent should enter out-of-home care – in a structured decision-making framework, and not substantially to prejudge the case merely because its object is an adolescent. We will track and analyze our performance in this area with particular care, making changes as necessary. When adolescents' situations do not rise to the level of abuse or neglect, properly considered, but they still need help, we will refer them to an appropriate community-based service provider.[67]

To ensure adolescents' permanency:

1. We will eliminate the goal of long-term foster care.[68] Adolescents, no less than younger children, should have goals of family reunification or, when that is no longer possible, adoption. We will evaluate all children with this goal, and attempt to move them to either adoption or legal guardianship. Resource families willing to foster and adopt adolescents will be specifically recruited, trained and supported. Long-term foster care as a goal is entirely concessionary. It typically says "this child can't be adopted but is too young to have a goal of independent living, so let's make the status quo the goal." This should never happen. Foster care should always be viewed as a means to an end, never the end in itself.
2. We will continue to vigorously pursue adoption for children until at least their 16th birthdays, and longer when appropriate, changing their permanency goal to independent living only when there is absolutely no alternative.
3. We will provide incentives and supports to those who adopt a child 13 or older, including several respite weekends per year[69] and links to mobile response mental health teams.[70]

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[66] Some of these strategies contribute to more than one of our core commitments to adolescents' safety, permanency, well-being and preparation for early adulthood, and are discussed under the one to which they contribute most directly.

[67] The linkage to services for children not abused or neglected but at risk of such is discussed in the section of this plan on building a network of prevention. Adolescent safety will also be enhanced by the expansion of New Jersey Homeless Youth Act services discussed in the section of this plan on reducing inappropriate reliance on institutional settings.

[68] Resource parents now with children in "long-term foster care with custody" – a small but expanding category designed to provide children with very challenging needs with as much stability and certainty as possible – will be encouraged to change these arrangements into subsidized guardianships, and the system will provide all necessary support for such transitions. But there will be no bait-and-switch. If these resource parents decide to maintain the current arrangements, their decisions will be respected.

[69] The system will pay for and arrange several weekends of programming each year for children adopted as teenagers, providing their parents with some routine respite and the teens with an opportunity to come together with their peers and, through professional programming the system will arrange, discuss the difficult issues of identity and belonging that often accompany being adopted as an adolescent.

[70] These teams, which are expanding statewide, provide immediate in-home response and eight weeks of services to families in crisis, and should help allay the fears of prospective adoptive parents of teenagers who worry that once their connection to the child welfare system ends they will have nowhere to turn if their child occasionally seriously acts out.

4. We will increase the DYFS kinship guardianship payment rates to equal foster care rates.[71]
5. We will carefully track whether these increased payments and supports increase adolescents' adoption and kinship guardianship. If they do not, we will consider additional incentives, financial and otherwise.

To ensure adolescents' well-being:

1. We will develop and implement a targeted strategy to recruit resource families for adolescents, focused on child-specific recruitment, to enable teens to live in the least restrictive, most family-like settings.[72]
2. Through the Adolescent Specialists, the outcome-driven case practice model for permanency workers, and the youth development orientation, we will ensure that adolescents receive the full range of services available as needed to all other children in the system.
3. Through contracts with community-based organizations (and ultimately in partnership with the community collaboratives, as they roll out), we will provide adult mentors for all adolescents in care. The mentors will be expected to spend at least ten hours per month with the child, helping him to stay in school and guiding him through the difficult developments and decisions of the teenage years.[73]
4. By December 2005, we will double the number of School-Based Youth Services Programs – an independently evaluated and successful program designed to address adolescents' physical and mental health needs, reduce teen pregnancy, and promote healthy adjustment.

To ensure that adolescents are prepared to live as healthy, productive adults with strong relationships with other supportive adults:

1. We will cease the widespread practice of closing adolescents' cases automatically when they turn 18, and will keep open adolescents' cases, at the adolescents' option, until they reach 21. Adolescents approaching age 18 will be encouraged to remain in the system thereafter, and informed of the resources available to them post-18 to help continue the transition to adulthood. This change will be reflected in the policy, practice and training.
2. When deemed developmentally appropriate by the child's permanency worker (presumptively at age 13), the case planning process (including particularly all family team conferences) will include the development and refinement of a concrete plan leading toward healthy, productive adulthood, regardless of the child's permanency goal. These plans will focus particular attention on the need to identify and involve caring adults already known to the child who can provide ongoing support both during and after the child's involvement in the child welfare system. Efforts will then be made to develop the child's relationship with these adults, and to involve them in the child's planning process. Adolescent specialists will work with permanency workers on this aspect of children's plans. This planning will supplement, not supplant, other permanency efforts for these children.

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[71] This is discussed more fully in the section of this plan on Recruiting, Retaining & Supporting Resource Families.

[72] We also will make a concerted effort to identify and move all children in congregate settings more restrictive than they need into less restrictive, more appropriate placements. See the section of this plan on reducing inappropriate reliance on institutional settings.

[73] This reference to mentoring does not refer to contract mentoring services that are used as in-home supports. Rather, as stated here, mentoring refers to establishing long term, stable relationships with adults in the community.

3. We will contract with community- and faith-based organizations to provide case management and aftercare services to adolescents who do not wish to remain in the system's custody, until they turn 21. The services will include housing assistance (of up to $600/month) employment readiness, and emergency food and clothing grants. These contracts will require that the agencies continue the process of involving caring adults outside the child welfare system in children's lives, in the hope and expectation that this support will become a permanent part of the adolescent's life.
4. We will partner with the Department of Labor to develop a program linking young people leaving the child welfare system to a range of job readiness, training, career counseling, apprenticeship, and related vocational programs.
5. We will automatically enroll every eligible child in care in the Chafee Medicaid Extension program when he turns 18, will keep him enrolled until he turns 21, and will develop a protocol for young people who lose their cards to obtain replacements, even if they are no longer in the system.[74]
6. We will ensure that all adolescents in out-of-home care receive a full life skills training program, including a range of follow-ups to the initial course if completed well before the adolescent's likely departure from the system.
7. We will provide all adolescents in the system who graduate high school or received a G.E.D. with an application for a scholarship for higher education or vocational training under the state's tuition waiver program, and with necessary assistance completing the application and exploring educational and vocational training options.
8. We will develop 40 transitional living units, as defined in the New Jersey Homeless Youth Act, each year for five years (a total of 200 units around the state) for adolescents leaving the system with no place to live, providing them a bridge of six to nine months, with staff support and supervision, from DYFS placement to a complete lack of involvement with the system.

Implementation Steps for Overarching Strategies: Adolescent Specialists and Youth Development

- By August 2004, develop a new, state-of-the-art youth development training curriculum, in consultation with national best practice.[75]
- By October 2005, begin training DYFS staff to be competent in DYFS's new youth development ethos as part of the integrated training in the new case practice model. The annual Independent Living conference to train DYFS staff will focus on youth development and the commitments in this section of this plan. Staff competent in youth development will:
    - Use strength-based approaches to involve adolescents at all stages of decision-making about their case

[74] Young people departing facilities of the Juvenile Justice Commission with open DYFS cases will also be provided with Chafee Medicaid Extension cards and the same access to replacements.

[75] If a curriculum appropriate to New Jersey's needs can be located, rather than developed, this step will happen sooner.

  - Develop all case plans expressly with adolescents' input to reflect their needs and articulation of goals
  - Believe that teens are adoptable and actively promote this permanency goal, if appropriate
  - Understand the developmental needs, challenges and vulnerabilities associated with adolescence
  - Have the skills to build trusting relationships with teens from diverse cultures

- By July 2005, begin hiring and training a cadre of Adolescent Specialists (ASs), each with a caseload ratio of 1:30 youths, ages 13+. Keep the AS training pipeline full until the position is fully staffed statewide. Assign first-trained ASs to areas with the greatest number of adolescents in the system. Adolescent Specialists will:

  - Cooperate with mentors, Child Protective Services Workers, Child Permanency Workers, Resource Family Support Workers and Case Practice Specialists to wrap services around the adolescent based on ongoing needs assessment
  - Facilitate placement of adolescents in the most appropriate out-of-home settings, if removal is required
  - Work to return any adolescents from the AS's geographic area who are inappropriately placed in congregate care settings
  - Link youth with myriad state government and community-based organizations from whom the adolescent is in need of or receiving services
  - Make bimonthly home visits to identify issues or concerns for immediate resolution
  - Facilitate the enrollment of youth in the Chafee Medicaid Extension program prior to turning 18
  - Play a significant role in family team meetings and other case planning conferences
  - Link youth to the tuition waiver program and scholarships/tuition payment

Implementation Steps for Attending to Adolescents' Safety, Permanency and Well-Being:

<u>Safety</u>

- Beginning October 2004, DYFS will design its SACWIS to capture data specific to adolescents:

  - How many calls come in alleging abuse or neglect of teens, ages 13+?
  - How many allegations get substantiated for abuse/neglect?
  - How many and what type of cases get opened for supervision?
  - What services are delivered to adolescents and do they actually match the assessed need?
  - How are referrals on homeless teens handled by DYFS Screening, Intake and Case Management?

<u>Permanency</u>

- By May 2004, eliminate the permanency goal of long term foster care, and amend regulations and policy to reflect this change for new permanency cases.

- By May 2004, eliminate the ability to select LTFC as a permanency goal on all DYFS forms and computer coding systems and inform the judiciary of this decision.
- By July 2004, request that the Legislature amend the DYFS kinship legal guardianship statute to allow persons who have been providing consistent care and support for a child but who do not have a kinship relationship to become legal guardians and raise the child to adulthood.
- By October 2004, establish policy enabling all subsidized adoptive parents of 13-18 year olds to receive three respite weekends per year for their adolescent(s). Simultaneously, expand existing contracts with weekend respite providers to increase capacity of Outward Bound and similar enrichment programs.
- By January 2005, use the Child and Family Service Review (CFSR) Program Improvement Plan (PIP) process to review all current LTFC cases to determine if they should be moved to an adoption or subsidized guardian status.
- By June 2005, examine the effect of equalized kinship board rates and increased resource family board rates on the rate of new adoptions and subsidized guardianships to determine if the establishment of a premium rate for adolescent resource homes is warranted.

Well-being

- By December 2004, count the number of existing foster homes that will accept teens, and the number of foster beds in those homes. Also, ascertain the number of homes in the pipeline that have been home studied for teen placement and expedite licensure. Use the DO "youth waiting in offices" logs to compare current need for resource family homes against our existing stock.

- By December 2004, use the data from DYFS's resource home gap analysis (described above) to build special recruitment strategies into the statewide resource family recruitment plan, including the identification of homes for adolescents on vacation or college break.

- Develop a Request for Proposals to select community- and faith-based organizations to recruit, hire and supervise 500 adult mentors statewide, each of whom will be paired with up to two youths, age 13+ who are in out-of-home placement, and be paid $100 per month (minimum of ten monthly hours of service) per youth. Mentors will be expected to work cooperatively with DYFS's Adolescent Specialists to sustain youths 'school enrollment, assist high school drop-outs to get their diploma or GED and guide youth through critical decision-making during adolescence. Mentoring programs will be based on evidence of success and best practice standards, mindful of the fact that for youth who have experienced substantial instability in their lives, poorly delivered or unstable mentoring can do more harm than good. All mentors will be fingerprinted and their backgrounds checked. (August 2004 – December 2005)

Implementation Steps for Preparing Adolescents to Live as Healthy, Productive Adults:

- By October 2004, issue higher education/vocational training scholarship applications to all youth in DYFS out-of-home placement, including homeless youth programs, schools and community-based agencies to increase the number of youth who enroll in post-secondary education; by July 2005, conduct an evaluation, in partnership with the New Jersey Commission on Higher Education, of the tuition/scholarship program to determine how many youths applied, how they are using the funds and track education attainment of youth who received the funds.
- By May 2005, develop a Memorandum of Understanding (MOU) with the Department of Labor and Workforce Development and the Juvenile Justice Commission to create statewide linkages for aging out youth who require career counseling, job training, apprenticeships, New Jersey Youth Corps programs, vocational rehabilitation or employment. The MOU will:
    - Link 50 aging out youths per year with DOL-sponsored apprenticeships;
    - Create an official seat for Adolescent Specialists on each county-based Youth Investment Council;
    - Facilitate four regional job fairs per year, which will be directly marketed to aging out youth;
    - Facilitate the development of an interdepartmental workgroup to develop a plan connecting adolescents under DYFS supervision with One-Stop Career Centers statewide;
    - Identify career development specialists to be DOL liaisons to family team meetings and other career development conferences involving case planning;
    - Specify that 25 aging out youths per year will enroll in the New Jersey Youth Corps program, if they have dropped out of school and require an alternative learning and career development environment;
    - Develop a plan to train a cadre of DOL, County One-Stop, Youth Investment Council and Workforce Investment Board staff to improve their understanding of the child welfare system and develop youth development competencies;
    - Annually, 100 youth in out-of-home placement, ages 16-21, will become employed through career development services provided through the DOL's Workforce Investment Act programs.
- By June 2005, create the data system upgrades necessary to automatically enroll every eligible youth turning 18 in the Chafee Medicaid Extension program and maintain enrollment status to age 21. A protocol also will be developed by this date to replace lost or stolen Medicaid cards.
- By February 2005, issue a Request for Proposals to create 40 new transitional living beds for approximately 55 youth who have aged out of the foster care system but for whom permanency with a family is not an option. In addition, by the same date, develop a protocol to determine placement priority for the beds. Each year, add 30-40 more transitional housing beds.

- By December 2004, change regulations and policies to enable DYFS to maintain an open case on any youth to age 21 if it is in the best interests of the youth to maintain open case status and if the youth agrees to it.
- By December 2004, evaluate the current life skills contracts, including unit costs, and develop a plan to ensure all youth in out-of-home placement receive life skills training with refresher courses for completers. The Ansell Casey assessment tool will be used to evaluate the competencies attained by participants.
- By August 2005, develop a Request for Proposals to select community-and-faith-based organizations to provide an array of aftercare services to an average of 200 youth annually, ages 18 to 21, who age-out of DYFS, but require specific supports (e.g. emergency food, clothing and housing grants and ongoing housing subsidies) to prepare for adulthood.
- Beginning January 2005, all youths in DYFS out-of-home placement, when deemed developmentally appropriate (typically at age 13), will use the case planning and family team conference process to develop a set of goals and actions steps to prepare them to live as healthy, productive adults. This component of an adolescent's case plan will be updated annually. By December 2005 all existing youth in placement will have developed their new action plan.

■ REDUCING INAPPROPRIATE RELIANCE ON INSTITUTIONAL SETTINGS

When children must be removed from their homes, they should be placed in the most family-like setting that can meet their needs. Most often, this means with a resource family who can provide love, safety and developmental support to, at most, several children. Research has proved the obvious: that children do better in settings most like their homes. Larger settings (which we will generically call "institutions") should be reserved for only those children whose needs cannot be met by a resource family provided with appropriate supports. Institutions are frequently located far from children's family, friends, schools and communities. (Some are out of state.) This adds to the trauma of removal and makes visitation and reunification harder. Institutions can also be unpleasant places, particularly for young children.

Despite all this, New Jersey places some children into institutions solely because appropriate resource homes have not been developed – which is to say because there's no place else to put them. This is unacceptable. There will always be some children who genuinely need such settings, and New Jersey must have enough to meet this need. Because the process of assessing children has been so haphazard, and because some children should be moved out of congregate settings into resource family homes while others are sitting in more restrictive settings (like psychiatric hospitals, detention centers or secure confinement) awaiting congregate beds, it is impossible now to know the right size of the system – how appropriate demand relates to present supply. We must determine this in order to "right size" the system.

We make these **commitments**:

1. We will assess all children at risk of institutional placement, and will place them in the least restrictive setting able to meet their needs.
2. We will determine the right size of the congregate care system, and ensure that the necessary number of beds are available.[76]
3. In allocating congregate beds of all types to children who genuinely need them, we will ensure that all elements of the children's services system prioritize the following groups:
    - Children suffering from abuse or neglect
    - DYFS-involved children in psychiatric hospitals
    - Children in detention or secure confinement awaiting less restrictive settings
    - Children in out of state residential settings
4. We will improve the quality of the environment and services in all institutional settings for the children who need them.

The **current situation** is very far from these ideals:

There are several types of institutions: congregate care facilities, Residential Treatment Centers (RTCs), group homes, shelters,[77] detention facilities and secure confinement. All are non-

[76] We will approach this task to meet children's genuine needs, but mindful of the "if you build it, they will come" possibility.

family-like settings where between 5 and 110 youth reside.[78] Before discussing each of these settings, it is important to note the recent history of New Jersey's Child Behavioral Health system, and how its current capacity relates to the best available evaluation of the need for its various services.

The system of care approach implemented in New Jersey beginning January 2001 is based on the Bazelon Center for Mental Health Law's[79] identification of a full community-based service continuum. Specific capacity for the State of New Jersey was estimated based on a point-in-time review of the foster care population ages 6-21, the kinship care population, children in psychiatric hospitals, residential treatment facilities, group homes, shelters and detention, as well as children managed by County Case Assessment Resource Teams (CARTS). Based on this review it was estimated that 30,000 children in New Jersey were in need of or at risk of needing behavioral health services from the public system. Of that number it was estimated that 4,000 children were in need of or at risk of needing the most intensive case management services. These are children known to multiple child-serving systems (child protection, mental health, juvenile justice) and are in need of multiple services and cross-system collaboration.

There were an estimated 10,000 children with moderate-level behavioral health needs. These children may also be known to more than one child-serving system, but they do not require high-intensity service responses. In addition to the 14,000 children estimated to need moderate or high-intensity interventions and case management, it was estimated that an additional 16,000 children and youth would come to the attention of the public behavioral health system for treatment at some point during their childhood or adolescence.

To support the estimated need for interventions and services the State of New Jersey began development of the System of Care that included an intensive level of case management (Care Management Organizations, or CMOs) to organize and support the 4,000 children in need of this level of service. In addition, plans were developed to expand the capacity of Youth Case Management to organize and support the 10,000 children with needs at the moderate level. Simultaneously, plans to expand the continuum of community-based services including Behavioral Assistance, Intensive In-Community and Mobile Response were initiated.

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[77] Residential Treatment Centers include three publicly administered centers run by the DHS and privately operated, for-profit and nonprofit programs under contract with DHS that provide 24 hour supervision, treatment and an on-site school. Group homes are all privately contracted, are based in houses in the community, offer 24 hours supervision, and generally rely on community supports for children's treatment and on public schools. Shelters are operated by both public and private entities, with a diversity of facility types from highly institutional cement block structures to home-like community settings. The shelters were created as emergency short-term placements for children in need of a temporary residence, but have largely become group homes by default, owing to long lengths of stay. Residential and Group Home facilities are accessed solely through DYFS and the Division of Child Behavioral Health Services (DCBHS, renamed in this plan the Division of Child Behavioral Health Services). Shelters can be accessed by DYFS, the DCBHS, the Juvenile Justice Commission (JJC), the Courts, the Police, and by individuals. DYFS uses congregate care for children who cannot be easily placed with a resource family, and the courts use congregate care for children who are at risk of entering pre-trial detention and for adjudicated youth.

[78] There are 258 contracted group home beds and 886 contracted Residential Treatment Beds in the state.

[79] "Making Sense of Medicaid for Children with Serious Emotional Disturbance," September 1999

The system's current ability meets the estimated need for its services is summarized in the following chart:

Service/Intervention	**Capacity as of 7/1/04**	**Capacity as of 7/1/05**	**Capacity as of 7/1/06**	**Additional needed**
Care Management Organizations (CMO)	1560	1560 plus 720 additional openings for a total of 2280	2280 plus 1720[80] additional openings for a total of 4,000	TBD through future needs assessment 7/1/04-3/1/05
Youth Case Management	10,000			TBD through future needs assessment 7/1/04-3/1/05
Residential Care (RTCs, Group Homes)	958 capacity in 51 facilities			TBD through future needs assessment 7/1/04-3/1/05
Psychiatric Community Residences	149 capacity in 17 facilities			TBD through future needs assessment 7/1/04-3/1/05
Treatment Homes	480 capacity in 21 treatment home provider agencies	480 treatment home beds plus an additional 75 treatment home beds 20 emergency treatment home beds (begins in June '04 through June '05)		TBD through future needs assessment 7/1/04-3/1/05
Mobile Response & Stabilization Services	3920 children and families	6720 children and families served	Estimated additional capacity to serve 7700 children and families will be realized at full phase-in end of the FY '05 development	TBD through future needs assessment 7/1/04-3/1/05

[80] This includes 240 openings that will not have completed phase in by July 1, 2005, one service area uncovered and the final increase in each CMO capacity expanded from 180 to 240.

Service/Intervention	Capacity as of 7/1/04	Capacity as of 7/1/05	Capacity as of 7/1/06	Additional needed
Intensive In-Community/ Behavioral Assistance/Assessment	96,600 hours of intensive-in-community/assessment 106,153 hours of BA 274 providers enrolled with Medicaid	109,200 - 158,200 hours of IIC/Assessment 120,000 - 173,846 hours of BA Variance based on increased Medicaid penetration rate Over the last three months an average of 15 new providers have applied		TBD through future needs assessment 7/1/04-3/1/05
Family Support	10 Family Support Organizations	10 current FSOs plus 4 additional Family Support Organizations for a total of 14 Increased capacity to provide support to the Youth Case Management population	1 additional Family Support Organization for a total of 15	TBD through future needs assessment 7/1/04-3/1/05

Residential Treatment Facilities and Group Homes

As of January 2004, there were 1,791 children in Residential Treatment Centers (RTCs) and group homes (together, RTCs and group homes are often referred to as "congregate care").[81] Of these children, 219 were in out of state placements[82] and 1572 children were in New Jersey

[81] The vast majority of these children, 1,386, were under the jurisdiction of DYFS; the remaining 186 were under the jurisdiction of the DCBHS.

[82] This includes disproportionate numbers of girls, children identified as having sexually abusive or fire-setting behavioral disorders, and children with developmental disabilities.

(1,139 in RTCs and 433 in group homes).[83] 53.7% of these children were 14-17 years old; 17.2% were 13 or younger; and 29% 18 or older. 65% were male, 35% female. 48% were African-American; 36% Caucasian; 12% Hispanic; and 4% other.

In August 2003, the Division of Child Behavioral Health Services (DCBHS) profiled a cohort of children who had been in residential levels of care between August 2001 and October 2002. 39% (381 children) were deemed discharge-ready; this group had been in these inappropriate settings from 6 to 18 months.

Prior to August 2003, children entered residential care and group homes not because of a specific behavioral or mental health need but because a foster care placement could not be located for them. In an attempt to assure that residential and group home placements were reserved for children with particular behavioral and mental health needs, the DCHS created and instituted a strength and needs assessment, the "Lyons' Tool," which is overseen by Value Options, a private contractor to the DCBHS. The tool is designed to match each child's needs to a particular level of care.[84] This system has been in place for a short time and, owing to both inadequate assessment and insufficient resource homes, children continue to enter and remain in congregate care who would be more appropriately served in family-like settings.

Even when a child does have a behavioral or mental health need, the DCBHS has learned that they can often be effectively served in family-like settings in the community. In July 2002, the DCBHS compared the risk behaviors of children in RTCs, group homes and treatment homes to those of children served by the Care Management Organizations.[85] The two groups had the same levels of need. Yet the CMOs were able to serve the majority of their children in the community through child/family teams, intensive case management, and in-home services and supports.[86] Their efforts demonstrate the potential of this approach for reducing congregate care.

It should be noted that the inappropriate placement of children in congregate care has ripple effects throughout the child welfare system. While children who do not need congregate care treatment fill such beds, other children languish in even more restrictive (and far more expensive) placements, such as psychiatric centers and detention facilities, awaiting congregate care vacancies.

Shelters

Shelters are also serving as inappropriate placements for many children. Intended in theory and regulation as emergency placements of up to 30 days for adolescents in crisis, in practice they often serve as long-term placements. There are approximately 549 children in shelters, and the

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[83] An additional 650 additional children were being served in treatment homes, a more family–like setting.

[84] The needs and strengths of every child entering congregate care, along with other clinical information, is reviewed by the Child Behavioral Health System's Contracted System Administrator to match the youth's needs with the residential providers' profiles of populations and services.

[85] CMOs, overseen by the DCBHS, work in teams with children with severe emotional and behavioral problems who require intensive case management, both in and out of the home.

[86] These services are funded through Medicaid and flex funds. 87% of children in CMOs have Medicaid, as do all children placed out of their homes by DYFS. Flex funds are used to purchase goods or services (e.g. "Y" memberships or respite care) when there is no other source of funds.

average length of stay is 5.4 months.[87] Shelters were designed for adolescents, but are serving children as young as five in the same facilities as children in their upper teens.[88]

Detention

There are children in detention[89] and secure confinement[90] inappropriately.[91] Family-like placements, unlike detention, allow children to retain ties to their families and communities.[92] Many enter detention not because they are a risk to public safety or unlikely to appear in court (the only two legitimate reasons for detention) but because they lack stable family environments and there is no alternative place to house them.[93] There are others whose initial placement in detention may have been appropriate, but are now there waiting for an opening in an RTC or group home. On January 20, 2004, there were 67 children in detention awaiting placements from DYFS or the DCBHS. As of that date, they had been waiting an average of 68 days since entering detention.[94]

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[87] Shelter providers, recognizing that they are, in practice, serving children for extended periods of time, have developed various means to provide children with medical, educational and mental health supports.

[88] Many shelter providers also provide services under the New Jersey Homeless Youth Act, which created:

- street outreach – mobile outreach to children living on the streets to connect them to community services;
- basic center (crisis shelter) – 24-hour walk-in safe havens for children in crisis, without parental consent, with a goal of avoiding DYFS involvement; and
- transitional living programs for older adolescents.

[89] Detention centers are county-run, pre-trial secure facilities for children accused of crimes.

[90] Secure confinement is in post-adjudication facilities run by the state Juvenile Justice Commission. The JJC also runs residential community homes for adjudicated children and children on probation.

[91] Contrary to popular belief, there is little difference between many children who end up in the delinquency (juvenile justice) system and those who end up in the dependency (child welfare) system. Children in the juvenile justice system are, in vastly disproportionate numbers, either involved in the child welfare system at the time of their arrest or "alumni" of that system. Other than those adolescents who commit high-end violent offenses, which system one ends up in is often a function not of the child but of the adult who first calls attention to the child's difficulties and which system he decides to call first.

[92] Pre-trial detention has been shown to be an important determinative factor in many children's ongoing involvement in the juvenile justice system. If children have been locked up in detention, unable to demonstrate the ability to attend school and avoid repeated criminality, they are more likely to be sentenced to secure confinement if adjudicated delinquent than their otherwise similar peers who remained in the community pre-trial.

[93] Studies also show that children in foster care are far more likely than otherwise similar children to be placed in detention when arrested, owing largely to the child welfare system's failure to take responsibility for them at this critical time. A New York City program developed in conjunction with the Vera Institute of Justice (Project Confirm) has markedly reduced this disparity by ensuring that child welfare workers accompany their clients to court hearings, as would the parents of children living at home, and provide other appropriate supports. The program has saved New York substantial funds, because detention placements are paid entirely with state dollars, while foster care placements are paid by a combination of state and federal dollars. We will replicate Project Confirm as part of this reform effort.

[94] New Jersey was recently selected as a site for the Juvenile Detention Alternatives Initiative (JDAI), an initiative of the Annie E. Casey Foundation and the nation's most successful effort to reduce juvenile detention without sacrificing either public safety or court appearance rates. In addition to the strategies set forth in this section, DHS looks forward to partnering with the Juvenile Justice Commission on this important effort.

To meet our commitments in this area, we will employ five **strategies:**

1. Assess, using a designated assessment tool,[95] every child in or waiting for a congregate care, psychiatric settings, or Homeless Youth Shelter to determine the least restrictive environment in which their needs can be met. Conduct the same assessment for children in detention or JJC facilities[96] awaiting a DHS placement.
2. Transfer, as appropriate and following a family team meeting, all youth identified through the assessments to less restrictive placements.
3. Expand, as needed, the capacity of congregate care and other detention alternatives including Treatment Homes,[97] In-Home behavioral supports[98] and Care Management Organizations (CMOs).
4. Evaluate and improve, as necessary, the safety, quality and services within congregate care and institutional facilities.
5. Develop practices for assuring, going forward, that all children are placed in the least restrictive, most family-like setting able to serve their needs, and for holding the Child Behavioral Health System and the private agencies that provide congregate care and in-home support services accountable for meeting these children's needs.

We will also close the front door to congregate care for the youngest children: as of July 2005, no child under ten will be permitted to be placed in a congregate setting, unless such placement is deemed medically necessary, and as of July 2006 this preclusion will apply to children under twelve.

1. Conduct assessment of children in, and waiting for, congregate care placements and children in psychiatric facilities.

Implementation Steps

- Conduct assessments, using the Lyons tool, of every child in or waiting for group homes, residential treatment centers, psychiatric settings, homeless youth shelters, and all other shelters to determine where they came from, their residential and service needs, and whether they require congregate care or can appropriately be placed at home, with kin, or in a treatment home, with or without some form of in-home support. (By December 2004, all children in RTCs, group homes, psychiatric facilities and shelters will have an assessment within two weeks of admission and every 90 days thereafter.)
- Conduct the same assessments for every child in detention or secure confinement awaiting a DHS placement. (Starting July 2004 and ongoing. By February 2005, all children in detention will have an assessment within two weeks of admission and every 90 days thereafter.)

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[95] The Lyons' assessment tool is now being used, and is referred to throughout this section. Other tools, if deemed more appropriate, may be considered.

[96] Some children are sent by judges to secure confinement on so-called "recall orders," which state that the child shall remain only until DHS is able to provide a more appropriate setting.

[97] In treatment homes, the parents have received training in serving children with emotional or behavioral problems.

[98] In-home behavioral supports, overseen by the DCBHS, provide families with assistance in effectively supervising their children.

2. When Appropriate, Move Children Identified Through Their Assessments to Less Restrictive Environments.
Implementation Steps

- Work with the Child Behavioral Health to prioritize youth identified through the Lyons' Assessments for referral, as appropriate, to congregate care or treatment homes, and for receipt of In-Home Behavioral Health and CMO support, and ensure they receive these placements and services. (ongoing task)
- For children in congregate care who are ready for discharge, particularly youth in out-of-state placement, provide them with a case manager responsible for transitioning them back to the community or more appropriate placements/services. (This is currently being implemented)
- For children in detention, psychiatric facilities and shelters waiting for a congregate care placement, assign them to case managers who will oversee any necessary evaluations, identify an appropriate placement, transition the child to that placement, and locate and coordinate needed community-based services. (By September 2005)
- Require that a family team meeting be held before any child in any congregate setting is moved. (By June 2005)
- Develop mechanisms to hold the above-described case managers responsible for transitioning children to appropriate placements from detention and congregate care. (By September 2005)
- Effective immediately, no additional congregate care facilities will be developed for children under age twelve (including group settings for "boarder babies" remaining in hospitals beyond the point of medical clearance).
- Effective immediately, the policy of the state will be to place all children under six with resource families, not in congregate settings of any sort. By July, 2005, no children under six will be in congregate settings.[99]
- Beginning immediately, a strategy will be developed and implemented to develop alternate, community-based alternatives for children unnecessarily placed in any congregate care setting, including detention.
- Effective July 2005, we will issue a policy that group homes will house no more than eight children. By July 2005 we will develop a plan for achieving full compliance with this policy, including targeted resource family recruitment efforts and transitional planning for providers with larger facilities to work with us, as appropriate, in other ways.
- For children in certain congregate settings, the use of physical or mechanical restraints and psychotropic medications requires constant attention. Under the direction of the new system Medical Director, we will revise our policies governing their use by May 2005.[100]
- The Arthur Brisbane Child Treatment Center (ABCTC) will be closed by the end of calendar year 2005. To implement this decision while assuring quality care and treatment for children and youth we will:
    1. Develop and implement alternative treatment settings for children and youth age 14-18 who require long-term psychiatric care. (Timeline: children will begin to

[99] There will be a single, narrow exception to this policy for children with high-level special needs – for example, extreme medical conditions – so severe that they can only be maintained safely in congregate settings.
[100] The revised policies will be developed in partnership with Panel, which will have approval authority over them.

transition from ABCTC to alternative settings in October of 2005 with transition completed by December 2005.)

2. Develop, by September 2004, alternative psychiatric treatment for children and youth age 11-13. (Timeline: stop admissions to ABCTC for children age 11-13 in September 2004, and transition all children this age to alternative treatment setting by December 2004.)
3. Work with the Juvenile Justice Commission to develop and implement alternative treatment arrangements for adjudicated, committed youth who require acute and/or long-term psychiatric treatment. (Timeline: stop admission of this population to ABCTC by January 2005, and transition current population to alternative arrangements by the end of February 2005.)
4. Develop and implement 20 step-down beds for children and youth, with a no eject/no reject requirement of the provider(s). (Timeline: step-down capacity on a no reject/no eject basis will be available by May 2005. Youth ready for step-down will begin to transition then, and the transition will be complete by July 2005.)
5. Expand community-based services to assure interventions are readily available to meet the treatment needs of children leaving ABCTC and returning to the community.

3. Enhance, As Necessary, Capacity of Alternatives to Congregate Care and Detention.

Implementation Steps

- A subcommittee of the County Child Welfare Planning Group, described in the preventive services section of this plan, will conduct an analysis of each community's capacity to serve the children identified through the Lyons Assessment as needing alternatives to congregate care. Based on the analysis, develop a continuum of new community-based services, particularly treatment-rich services and highly structured programming for children with mental health and emotional/behavioral disorders. The committee will assure that there are sufficient emergency crisis beds, long-term and short-term treatment-rich placements in family-like settings, and in-home supports. (Starting September 2005 and concluding in March 2006)
- Place emphasis on recruiting resource families for youth in or at risk of placement in congregate care because of a lack of appropriate alternatives, particularly children under ten in shelters. (See Resource Family section of this plan.)
- The Children's Behavioral Health System will create 75 Treatment Home beds and 45 Emergency Treatment Home beds to use as alternatives to congregate care. (Beginning in April 2004 and completed in February 2005)
- Expand the capacity of in-home community-based services and supports, including Behavioral Assistance, Intensive In-Community, Mobile Response[101] and case management capacity (CMOs and Youth Case Management) throughout the state to allow families, the police and providers to call when a living arrangement is at risk, or a

[101] Mobile Response (MR) responds to families and congregate care providers in crisis situations with a child. Once the presenting crisis is addressed, MR provides eight additional weeks of support to attempt to resolve the causes underlying the crisis.

child is at risk of being placed in detention because of inadequate supervision. (Beginning in May 2004 and continuing through June 2006)

4. Evaluate and Improve as Necessary the Safety, Quality and Services Within Congregate Care Facilities.

Implementation Steps

- Develop, through the system's continuous quality improvement (CQI) program, a feedback loop through which the results of all IAIU investigations indicating any problem in a congregate care setting are communicated to DYFS and DCBHS, as applicable, and become the basis for an immediate, closely monitored corrective action plan. (June 2004 – September 2004)
- Conduct a study on the experiences of and outcomes for youth in congregate care, examining such issues as: percentage of youth in each facility who were the subject of a substantiated critical incident report; percentage of youth with weekly in-person contacts with caring adult; percentage of youth enrolled in school; percentage of youth discharged who are reunited with parents, placed with a resource family and/or have a high school diploma; and AWOL and on-site arrest rates. (November 2004 – February 2005)
- Based on results of the study, develop and implement a plan to improve those areas needing improvement. (March 2005 – June 2005)
- Examine, and revise as necessary, all licensing, regulatory, and staffing standards within congregate care facilities to ensure they promote a safe, child-friendly environment, youth development and individualized treatment in accordance with best practice. Review standards in light of a nation-wide assessment of statutes, standards and regulations governing human service programs. (By June 2006)
- Institute facility safety assessments at congregate care programs in the intervening year between biennial licensing inspections, as part of the new licensing practice model based on the congregate care safety assessments. (October 2004 to December 2006)
    - Establish multi-disciplinary teams led by licensing inspectors which include abuse investigators, contract administrators, case practice specialists, and representatives of community and child advocacy organizations.
    - Conduct executive-level roundtables to develop strategic approaches to ensure that problematic facilities correct any cited deficiencies and sustain those improvements.
- Employ youth and parents to participate in contract monitoring, licensing visits and provider training. (April 2005 – June 2009).
- Incorporate performance based outcomes and no eject/no reject policy into all providers' contracts, and hold providers accountable for meeting those outcomes. (January 2005 – December 2005)
- Identify outcome goals for children based on the results of the study on outcomes for youth in congregate care.
- Identify benchmarks and develop practices across systems (casework, investigations, contracting, licensing, etc.) targeted to the outcome goals.

- Develop quality assurance reports to monitor progress towards meeting the outcome goals.
- Elicit support and participation of the provider community.
- Closely monitor, on a continuing basis, the safety and well-being of children at the Arthur Brisbane Residential Treatment Center (the state's only public psychiatric hospital for children).

5. Develop practices going forward to assure that all children are placed in the least restrictive, most-family like setting able to serve their needs.

Implementation Steps

- Study and revise, as necessary, DCBHS's assessment, referral and placement process to make certain that children, in a timely manner, wind up in the least restrictive, most family-like setting able to meet their individualized needs. (Beginning July 2004 and on-going)
- Require providers, in collaboration with DCBHS, to regularly assess children's ability to move to less restrictive settings. (Starting May 2004 and every 90 days thereafter)
- From day one, implement family team meetings at congregate care facilities, to provide support for stepping children down as quickly as possible. (Starting July 2005 and ongoing)
- Work with the detention officers, police and hotlines to focus shelters on 10-day emergency placements for runaway and homeless youth and as day drop-in centers for DYFS youth awaiting more permanent placements.
- Develop appropriate shelter rates and eliminate any disparities between rates charged to DYFS and the Counties.
- Inform, and educate family court judges, probation officers and police about, the New Jersey Homeless Youth Act, which provides arrested youth who do not pose a danger to the community or a risk of flight the option of entering a homeless youth shelter rather than detention. (By June 2005)
- Develop procedures to assure that all court-involved children who can appropriately be placed in a shelter are given access to a shelter bed. (By March 2005)
- The Division of Child Behavioral Health Services will assure that all court requests for assessment, case planning, or placement, when appropriate, are completed within two weeks. The Children's Behavioral Health System, the Administrative Office of the Courts' Juvenile Division and the Juvenile Justice Commission, together with key members of the judiciary, will enforce a protocol ensuring that children involved with the Family Court can access mental health, behavioral health and substance abuse services. The process will also identify a case manager for court-involved children with high intensity service needs. (This is in the process of being implemented, and will be completed by July 2004)
- Develop protocol for congregate care and shelter supervisors, the police and probation intake staffers to access Mobile Response and Stabilization Services and Family Crisis Intervention Units when a child is arrested for a minor offense and his home or placement situation needs to be stabilized. (By March 2005)
- Train judges, police, probation intake staff, appropriate Juvenile Justice Commission staff, and congregate care and shelter supervisors in these new protocols.

- As of July 2005, no child under 10 will be placed in any congregate setting, unless deemed medically necessary; as of July 2006, this will apply to all children under 12. (By July 2006)

■ UNIFYING THE SYSTEM, PARTNERING WITH COMMUNITIES, AND DEVELOPING A NETWORK OF PREVENTION

At the core of this plan is the development, for the first time, of an integrated network of services for children and families throughout New Jersey, in rich partnership with the communities reliant on it. This plan brings together four divisions of the agency – the child welfare system (DYFS), the Division of Child Behavioral Health Services (DCBHS, formerly the Partnership for Children), the newly created Division of Prevention and Community Partnerships, and the newly created Office of Training – under a single umbrella, the Office of Children's Services (OCS). The purpose is to build a continuum of adequate services, in which families at various levels of risk are served by the part of the system most appropriate to their need.[102] OCS will also rely on its strong relationship with DHS's Division of Family Development and it's service array.[103]

Current Situation

Up to now, there has not been a system of care for children and families. Instead, there have been several systems working parallel to each other. This has made it difficult for families to get what they need. It also has led the separate systems to contort themselves to attempt to meet children's and families' needs. While the motives have always been good, the results have not been consistently so. For example:

- Because there has not been a continuum of care easily accessible to families at low or moderate risk of child abuse or neglect, DYFS has opened cases on many such families in order to provide some assistance. This has stretched DYFS far beyond its core mission of abuse and neglect cases, so it is able only to do too little for too many. It also results in some families being unnecessarily stigmatized by involvement in the child welfare system.
- With the advent of the Division of Child Behavioral Health Services, that system, not DYFS, has controlled access to behavioral health services, particularly residential treatment programs, often needed by DYFS clients. Implementation of this effort stalled before it was state-wide, leaving inconsistencies in access from one part of the state to another.

In addition to these unproductive systems for accessing services, there are other problems. There are not enough services, particularly the core services that lead most directly to child abuse and neglect and family dissolution: those designed to address housing, domestic violence, substance abuse, mental health, and physical health. And the services that do exist – while inadequate, state-wide they are quite substantial – are not developed or planned for by the communities that need them, are thus not consistently matched to the area's needs, and are not organized in such a

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[102] The changes in organizational structure are discussed in the section of this plan entitled The DHS Office of Children's Services: Creating an Integrated System of Care for Children and Families.

[103] DHS's Division of Mental Health Services (DMHS, the adult mental health system) will also contribute to this effort. A joint planning effort between DMHS and OCS will evaluate ways to prioritize, within the DMHS service array, adults at risk of family dissolution. A separate joint planning effort, between OCS and the Division of Developmental Disabilities, will develop integrated strategies for addressing the needs of families involved with both the child welfare and developmental disabilities systems.

way that those who need them can access them promptly. Finally, the relationship of the child welfare system with the communities it serves is fractured and often antagonistic.

Commitments

To address this will require a series of fundamental changes:

- We will reorganize DHS in support of a unified system of care for children and families, with various elements of the system – some public, some private – providing services to children and families depending on their level of risk.
- We will develop this system in partnership with families and communities throughout the state, and with a particular emphasis, via community collaboratives, on the places where abuse and neglect is most prevalent.
- We will provide additional resources right away for the five core preventive services - housing, domestic violence, substance abuse, mental health, and physical health – and will give priority to DYFS-involved children and families.
- We will engage in a data-driven research-based process of analyzing the range of existing primary preventive services state-wide. Working with the communities, we will organize them so they will be most easily and directly accessible to families when, and in the form, needed. We will fill the gaps between the services each community has and those it needs in order to keep children safe while minimizing the need for DYFS involvement.

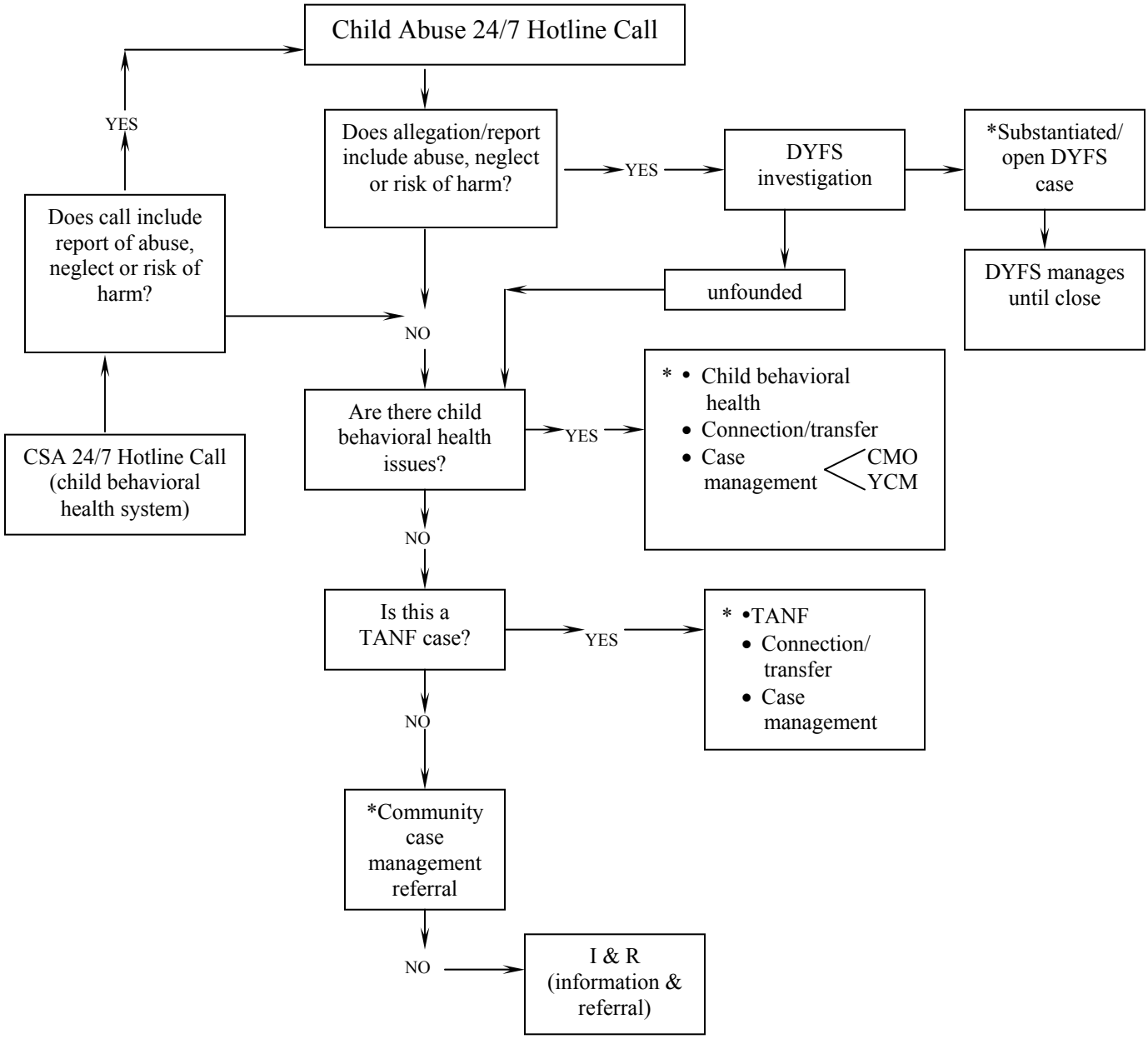
♦ The Operation of the Unified System

How families and children will access the integrated system, and how they will be served depending on their level of risk, are represented on the flow chart on the next page.

To Work:

(1) IT must be in place

(2) Auditing process for look behind



*Each of these case management functions will complete a child welfare assessment, hold family team meetings at appropriate times, develop a case plan and manage its implementation.

At every stage of a family's involvement with this system, the primary question will be child safety. Personnel at all levels – from DYFS employees to community case managers, and everyone in between – will be trained on the warning signs of abuse and neglect, and directed to call the child abuse hotline whenever there's any concern.

When a call comes into the hotline, the first decision is whether it raises sufficient concern even to warrant a DYFS investigation because of the apparent risk of abuse or neglect. This decision, like all decisions involving child safety, will be guided – but not formulaically determined – by a carefully designed, research-based protocol that prompts particular questions.

If a DYFS investigation is warranted, a child protection worker will be immediately assigned to conduct it. If there is abuse or neglect, a DYFS case will be opened, and a decision will be made as to whether the child must be removed from her home to be safe. Unless the child is in imminent danger (in which case the child will, of course, be removed), this decision will be informed by a family team meeting convened by the DYFS permanency worker. The family's strengths, challenges and desires, and the available resources both within the extended family and in the local service array, can be discussed.

Sometimes the outcome will be obvious, sometimes not. It will depend on two basic variables: (1) what are the dangers or causes for concern?, and (2) can they be addressed sufficiently, employing the available resources, to keep the child safe by means other than removal? A safety assessment will inform this decision-making process. If abuse or neglect is substantiated, a DYFS case will be opened for services even if it is determined that the child need not be removed from her home.[104]

If a DYFS case is not necessary, the matter will not end, but will move to lower levels of the integrated system (represented by lower boxes on the flow chart). The next question will be whether, although a DYFS case is not necessary, the child and family could still benefit from services, so their situation does not rise to the level of abuse and neglect and require DYFS involvement. If so, there will be several possible outcomes. If the situation involves child behavioral health services, the case will be transferred to that system for case management and the provision of necessary services.

If child behavioral health is not a presenting issue, the case will fall to the next level of the flow chart, the TANF (Work First New Jersey) system. A family at risk of DYFS involvement and also receiving TANF[105] will be transferred to intensive case management in the TANF system (case managers will have caseloads of 25, compared to the 75 of regular TANF case managers) so they can receive the attention and services they need but will not be saddled by two case managers from two different systems who do not necessarily see eye to eye. Clients' TANF responsibilities will be better coordinated with the child welfare issues.

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[104] Immediate case closings in such situations will be permitted on an exceptional basis, for good reason documented in the case file.

[105] A recent analysis showed that approximately 25% of families with open DYFS cases also had open TANF cases.

If the family does not have an open TANF case, but preventive services are deemed appropriate, the case will go to a contracted community case management agency that will be contractually required to manage such cases. This will include seeing the family at specified intervals, to arrange for the provision of appropriate services, and to call the DYFS hotline if they perceive any danger to the child(ren).

If there is very little cause for concern regarding the child's safety but some reason to believe the family might benefit from the receipt of primary prevention services, or if the family declines a recommendation to receive case management services from DCBHS, TANF or a community-based agency (and this decision is not itself deemed to jeopardize child safety), information and referral (I&R) to locally available services will be provided.

The family's willingness to participate in recommended case management at a level lower than DYFS raised the general matter of coercion versus voluntariness throughout this integrated system. DYFS cases are not voluntary. If child abuse or neglect is substantiated, DYFS must open a service case. Although DYFS should and will make all efforts to engage with the family in a relationship based on mutuality and respect[106] -- both because it is the ethical thing to do and because it is the most effective way to address families' needs – in situations involving abuse and neglect, decisions to open and close cases reside with DYFS and the courts, not the families.

If there is no abuse or neglect, the state has no legal right to impose anything on families, and will not.[107] At the levels of the system below DYFS – child behavioral health, TANF, and community case management – families will be free to participate or not. Case workers will be trained to partner with families (employing family team meetings and other methodologies) in such a way that they will be willing to accept case management and other services, to help their family and avoid the possibility of future DYFS involvement, in situations in which it is believed that services are necessary but there is not a legal basis to impose them. There will be carrots, but no sticks.[108]

But neglect is a somewhat elastic concept,[109] and can depend on whether a family is willing to address any child safety concerns that have been raised. In a case of clear neglect in which a DYFS case must be opened, if a family is genuinely willing to partner with DYFS to address the concerns, removal of the child from the home may not be necessary. But in a situation of more moderate risk, where the question of neglect is less clear, the family's willingness to take the steps deemed necessary to keep a child safe may itself tip the balance as to whether an in-home DYFS case is opened.

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[106] The difficulty of transitioning to this role when a case is opened from the prior investigative function when an allegation is being reviewed is why these roles are being divided, by this plan, between two different caseworkers.

[107] As discussed elsewhere in this plan, the voluntary placement of children with DYFS will soon be phased out.

[108] For families involved with TANF, the TANF intensive case managers will work with the family to integrate the necessary services with the TANF obligations – for example, by reducing the work requirement to provide time to attend family counseling. But they will not condition continued receipt of TANF grants on participation in the services, as doing so would bring the coercive authority of the state in through the back door although abuse or neglect has not been found and no DYFS case opened. TANF clients can continue to receive case management services for two years after they are no longer eligible for cash assistance.

[109] Abuse cases are generally more certain, but neglect cases are far more common.

Whenever a case is opened, at any level of this system (by DYFS, the behavioral health system, as an intensive case management TANF case, or with a community case manager), a family team meeting will be held, to engage the family in addressing the presenting issues. When a case is open in both DYFS and DCBHS (because there has been abuse or neglect, and the child needs behavioral services), there will be two case managers, one from each system. Both will be expected to attend family team meetings, and to work together in planning and managing the case. The DYFS case manager will have ultimate decisional authority and responsibility, regardless of which system the child entered first.

As the arrow down the right side of the flow chart shows, DYFS policy will be that in **all cases** in which there is a substantiated finding of abuse and/or neglect DYFS will retain case management responsibility until the family is stable and no longer in need of services. While this means that there may be low risk cases in the DYFS system, we make the commitment to stay fully, directly engaged until services are no longer necessary.

Cases will be able to enter the continuum of care at the lowest level, through community case management. Once this system is robustly developed, a family facing difficulty will be able to access community-based preventive services locally, not by going through the child abuse hotline, but through an alternative "front door," likely a local case management agency designated by the local child welfare planning council or, as applicable, community collaborative (both of which are discussed in the following section).

Cases will not move only down the flow chart. When necessary, they will move up. For example, if a call comes into the child behavioral health hotline but raises issues of child safety (as revealed by the operator's use of an appropriate questionnaire), the call will be transferred to the child abuse hotline.[110] If a family is receiving case management from any of the non-DYFS components of the system but child safety concerns escalate, the case manager will be required to refer the case to DYFS for investigation.

All of this discussion has been prospective, about how this system will work for future cases. But there are approximately 52,000 children who now have open in-home DYFS cases, an increase of 45% since January 2003. While this increase is not surprising (systems in crisis tend to open cases far more willingly than they close them), it has overwhelmed the system. Most importantly, some of these cases should more properly be handled by other aspects of the system. All of these children must be visited. Safety assessments will be conducted, and child safety will remain paramount. When DYFS cases can be closed consistent with child safety, they will be. When transfers or referrals to other aspects of the system are appropriate, they will be made, and the hand-offs carefully managed to ensure that no cases are lost in the transition.

[110] Calls on either the child abuse and neglect or the child behavioral health hotline will be transferable directly to the other hotline, operator to operator, without disconnecting the calling party.

♦ Partnering with Communities to Build Networks of Prevention

The integrated system described above, in which children and families will have access to a range of services in their own communities – either when they are already involved with DYFS or to avoid the possibility of becoming so – can only become a reality if the child welfare system and communities state-wide work together to make it so.

Each community in New Jersey has a range of formal and informal supports that could serve as the first line of defense in addressing families' needs and reducing risk of harm to children. All across the country, there are examples of communities where residents have rallied to strengthen the fabric of community support and provide a healthy, cohesive environment in which children are safe at home and in their neighborhoods. OCS will work to build public-private partnerships with communities to create networks of prevention state-wide. This effort will have two levels:

1. State-wide, OCS will partner with local communities. Community developers assigned to each District Office will work with the communities in their districts and with Child Welfare Planning Councils, to be developed in every county.

2. In communities of highest need, community collaboratives will be formed to work more locally and intensively.

Before describing these strategies, it is important to note one point: the relationship between DYFS and the communities it serves is very mixed, and much of the fault for this lies with the agency. Instead of seeing communities and their networks of formal and informal supports as allies, as the most important resources to support children and families, DYFS has too often acted as if the agency had all the answers and the role of families and communities was simply to comply with the agency's dictates. We now know this was a serious mistake, and are committed to a fundamentally different way of operating. But actions have consequences, and ours have caused animosity and distrust in many neighborhoods. We will approach communities as co-equal partners and strong assets for children and families, and hope our actions will enable us to rebuild the trust and real working partnerships without which this effort cannot succeed.

In coming months, the Office of Children's Services will create Child Welfare Planning Councils in every county. The structural details of these Councils – staffing, relationships with DHS and OCS, size, etc. – will be determined in dialogue with both governmental and community partners. Community Collaboratives will roll out more gradually, with six collaboratives started in the first year,[111] six in the second, and several dozen over five years. The details of their structure will be, to an even greater degree, determined in partnership with the communities they will support.

The goals of the groups at both levels will be two-fold: developing local solutions to local challenges, and engaging an ever-wider range of local people in contributing to their amelioration (with the state providing necessary support, not abdicating its responsibility).

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[111] Incipient community collaboratives already exist in Newark and Cumberland County.

These two levels of partnership will have much in common:

- Clients of the system, local leaders from many sectors (civic, business, religious, educational, and others), service providers, and others will be asked to come together to help plan and actualize a system of care for their community's children and families. OCS community developers and other relevant staff will provide support and be represented, but will control neither the membership nor the details of the agendas.
- Both the planning councils and the community collaboratives will be community-led bodies, with their own governance structures, independent of the state, mechanisms for receiving and being accountable for funds, and the option of becoming legally independent non-profit organizations.
- The child welfare planning councils will roll out, as do fifteen of the OCS county offices (some of which will cover multiple counties). The OCS Division of Prevention and Community Partnership will have a "Team leader" in each area office, who will be responsible, working with the local community, for getting the planning councils up and running. Small planning grants will support this work. In year one of this plan's implementation, half the county team leaders will be in place and will begin developing child welfare councils. The other half will follow in year two.
- OCS will provide all available statistical information about each county or local community, so the process will be as data-driven as possible. No information will be withheld except confidential child- and family-specific information. As the processes develop, data will also inform the evaluation of past decisions and prioritizations, so communities evaluate themselves honestly and continually improve.
- Local services for children and families at all levels of risk and need will be mapped, including, at minimum, all DHS-funded services, with the goal of developing a comprehensive picture of what is available to children and families.
- The community's assets that can support children and families – however the group decides to define the term – will also be mapped.
- Governance structures will be developed, so the Child Welfare Planning Councils and Community Collaboratives become ongoing institutions. These structures will be determined by the groups themselves, not by the state, guided by the principles of shared decision-making and real authority for local voices and interests, particularly those of child welfare clients.
- It will be important that both types of groups, but particularly the Councils, develop cooperative working relationships with the several existing county-wide human service planning groups.[112] Over time, it will likely be productive to consider consolidation of some of these bodies.
- The community will be asked to focus on its own needs – to say what additional resources would most help its own children and families, including those involved with DYFS and those who need assistance to avoid such involvement.
- The focus of these groups will always remain on improving child welfare outcomes: reducing the incidence of abuse and neglect; reducing the necessity of out-of-home care; reducing the length of stay in foster care; reducing the proportion of foster children

[112] These include the County Human Service Advisory Councils, Comprehensive Assessment Resource Teams, County Inter-Agency Coordinating Councils, and Youth Service Commissions.

placed in institutional settings; increasing the proportion of DYFS-involved families whose cases are closed safely and with their families intact; reducing the need for DYFS-involvement at all, etc.

- Once local goals and priorities are established, all groups (community-based, county-wide, and state) will be asked to devote their resources (fiscal and otherwise) to a collaborative effort to achieve them.
- Councils' and Collaboratives' plans must attend to the range of service needs, from primary prevention to "deep end" services, so neither end of the spectrum crowds out the other. Balance is essential to healthy communities and good outcomes.
- Once these bodies have developed sufficiently, they will be provided with discretionary funding to purchase necessary services. All contracts will be required to be outcome-based, and will be monitored carefully.
- There will be public funding for collaborative staff, and a strong preference for local residents in these positions.
- The groups will select the local agencies best suited to provide the community case management on the continuum. These agencies will be trained on the same child safety protocols DYFS will be using (based on the structured decision-making model), and required to call the child abuse hotline whenever they think a child may be in danger. At every level of the system, child safety will be paramount.
- A new DHS division, the Division of Prevention and Community Partnerships, within the Office of Children's Services, will provide support for both the Child Welfare Planning Councils and the Community Collaboratives. The high-level placement of this responsibility within DHS and OCS should ensure that community development and partnership remain cardinal priorities at the state level.
- The public CQI groups in each county, described in the section of this plan on continuous quality improvement, will be subcommittees of the Child Welfare Planning Councils, and will have overlapping membership with the governing bodies of any Community Collaboratives in the county.
- Periodic county-wide needs assessments will be conducted, with state funding provided for this purpose, by each Child Welfare Planning Council, working in partnership with any Community Collaboratives in the county. These needs assessments will cover the entire service spectrum, from abuse and neglect to primary prevention; will cover all aspects of the Office of Children's Services' obligations, including child welfare, behavioral health, community prevention, and services required by children involved in the juvenile justice system.[113] County-based budgeting across this range of services, based on the needs assessments, covering resources from the multiple child-serving systems, will be developed by FY 2007 and will serve as planning tools by FY 2008.[114]

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[113] This emphasis on partnering with communities in the areas of planning, budgeting and primary prevention should not be interpreted as circumscribing our desire for community partnership. As this plan unfolds, we may well seek expanded partnerships with non-profit providers, particularly those deeply rooted in the communities they serve, in such areas as resource family support workers, adolescent specialists, case management for certain children in out-of-home placement, and others. In numerous areas, the optimal balance between public and private provision of a service will be a question to which we devote ongoing attention.

[114] Budgets delineating and categorically breaking down all the child- and family-related funding flowing into each county will be prepared by FY 2007; these documents will then be among the bases for developing and planning each county's subsequent allocations, beginning in FY 2008.

♦ Expanding Necessary Services

Final determination of what services are now necessary in each of the state's communities, and how they compare to what is now available, must await the outcomes of the community-based, data-driven efforts described above. But some things cannot wait. There are five issues that relate most directly to child safety and family dissolution: housing, substance abuse, mental health, domestic violence, and physical health. We are now adding significant resources to each of these areas; the additions are summarized below.[115] This array of services is for both families involved with DYFS and families at risk of such involvement who will receive the services at a lower level of the integrated system. Children and families may step up or down the levels as individual circumstances dictate. The final section describes the State's commitment to the creation and coordination of an array of services and supports for prevention and early intervention. Combined, these activities will form a unified spectrum of services for children and families.[116]

Substance Abuse—children and families involved with DYFS

Current

- Approximately one-third of substantiated child abuse and neglect cases involve a substance abuse problem in at least one caregiver. These are the cases we know about. Nationally, the prevalence rates of families involved with child welfare with substance abuse problems is anywhere from 60-80%.
- Although the Department of Health and Senior Services' Division of Addiction Services (DAS) provides a variety of substance abuse services, for every slot filled—there are three additional people waiting.
- The Department of Human Services (DHS) now spends approximately $30 million in a variety of substance abuse services across several divisions.
- Yet, there are only a limited number of slots available to serve women and an even smaller proportion for women and children involved with DYFS—where the treatment model incorporates child safety outcomes, Adoption and Safe Families Act (ASFA) timeframes, parenting and reunification issues.
- DHS and DAS slots available to women with child protective or welfare issues and substance abuse currently total 1,106 per year in outpatient, intensive outpatient, and short and long term residential services and methadone maintenance.

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[115] In addition to the specific services identified here, substantial "flexible funds" are also being made available, subject to appropriate usage guidelines, to help birth, resource and adoptive families meet various needs essential to children's safety and well-being (e.g., a child car seat or crib, or a refrigerator when the motor dies).

[116] A problem closely related to the adequacy of services around our state is the reportedly low salaries and benefits offered by many of the non-profit social service agencies with which we contract for the provision of services, which may impact negatively on the quality of services by causing, for example, high staff turnover. A task force with both state and private provider representation will be established within sixty days and asked to report on the existence and scope of this issue and, if warranted, to propose solutions. Recommendations regarding resolutions will be developed by December 2004, and will be subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

- DYFS District Offices do not have enough substance abuse specialists to perform assessments and case consultation. Families are wait-listed and do not receive treatment when they need it.
- Both inpatient and outpatient services for adolescents with substance abuse issues are limited. Few DYFS involved adolescents will volunteer that they have a problem with substance abuse and it rarely exists in isolation. Therefore, some programs are reluctant to provide services because, "He's still in denial", or "You'll have to address her mental health issues before we deal with her substance abuse," and (vice versa from the perspective of the mental health treatment provider). A holistic treatment approach is needed.
- About 33% of DYFS-involved families are also active with the Temporary Assistance for Needy Families (TANF) program operated through the Division of Family Development (DFD).

New

- DAS will move under the umbrella of DHS—yielding greater efficiency and improved coordination of substance abuse services within DHS as well as enhanced opportunities for federal reimbursement.
- DFD, DYFS and the substance abuse community have agreed to use the same assessment tools to determine the best substance abuse treatment options for families. Guidelines regarding level of care will use the American Society of Addiction Medicine (ASAM) criteria.
- All children entering foster care will be assessed for the impact of substance abuse (either their own or a parent's); medical screening (e.g., urinalysis) will be used only where indicated.
- As first step of a five year initiative, $3 million was included in FY 04 to specifically meet the treatment, child safety, timeframes, transportation, and childcare needs of DYFS families in an additional 71 treatment slots, including both outpatient, intensive outpatient slots, long term residential beds, residentially assisted partial care, and methadone maintenance.
- At the end of three years, a total of $28.3 million (if funding is dedicated) will have been invested to expand these coordinated and specially designed substance abuse treatment services, providing approximately 2,302 additional slots across the various treatment modalities, which approaches the national estimate of a 60% prevalence rate.[117]
- The allocation and effectiveness of these new substance abuse resources will be reviewed on an annual basis to fine-tune the expansion process to improve access and target resources to the areas of highest need.
- Substance abuse providers will participate in the Family Team process to ensure that treatment is coordinated.
- Additional certified substance abuse specialists will be contracted to work in each DYFS office to perform substance abuse assessments, treatment referrals, case consultation and

[117] As part of this plan, DMAHS will maximize the use of federal funds for adults across funding streams with a goal of increasing funding for substance abuse services by 10%.

training. With the expanded treatment options listed above—women will have increased access to the types of services they need when they need them.

- The Administrative Office of the Courts (AOC), DAS and DYFS will collaborate to expand the Family Drug Court model starting with Morris County. Two additional family drug courts will be established, based on a careful evaluation of this model, in the neediest communities by June 2008 at an estimated cost of $1 million per court. All staff will be cross-trained.
- By March 2005, we will begin a process to better identify substance abuse problems in adolescents by referring the youth for assessment within 24 hours of identifying a need for substance abuse services. DAS and DYFS will work together to develop a curriculum for cross training of their agency's staff to identify needs through screening.
- Integrate adolescent substance abuse services into behavioral health services using the federal Substance Abuse and Mental Health Services Administration (SAMHSA) model to create 750 slots over five years.
- In the first year, we will expand capacity to create 125 new outpatient treatment slots and 25 new inpatient treatment beds for substance abusing teenage mothers with young children who want to keep their children with them during their substance abuse treatment, at an annualized cost of $2.3 million beginning in July 2004. An additional $1M in capital funding will be requested in FY 2005 to provide the needed infrastructure to support the service expansion.
- We will develop a plan to meet the 600 remaining slots over four years and determine the appropriate number of slots for each type of treatment.
- Integrated behavioral health and substance abuse services must address the unique challenges of adolescents transitioning into adulthood, incorporate independent living skills into treatment modalities to increase the capacity to become self-sufficient, and meet child care needs of adolescent parents.
- Work with existing substance abuse providers to incorporate on-site psychiatric and psychological Medicaid eligible services into their adolescent treatment components by September 2005.
- Existing providers of behavioral health services will develop the skills needed to integrate effective substance abuse practice, intervention and treatment into their current program models. Training and consultation will be provided in conjunction with DAS.
- Create an interdisciplinary adolescent best practice task force to develop standards for working with youth involved with DYFS, JJC, the courts, DAS, and behavioral health providers.
- DYFS, the CMOs and Youth Case Management will work with the JJC to prioritize mutually involved youth for services.
- DYFS, DFD through the County Boards of Social Services (BSS), and Medicaid will use an information systems' match to identify mutual clients and coordinate care at the local level.

Substance Abuse—adolescents at risk of involvement with DYFS

New

- Use proven best practices to provide substance abuse services to adolescents to identify substance abuse problems, intervene earlier and adapt services to meet the unique developmental needs of adolescents. DAS and DYFS will coordinate the work of the DYFS substance abuse and adolescent specialists and the community treatment provider network. Future community based intervention and prevention models will incorporate child welfare outcomes (e.g., reduction in out-of-home placements,) as well as substance abuse outcomes. Activities will shift toward what we know works to decrease or prevent adolescent substance abuse.

Domestic Violence—children and families involved with DYFS

Parents involved with domestic violence situations were among the top three reasons for referral to DYFS in 2002. Domestic violence intervention services need to be carefully integrated into child welfare programs and practice to preserve safety.

Current

- Domestic violence services for families and children are insufficient and not available in all locations.
- Domestic violence issues are complex and require advanced practice skills to keep children and families safe.
- Children involved with domestic violence need safe places to visit with non-custodial parents. The risk of domestic violence incidents is often increased around visitation.
- Women and children fleeing from domestic violence need to be able to move from emergency shelter care to more stable living situations. Nationally, half of all homeless women and children are involved with domestic violence issues.

New

- Replicate the successful "Peace: A Learned Solution (PALS)" project statewide over five years to help children heal from the effects of domestic violence. Programs will be added to three counties in the first year, and an additional three the following year, at a total cost of $2.3 million. For children and families already affected by domestic violence, this program provides comprehensive assessment and case management; child care, before and after school care, and summer camp; group and individual play, drama, dance/movement therapies; educational support, and individual therapy for the non-offending parent. Transportation and follow-up services are also available.
- Examine current DYFS policy and practice as they relate to:
    - Identification of domestic violence during course of investigation;
    - Development of investigation strategies that do not involve blaming the non-offending parent;

  - Safety assessments for families affected by domestic violence (e.g., assessing imminent danger to child and non-offending parent despite the absence of physical injury);
  - Risk assessments for families affected by domestic violence, including the potential for harm to children from witnessing domestic violence (with attention to not removing children from the care of domestic violence victims when doing so is not necessary to keep the children safe);
  - In cases that rise to the level of child abuse or neglect, substantiating physical abuse and/or neglect (when appropriate) against the batterer and emotional abuse against the batterer for exposing the child to batterer's behavior (i.e., verbal, physical, sexual violence), rather than failure to protect against the non-offending parent;
  - Case monitoring to determine whether the case plan developed by the worker, in conjunction with the adult victim of domestic violence, is based on the results of the assessment;
  - Services offered to the adult and child victims of domestic violence, as well as batterers, being based on the needs expressed by the family, as well as those needs identified during the investigation and safety and risk assessments; and
  - Supporting all family members in obtaining the recommended services and monitoring DYFS's compliance in doing so.

- Identify Domestic Violence Liaison(s) for each DYFS District Office to assist DYFS workers in effectively investigating, assessing, and offering appropriate services to families in which domestic violence is occurring. This would enhance children's safety by enhancing the safety of the adult victim.
- A statewide system of specialized assessment, treatment, and support services for adult and child victims and batterers should encompass the following characteristics as outlined in the National Council of Juvenile and Family Court Judges report, Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice:

  - First and foremost, the respective services should be provided by professionals who have expertise in the area of domestic violence.
  - Services are provided soon after problem identified and in settings appropriate for the family.
  - Service providers are trained to respond appropriately to multiple victims within the family (i.e., child and adult).
  - Services are offered to adult and child victims in a respectful and non-blaming manner.
  - Services are provided in a seamless and consistent manner to minimize the number of providers involved with the family.
  - Service providers collaborate with other providers and community groups on behalf of the client.
  - Services are provided in a culturally competent manner.

  - Community leaders and elected officials provide adequate resources to allow service providers to meet the family's needs and prevent out-of-home placement of children.

- Evaluate the impact of the Domestic Violence Case Practice Protocol (DVCPP) periodically, via the agency CQI program, to determine whether it is leading to the desired outcomes for children, victims and families. The evaluations should focus on whether caseworkers are identifying domestic violence, and offering appropriate interventions, at all phases of a case.
- Extend Human Service Police (HSP) protocols to enhance the safety of DYFS workers, children and families while abuse and neglect allegations are being investigated and domestic violence is involved.

Domestic Violence—children and families at risk of DYFS involvement

New

- Develop and implement a massive public awareness campaign to surface, and help eradicate, the largely hidden epidemic of domestic violence. Create a broad-based advisory committee to shape this campaign, and contribute its expertise to the state's effort to provide culturally appropriate education and training for professionals and paraprofessionals.
- Use DCA Homeless Prevention funds and federal tenant based rental assistance funds to provide housing assistance to approximately 400 women transitioning from domestic violence shelters to safer and more stable living arrangements (100 long-term and 300 short-term) for a total of about $6.3 million redirected to this population over five years. The federal Housing and Urban Development (HUD) Section 8 Housing Choice vouchers will be prioritized for this population.

Behavioral Health—children and families involved with DYFS[118]

Current

- Behavioral health services for children and youth are fragmented, community based resources are insufficient, and the system relies too heavily on congregate care instead of family-like settings.
- Service design and delivery is not matched through needs assessments, and there is competition for limited resources among DYFS, JJC, court-involved and non-court-involved families.
- Families often cannot access services unless they are or become court or DYFS involved, even in the absence of protective service or serious delinquency issues.

[118] This section and the one that follows discuss various important enhancements to the behavioral health program. But more is needed. Starting in July 2005, comprehensive assessments of the state's ability to meet children's behavioral health needs will be conducted in each county, in partnership with the county child welfare planning council. Subsequent implementation plans will include steps necessary to address all identified unmet needs.

New

- Behavioral health services will be provided based upon a common assessment tool, which will be used across service systems. By January 2005, it will be used for all children entering foster care and will also be used as part of the more comprehensive health and mental health assessment/evaluation that will be completed for each child within 30 days of their entry into out-of-home placement. It identifies the strengths and needs of the child as well as the need for caregiver supports. An array of in-home services may be identified as a result of this comprehensive assessment that can be provided to children and their Resource Families. This should minimize disruption and re-placement of children in foster care.
- A protocol will be established within 30 days of the effective date of this plan, between DHS, the JJC and the AOC to define the process for referral of court involved youth with behavioral health needs for assessment, assignment to the appropriate level of care or case management and the development of an individualized service plan. The DYFS court liaison will review the Judge's order and route it to:
    - DYFS, if the required action is related to permanency or protection issues;
    - The Division of Child Behavioral Health (delegating DYFS authority to the DHS Contracted Systems Administrator), for assignment to the appropriate level of case management (either youth case management or CMO care management); arranging for the provision of intensive in-community services, out-of-home treatment or evaluation; and the development of a 14 day plan to be submitted to the court if the required action is related to a behavioral health service need.
    - Youth case managers or the CMO will coordinate with the Court for any continuing assessment and service planning regarding the referred juvenile, regardless of any problems in gaining parental cooperation.
    - The Court, if necessary, will exercise its authority to enforce parental cooperation. The implementation of this mutually established protocol will reduce unnecessary referrals to DYFS for activities not related to child safety, permanency or protection.
- By June 2006, resource families will be educated regarding the behavioral health services that are available to them for the children in their care. A resource manual will be provided to them and will also be available online.
- Care Management Organization's (CMOs) capacity will be expanded to four new communities by February 2005 as part of a planned statewide phase-in. With a new blended caseload standard of 1:15, this most intensive level of care management will serve about 4,000 families when the statewide roll-out is completed. A Family Support Organization (FSO) is developed in tandem with each CMO to provide the family-to-family support from the perspective of "someone who's been there." FSOs are grass roots, consumer-led organizations that support families involved with CMOs, using a peer support model.
- An additional 75 treatment homes will be added by February 2005 to accommodate the needs of children stepping down from congregate care settings. This means that children who still need behavioral health care services can receive them in a family and community setting, freeing up the more intensive and restrictive services for those children who cannot yet be safely discharged. Children who cannot return home will no longer languish in residential centers while waiting for a family treatment home to

become available. Initial funding of $1 million will be provided at an annualized cost of $3.9 million.
- By February 2005, integrate guidelines for behavioral health into DYFS policies and practice through training in mental health issues.
- By February 2005, OCS assures that policies, procedures, and trainings are integrated across Divisions.
- Medicaid will conduct a cost analysis to determine the appropriate rate structure for specialized behavioral health services provided to DYFS children, including medication monitoring--especially for those services which are currently 100% state funded. The cost analysis and enhanced rate structure will be completed by January 2005.
- Create a database which will link DYFS, Medicaid and DCBH information systems and reporting capabilities to ensure that each child has a standardized identifier and that accurate health and behavioral health information can be readily reported to case managers, resource families or other caregivers or individuals involved in the child's care and treatment. The respective information systems will be integrated by January 2006.
- DFD will prioritize mutual DYFS parents who are receiving TANF or General Assistance (GA) benefits and also have a serious mental illness for the DFD Mental Health Initiative. This program provides linkages to mental health services including outpatient treatment, partial care, intensive case management and medication monitoring. It presently serves about 300 individuals per month in the seven counties of highest need[119], and will expand within those counties to serve an additional 150 individuals in December 2005.

Behavioral Health—children and families at risk of DYFS involvement

New

- Staff from the county Board of Social Services (BSS) will be trained in the DYFS Family Team service planning model and will participate in local teams as mutual families are identified to improve coordination and give families more of a voice in their own service plans. County BSS staff will be trained simultaneously with their DYFS counterparts in the model.
- Staff also will be cross-trained regarding child abuse and neglect and how to identify child welfare safety and risk factors using a "train the trainer" model. Cross training will improve the communication between DYFS and BSS staff and will result in more referrals for ameliorative services before a DYFS investigation becomes necessary. Cross-training sessions will begin in April 2004 and will be conducted at periodic intervals.
- The number of Youth Case Managers who coordinate behavioral healthcare for youth in the community will be increased from 75 to 167 beginning in April 2004, at a cost of $1.4 million. They will serve about 10,000 children statewide, targeting youth in detention, shelters, and DYFS youth, at an annualized cost of $5 million.

[119] This program exists in Atlantic, Camden, Essex, Hudson, Mercer, Passaic and Union counties

Health/Medical—children and families involved with DYFS

Current

- Medical care for children involved with DYFS is not consistently provided, especially true regarding children entering placement.
- Healthcare services are often fragmented, interrupted and inconsistent, which places already vulnerable children at greater risk for medical problems. Immunizations are frequently not up to date and poorly tracked.
- Children in placement with resource families are placed on Medicaid in a fee-for-service payment system with extremely low rates that do not cover the actual cost of care. DYFS has begun to enroll foster and adoptive children into managed care HMOs for physical health care.
- While DYFS currently has 27 nurses and nurse practitioners available to front-line staff, these numbers are not sufficient to meet the complex needs for medical assessments and case consultation for DYFS children in care or under supervision.

New

- DYFS will hire a consultant pediatric physician as a Medical Director by July 2004 to oversee all aspects of DYFS' response to health, mental health and substance abuse policies, practice and coordinated program development. The Medical Director will develop an interdisciplinary support team of medical consultants including participation from the areas of psychiatry, psychology, licensed clinical social work, and licensed certified alcohol and drug abuse, at a minimum. They will work with the existing DYFS Child Health Advisory Council to improve and enhance medical practice as it relates to DYFS children and families.
- The Medical Director will be responsible for developing, within six months of assuming the role, a plan to meet the basic medical needs of all children in out-of-home care, including at least EPSTD screenings, annual physicals, annual dental exams, and medical passports.[120] Consultation and support will be available. This plan must contain an ongoing training component for physicians/medical personnel who provide service within the child welfare system. Further, the plan will include a CQI component.
- The six month medical plan developed by the Medical Director will be guided by research based developed standards. The standards will be reviewed annually and updated as needed in keeping with current research. This plan will be subject to review and approval by the Panel, which will designate appropriate elements therein as court enforceable.
- Each DYFS office will have a minimum of one registered nurse available to it. Advanced practice nurses will provide area level supervision as part of an interdisciplinary specialty team. It is estimated that 32 nurses will be hired by July 2004 and four advanced practice nursing supervisors will be hired by January 2005. By

[120] This plan will be developed by January 2005, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

December 2005, 75% of the children whose in-home cases are opened by DYFS will be reviewed by a nurse.[121]

- By January 2008, we will maintain each child's medical history and treatment information electronically to improve quality and continuity of health care.
- By January 2005, we will generate and distribute management reports monthly to DYFS staff regarding utilization of healthcare services. This will enable DYFS to easily determine which children under its care haven't been to the doctor, have made frequent trips to hospital emergency rooms, etc.
- Each child entering foster care will have a pre-placement physical examination at a geographically accessible location in the community prior to entering care. DYFS will partner with the American Academy of Pediatrics NJ Chapter, Federally Qualified Healthcare Centers (FQHCs), and other community based doctors to develop this service during business hours and explore the options for urgent care during evenings and weekends. This will eliminate long waits in emergency rooms beginning in March 2004.
- A Comprehensive Health Evaluation for Children (CHEC) will be implemented for children entering foster care within 30 days of placement. This evaluation will screen for acute or chronic conditions, provide for immunizations, if needed, and also will incorporate behavioral, substance abuse and developmental assessments, as well as address all issues related to abuse or neglect. This program will begin implementation in October 2004 for children newly entering care and will be phased-in for children already in foster care. The comprehensive nature of this evaluation will limit its use only to highly qualified vendors and will build upon the specialty knowledge regarding child maltreatment that is already available in existing Regional Diagnostic and Treatment Centers and Child Advocacy Centers. Evaluations will cost $643.00 per child with an estimated 4,000 children receiving this service yearly. The annualized cost per year is projected to be $2 million in existing funding (combined state and federal).
- DYFS will continue to phase-out fee-for-service coverage by aggressively enrolling foster and adoptive children into HMOs. Beginning January 2004, all children newly entering foster care were required to enroll in an HMO to ensure they see a Primary Care Physician, have their care coordinated in one place and have improved access to specialty medical services that are more readily available through the HMOs' provider networks than is currently available through the traditional Medicaid program. Children entering out-of-home placement who already belong to an HMO will remain with the same one.
- Community providers and caregivers will receive continuing medical education credits for participation in training regarding the unique health care needs of children under DYFS supervision. Other community education avenues also will be developed in conjunction with the DYFS Medical Team and Child Health Advisory Council. DHS will reach out to the State Board of Medical Examiners to develop a program to increase physicians' awareness of, and sensitivity to, child abuse and neglect, and to encourage the Board's enforcement of physicians' obligations as mandatory reporters of suspected abuse and neglect.

[121] Children entering out-of-home placement will have full physical and mental health screens within 30 days of placement.

Health/Medical—children and families at risk of DYFS involvement

Current

- The Healthy Families America (HFA) home visiting program model for new mothers and families with young children, sends a family support worker from the local community to provide peer support, and education and skills training on parenting, nutrition, wellness and child development. The program is currently available in 20 locations throughout the state.

New

- Using the community collaboratives, in partnership with the county Boards of Social Services (BSS), the HFA model will be expanded to serve an additional 1,000 households who are receiving public assistance, doubling the number of households receiving this service. It will be targeted to women who are pregnant, have recently given birth or have a child under the age of 12 months. This program model has been effective in reducing child abuse and neglect referrals and promoting healthy child development in at-risk families.
- Six million dollars in TANF and food stamp funding will support the program expansion and will reach approximately 25% of all TANF households with an infant child under the age of one.

Housing—children and families involved with DYFS

New

- DCA will make $2 million in federal HOME Production Investment funding available in the first year, and $800,000 annually for the next four years, to create up to 40 affordable rental housing units for eligible low income DYFS families. Up to $100,000 in HOME Production Investment funding per unit can be used. This project replicates a similar project that was successful in creating housing opportunities for low-income families transitioning from welfare to work. DYFS and DCA will work together to develop: the application process, additional eligibility requirements (up to 40% of median income), and a Request for Proposal (RFP) for interested developers, and to obtain HUD approval, incorporating the changes into DCAs' required planning documents.
- DCA will reallocate $5 million in Balanced Housing Neighborhood Preservation funds to rehabilitate 250 resource family homes to ensure that children live in safe dwellings. This may increase the number of foster care slots available to serve DYFS families. DCA and DYFS will work closely together to develop the program rules, identify families in need and work with municipal officials through whom the funds are disbursed. Services will be linked to the community collaboratives where applicable. Funds will be made available by mid-May 2004.
- The Home Ownership Permanency Program (HOPP) operated by HMFA provides a total of $11.2 million through a combination of funds to assist families who are in the final stages of adopting a child or becoming the child's legal guardian. Through the Housing and Mortgage Financing Agency (HMFA), low interest loans are made to qualifying

families to purchase homes, creating a safer, more stable environment for their adopted children. Started in 1999, 72 families with 160 adopted children have purchased homes through HOPP, using $10.5 million of the funding allocation. The program also provides low interest rehabilitation loans to families who are adopting and want to make additions or accessibility improvements to their homes. A total of $5 million will be made available beginning in 2005.

- The HMFA and DYFS low interest loan program for organizations and public entities to create or enhance transitional and permanent housing opportunities for 125 youth with specialized needs who are "aging out" of foster care and to assist at-risk youth achieve self-sufficiency. A balance of $400,000 remains in HMFA funding to support continued transitional housing development, and will be increased by $1.6 million to make $2 million available over five years.
- DCA will develop a Project Based Section 8 program for low-income families involved with DYFS. One hundred new vouchers and $4.8 million will be provided over five years. Project Based Section 8 vouchers will provide 100 families with permanent affordable housing. DCA will prioritize the hiring of one additional staff member to manage the program.
- DFD will amend its regulations regarding Emergency Assistance (EA) and the TANF State Plan to permit the use of Emergency Assistance services and funds for DYFS families at risk of homelessness or child endangerment. Current regulations do not allow EA to be provided if it has previously been granted in reunification efforts or if the individual caused her own homelessness, (e.g., failed to pay rent on time). By December 2005, Emergency Assistance should be available to approximately 100 DYFS families at an estimated cost of $4.3 million.
- Emergency Shelter Homeless provider agencies will be encouraged to apply to become non-profit housing developers to create additional permanent housing slots for the DYFS population transitioning from emergency or transitional placements into more stable living arrangements. DYFS and DCA will work together to develop a Request for Proposals (RFP) by December 2004 to create 160 additional units over a five year period. A total of $7.7 million in Balanced Housing and other funding will support this development effort. Technical assistance will be provided to the emergency shelter providers.

Prevention and Early Intervention in Partnership with Individuals, Families and Communities

Current

- We must restructure and develop the State's current prevention and early intervention system into a locally based, user-friendly and culturally competent array of services and supports to engage and strengthen families to be able to address their needs in their communities. We can prevent child abuse and neglect AND the need for many families to enter the child welfare system if communities are given the opportunity, technical assistance and funding to build upon their strengths and develop the capacity to meet the needs of their children and families. While this will require more financial support and coordination from the State, the leaders of developing prevention and early intervention in New Jersey will be families, communities and county and local governments.

- We must ensure that every child and family can access a network of support in their community before harm or family disruption occurs.

New

- We will expand responsibility for the coordination and development of state-wide prevention/early intervention efforts for child welfare within the Office of Children's Services by creating and staffing the Division of Prevention and Community Partnerships.
- We will immediately expand childcare services and home-visiting services to be used by families in remaining months of FY 2004 (March – June 2004).
- We will examine use of Title IV-B and other federal programs to maximize federal participation rates for prevention funding.
- We will work with communities to conduct community needs assessments that will serve as the basis for funding allocations to ensure that communities can meet the needs of their children and families.
- We will ensure that FY 2005 and 2006 budgets include additional resources to expand and develop the following prevention and early intervention services and programs by utilizing performance-based contracting:
    - 250 additional child care slots[122]
    - Training for child care centers on prevention and identification of abuse and neglect
    - School Based Youth Services Programs
    - Parent Linking (teen parent program)
    - Community Collaboratives
- We will establish a continuous quality improvement system to evaluate the effectiveness and availability of prevention and early intervention services annually in every community. This information will be made available to the public each year, and inform planning and budget decisions on both state and local levels.
- Partner with at least five foundations and corporations to create a consortium by October 2004 to explore resource opportunities for prevention services. This consortium will also work with the State to evaluate the impact of all prevention and early intervention efforts statewide in three years (May 2007).
- We will work with communities and the Task Force on Child Abuse and Neglect to modify, expand and implement "New Jersey's Statewide Child Abuse and Neglect Prevention Plan" by June 2005, which will involve initial and on-going training to local communities and planning boards. This prevention plan will include a widespread education and awareness campaign, and will be reviewed every three years.
- We will work with the New Jersey Advisory Council on Domestic Violence, Department of Community Affairs, and the Legislature to reconstitute the Council, expand authority, and provide dedicated funding. By June 2005, the Council will formulate a public awareness and education campaign to reach at least four underserved communities or populations each year.

[122] In addition, 3 and 4 year-old children entering or in placement will be referred to pre-school or child care. All children in Abbott Districts will be eligible for Abbott pre-school programs. The costs associated for pre-school for non-Abbott District children are included in the expanded 250 child care slots.

- Beginning in December 2004, we will work with Division of Addiction Services (DAS) and youth to contract with a marketing firm to create a campaign to target adolescents to promote healthy lifestyle choices and the problems associated with substance abuse.
- We will collaborate with the New Jersey American Academy of Pediatrics to expand the Educating Physicians in the Community – Suspected Child Abuse and Neglect (EPIC-SCAN) program statewide by training physicians in three counties each year for the next five years.
- We will work with DCA to launch a HUD-Section 8 approved demonstration program by February 2006 to create 100 housing vouchers for permanent housing for low-income families in targeted areas of need. This program will, over time, be expanded to the federal maximum of 3700 vouchers.
- We will develop an interdepartmental affordable housing committee by September 2004 with DCA and the Housing and Mortgage Finance Association (HMFA) to pool and coordinate resources, establish joint priorities and guidelines, and streamline grants and programs to more easily develop affordable housing in areas of need. This committee will meet regularly and submit an annual report detailing progress and impact on developing affordable housing for low-income families in areas of need.

■ STRIVING FOR SAFETY AND PERMANENCY IN THE COURTS

Child welfare work is intimately intertwined with the judicial process, for several important reasons:

- Fundamental rights, in both the legal and moral senses of the term, are implicated by child welfare cases, which raise questions of whether a parent has abused or neglected a child and whether the parent/child bond should be maintained or severed;
- When children's cases are brought before the courts, the judge provides a critical monitor and institutional check of the child welfare system's awesome power over family life, a role that both protects rights and promotes children's safety by ensuring that the system is acting lawfully and meeting its obligations to all parties;
- When cases reach court, they are placed on various timelines that drive them to finality, and this additional pressure toward permanency is in children's best interests.

Our **commitments** are:

1. We will bring children's cases to court promptly to help protect children's safety and all parties' rights, and will move the cases forward in accordance with applicable standards to achieve permanency for children;

2. We will ensure that all parties are treated respectfully in court and that the culture of the courts is appropriate to the presence of children, and we will explore innovative court models to improve outcomes for children and families.

Before setting forth the several strategies we will employ to better meet these commitments, it is important to provide some **background and context** regarding the operational intersection of the judicial and child welfare systems:

The New Jersey Family Division of the Judiciary handles over 400,000 filings annually, representing about 40 percent of all Superior Court filings.[123]

The administrative complexity of the Division arises from the many diverse family case types. Dissolution is as different from juvenile as civil is from criminal, yet these dockets are handled in the same division, along with domestic violence, non-dissolution and children-in-court (child welfare) cases. Each type of case has very different programs, practices, and procedures, yet all are housed under one roof – one Presiding Judge, one Division Manager, and one Administrative Office of the Courts (AOC) division.

[123] By contrast, the Criminal Division files less than 40,000 indictments, and "regular" civil receives about 125,000 filings.

The organizational model of the New Jersey Family Division establishes four integrated docket teams, each headed by a Team Leader:

- Non-Dissolution/Dissolution (FD/FM)
- Domestic Violence/Domestic Violence Contempt (FV/FO)
- Children in Court (CIC), Abuse and Neglect, Termination of Parental Rights, Child Placement Review, Adoptions, Kinship Legal Guardianship (FN/FG/FC/FL)
- Juvenile Delinquency/Juvenile Family Crisis (FJ/FF)

In 1999, the Conference of Family Presiding Judges recommended, and the Judicial Council approved, standards for Children in Court case progress that adopted the federal Adoption and Safe Families Act (ASFA) timeframes. These standards also established Children in Court Advisory Committees in every county to coordinate the activities of local agencies involved with children in court cases. At the state level, the role of the ASFA implementation working group has been incorporated into the Children in Court Improvement Committee (CICIC), chaired by Hon. Ellen Koblitz, P.J.F.P., Bergen County, who also chairs the Conference of Family Presiding Judges.

The screening of all family filings for other related cases pending in the Family Division has been a standard practice since the Family Automated Case Tracking System (FACTS) was rolled out statewide in 1994. Children in Placement cases (FC) were added to the system in 2001, and Kinship Legal Guardianship cases (FL) in 2002.

The advances in recent years of docket tracking systems within AOC make it possible today to identify specific areas for improvement in the interests of children and families. Presently, there exists a significant backlog of approximately 270 termination-of-parental rights cases that exceed the standard for disposition within 6 months of filing. As of December 2003, 386 children's cases (out of a statewide total of 13,294) that had been active for at least 12 months had either never had a permanency hearing (105) or had no hearing within the last 12 months (281). These lapses are more disquieting when one recognizes that although the best practice standard for disposing of FG complaints may be 6 months, N.J.S.A. 30:4C-15.2 requires that the final hearing for an FG complaint be held within 3 months.

To be in compliance with the ASFA mandate, there must be a judicial determination that reasonable efforts to achieve a child's permanent placement have occurred within 12 months of the child's entry into foster care, and prompt action taken to effect that placement. This time frame is not being met in 100% of New Jersey cases. In the processing of abuse and neglect cases, there are a number of places where delays occur. Fact finding – the adjudication of the issue of abuse or neglect – is to be completed within four months when the child is placed out of the home. As of December 2003, there were 4,316 active pending abuse and neglect cases, 192 of which were out of fact-finding compliance.

Of the children placed voluntarily by their parents or guardians into an out-of-home placement overseen by DYFS, 1,306 children have been in placement for greater than 6 months without an FN docket being opened, in violation of DYFS policy in most instances.

DYFS has 5 days from the date of placement to make the case known to the courts. Of the 530 new cases identified to the courts in December 2003, only 34.8% had been filed within 5 days. 26% of the cases were noticed to the courts after the children had been in placement for more than 15 days.

Another area of concern is the inconsistent notice by DYFS of children's locations to assigned Law Guardians (the children's lawyers), which frequently makes it difficult for attorneys to meet with their child clients timely.

In light of these realities, and in order to meet our overall commitment, we will employ ten **strategies**:

1. The ICCF will monitor the action steps and strategies in this section.

The Interagency Council for Children and Families (ICCF) will report publicly and regularly on its findings with regard to these reforms. The ICCF will include the Attorney General; the Director of the Administrative Office of the Courts; the Commissioner of the Department of Human Services; the DYFS Director, the Public Defender; the Executive Director of the Juvenile Justice Commission and the Child Advocate. The ICCF will meet regularly to ensure that the designated public agencies charged with specific action steps achieve the benchmarks, timeframes and outcomes for this section.

The ICCF will monitor the implementation of the strategies and reforms contained within this section via regular meetings and oversight, and eliminate any barriers. Whenever necessary, the ICCF will make recommendations to advance the proper administration of these strategies. It will be the responsibility of the ICCF to ensure that significant progress is achieved during the life of this plan with regard to:

- the consolidation of court calendars to accommodate the work needs of counsel and necessary parties;
- better coordination, if not consolidation, of the FN and FG cases. Some counties were experimenting with amended complaints when a case moved from FN to FG status, rather than requiring the drafting of a new complaint when guardianship is filed. The status of this, as well as other mechanisms such as mediation to streamline the process, will be included.
- improvement in the sharing of information between DYFS and the courts. The fact that the systems use different case tracking systems that do not promote the sharing of information is a barrier to efficient and effective case processing.
- improvements in case tracking. Additional data should be collected and reported, particularly with regard to children re-entering out-of-home care, in order to improve overall case processing. ASFA requires filing for termination of parental rights if a child has been in placement for 15 of 22 months. It is unclear whether children's re-placement is tracked effectively.
- implement a strategy with the Administrative Office of the Courts, Office of the Law Guardian, DYFS and the DAG's office to secure the timely appointment of law guardians, either prior to or shortly following hearings on Orders to Show Cause.

- ensure that parents are notified promptly of court hearings, especially the return date on orders to show cause, have counsel and appear in court;
- strengthening the role of resource families in the court process;
- the recruitment, hiring and training of expanded personnel necessary to expedite proceedings, including DYFS caseworkers, Deputy Attorneys General, Law Guardians and counsel for parents, as necessary to process cases in a timely and thorough fashion;
- seeking adequate staffing and resources across agencies and branches of government to ensure that the Department of Human Services' elimination of the voluntary placement process does not impede permanency for children by slowing proceedings;
- evaluating the role of Child Placement Review Boards and the Court Appointed Special Advocates (CASA), in consultation with those entities; [124]
- establishing processes for the cross-agency exchange of relevant child-related information;
- monitoring the administration of alternative and innovative court models, such as family drug courts;
- monitoring the pilot project of alternative dispute resolution (ADR) now underway in the Essex, Mercer and Morris vicinages, involving both abuse and neglect (FN) and termination of parental rights (FG) cases, and, if deemed successful and appropriate, expanding ADR to the other vicinages;
- developing a protocol, to be implemented by December 2006,[125] to provide resource parents with timely notice of all court proceedings regarding children in their care;
- designing mechanisms to coordinate the review of cases involving the same parties that are before different courts;
- evaluating the merits and challenges of child welfare mediation and alternative dispute resolution models and, upon favorable evaluation, expansion to additional counties; and
- ensure implementation of recommendation by CICIC of a protocol and methodology for the timely notification by DYFS to Law Guardians of the location, and any change in the location, of children in placement (by January 2005).

Rationale: Permanency for children requires effective collaboration among entities involved in the Family Court process including the Administrative Office of the Courts, the Department of Human Services, the Department of Law and Public Safety, including specifically the Juvenile Justice Commission, and the Office of the Public Defender. The Office of the Child Advocate has among its core missions the mandate to promote the effective partnership of public entities charged with serving children at risk of abuse and neglect.

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[124] The Child Placement Review Boards (CPRB), are comprised of community volunteers. They review out-of-home placements. Tthe CICIC will work with the CPRBs over the next year to develop new ways for the Boards to continue devoting their monitoring capacity to the improvement of children's safety and well-being. One possibility would be for the CPRB volunteers to monitor the "back end" of adoption cases, post-TPR, to help ensure that such cases move efficiently to finalization. Another possibility, not necessarily inconsistent with the first, would be to explore ways the CPRBs could partner effectively with the Court Appointed Special Advocates program (volunteers who serve as "eyes and ears" for judges in child welfare cases).

[125] This protocol requires that SACWIS be developed sufficiently to interface with the AOC calendaring IT systems, and this is not anticipated earlier than 12/06.

Current Situation: The coordination of efforts among these entities could be significantly strengthened. The resources necessary to achieve proper administration of these strategies have been lacking.

Implementation Steps:[126] ICCF will meet by June 2004, to establish a coordinated agenda for implementing and monitoring the strategies in this section.

Timeframe: Within 6 to 30 months, as referenced in the benchmarks section of this plan.

2. Expedite the processing of adoption cases.

Rationale: Adoptions are taking too long to complete – 30 months on average once a child's case is referred to an Adoption Resource Center (ARC) upon receipt of the goal.

Current Situation: There are two phases in an adoption case. First, the birth parents' rights to a relationship with the child must be legally terminated and a docket filed for adoption. Second, the adoption petition must be approved by the Family Court. Different judges hear the termination of parental rights (TPR) and adoption portions of the case. In New Jersey, the goal is for courts to complete an adoption within two months of the filing, and the courts are meeting this goal. However, there are significant delays in the processing of TPR petitions. While there is a policy requiring these cases to be processed within six months, there is currently a backlog of 270 cases beyond this timeframe. The delays are due in large part to a shortage of Deputy Attorneys General, Law Guardians, counsel for parents, and often experts whose evaluations are required for a case to proceed.

According to "Rates of Compensation Paid to Court-Appointed Counsel in Non-Capital Felony Cases at Trial: A State-by-State Overview," prepared in August 2003 for the American Bar Association by the Spangenberg Group, the pool rate paid by New Jersey to counsel for parents is the lowest in the country. A pool rate increase is necessary to ensure that attorneys will accept parents' cases and proceedings will move forward fairly.

Implementation Steps:

- Hire and train additional Law Guardian personnel (by July 2005).
- Hire and train additional Deputy Attorneys General and personnel (by July 2005).
- Hire and train additional Parent Representation Unit personnel (July 2005).
- The CICIC will make recommendations by March 2005 to the ICCF to address the appeals process, once TPR has been granted. The length of the appeals process contributes to the long delays in adoption finalization and should be examined.

[126] Throughout this section of this plan, Striving for Safety and Permanency in the Courts, there are implementation steps that extend beyond the authority of DHS and will require the cooperation both of sister agencies or offices within the Executive Branch and of the Courts, a separate and coequal branch of state government. DHS will take all reasonable steps to seek the active partnership of all other necessary actors to implement the changes set forth throughout this section.

- Implement a $45/hour rate increase for counsel accepting assignments as part of the Parent Representation pool (which will bring New Jersey on par with the New York rate for in-court representation of $75/hour) (by September 2005).
- The CICIC will develop a strategy to increase the availability of necessary experts in Family Court proceedings (by October 2005).
- Implement a specialization curriculum as part of the DAG training to focus specifically on DYFS issues: Basic DYFS (DYFS organization and procedures, statutory scheme governing DYFS practices including ASFA), Fact finding (trial strategies), Guardianship (trial strategies), Basic evidence (commonly used documents, hearsay exceptions). A DYFS DAG Manual also will be provided for all DYFS deputies and include "Practice Tips," forms and sample questions for different types of DYFS hearings, etc. (by July 2005).
- The CICIC will develop a plan to ensure appropriate cross-training for DAGs, Law Guardians and counsel for parents (by October 2005).
- Consistent with all hiring commitments made in this part of the plan, the New Jersey Department of Personnel will raise the affected agencies' FTE counts by the number of new positions authorized herein, and ensure that the affected agencies will be permitted to backfill vacant positions in similar titles immediately, during the lifetime of this plan.

Time Frame: As set forth above

3. Reorganize the Department of Law and Public Safety's Division of Law to ensure that attorneys representing DYFS in Family Court are specialists in this area of law, are well trained, and are rigorously supervised for practice.

Current situation: Prior to a recently planned reorganization, there were 2 DYFS units within the Division of Law, one covering the north end of the state (DYFS-Newark), the other a unit within a bigger section called "Education, Health and Human Services." This did not allow supervisors and line deputies to focus their representation on specific clients and areas of law, and did not ensure that Deputy Attorneys General, and their supervisors, were trained as specialists in DYFS representation.

It should be noted that the reorganization was informed by a recent assessment of how Deputy Attorneys General could improve their representation of DYFS. This assessment concluded that the Division of Law needs to increase its supervisory staff and improve the supervision of DYFS deputies by reducing the practice of supervisors carrying their own caseloads.

Implementation Step: In order to maximize the Division of Law's representation of agencies, including DYFS, "Education, Health and Human Services" is divided into 4 practice sections, each with its own Section Chief, including two for DYFS.

The goal of the reorganization is to allow supervisors and line deputies to better focus representation on specific clients and areas of law so that DYFS receives the best representation possible. With this reorganization, the DYFS practice group is headed by an Assistant Attorney General with assistance from the DAG in charge of DYFS.

To ensure closer, more effective coordination between DYFS and the attorneys who represent it in court, we will also take the following steps:

- By October 2004, DYFS and the Department of Law and Public Safety will review and revise the existing protocol delineating how disputes that may arise between the two entities in individual cases are to be handled and resolved; the revised protocol will be distributed to all DYFS caseworkers and supervisors, and all DAGs representing the agency and their supervisors.
- By January 2005, we will develop and implement a plan for joint training of DYFS caseworkers and the DAGs who represent them.
- By July 2004, senior managers of the DAGs representing DYFS will be invited to participate as contributors to the Office of Children's Services senior management team, so there will be close coordination and partnership on all issues regarding child welfare and the courts.
- The caseload standards for DAGs representing DYFS are 70 PRS cases (protective service cases) or 20 GSP cases (TPR/guardianship cases) or 50 OAL (Office of Administrative Law) cases; these standards will be achieved by June 2005.

Time Frame: The reorganization will be completed within 30 days of the effective date of this plan.

4. Consolidate the Family Court case calendar so parents, attorneys and case workers do not spend unnecessary time in court waiting for their case to be heard.

Rationale: Attorneys, caseworkers and parents often spend lengthy periods of time in court waiting for their cases to be heard – time they could be attending to other important responsibilities.

Current Situation: DYFS caseworkers' primary responsibilities are fulfilled in the field, with clients, and in their offices. Parents also have jobs and other children to care for. Attorneys must spend time counseling their clients, preparing for trial and handling administrative and other work. Yet cases are at times inefficiently scheduled and then delayed, preventing the parties from adequately attending to their other responsibilities.

Implementation Steps: The CICIC will monitor Family Court calendar consolidation efforts in each vicinage and will make necessary recommendations to ensure that court calendars are more responsive to the needs of families, caseworkers and counsel to the parties.

The CICIC will evaluate and report to the Director of the Administrative Office of the Courts within 30 months of the effective date of this plan on the impact of the consolidation strategies on the amount of time children and families, DYFS workers, DAGs, Law Guardians, and counsel for parents spend in court. This report will also discuss the impact of these protocols on the efficiency of proceedings and timeliness of dispositions. The Director of the Administrative Office of the Courts will then share this report with the other members of the ICCF.

The strategies and recommendations for implementation by local family courts may include the following:[127]

- DYFS cases should be consolidated on the calendar, and each District Office's cases should regularly be scheduled no more than one day each week, on the same day each week, so caseworkers will not regularly have to appear more than once each week.
- In counties where "FN" and "FG" cases are handled by different deputies and are split between District Office and ARC workers, "FN" cases should be listed on a different day than "FG" cases.
- When more than ½-day of cases will be heard, the calendar should be divided between 9:00 and 1:30. The DAG should be consulted so that if a caseworker has more than one case, his/her cases are consolidated to allow her to spend no more than ½-day in court.
- The DYFS cases should be heard without interruption for other than emergent cases.
- Non-CIC courts that need DYFS information (juvenile, domestic violence, matrimonial, etc.) should obtain information in writing from DYFS. If an appearance is required because a written report is incomplete or unavailable, a specific time for the worker's or deputy's appearance should be set and kept.
- Fact-finding hearings should not be interspersed with regular reviews. Either a different day or part of a day should be allocated so shorter hearings can be efficiently consolidated.
- If the court determines that sufficient documentation is available to allow a hearing to proceed without the worker, and unless the DAG is appearing and requires otherwise, workers should be excused from appearing. If necessary, workers can arrange to be available by telephone.
- Consideration should be given to prospectively forming "teams" in counties where there are large dockets. That is, if one DAG and one Law Guardian work with part of one District Office, their cases can be consolidated, with the remainder handled by another DAG, law guardian and the other unit(s) within the DYFS office and scheduled at a different time.
- Hearing times of cases with pool attorneys representing parents should be coordinated so that the attorneys are not scheduled in two courts at once, thus keeping one set of parties and one court waiting.
- Courts should expect and enforce timely appearances by all parties at the given start time, e.g., 9:00 a.m. or 1:30 p.m.
- When all parties agree, cases can be marked "ready hold" for a set time, to accommodate one party who may know they cannot appear at the given time.
- The DAG assigned will be prepared and will know the case(s). In the rare instance that the DAG unexpectedly becomes unavailable, reasonable accommodations should be

[127] Not all these steps will be appropriate in every vicinage, depending on local variables including caseloads and others, but all will be considered in each vicinage.

made by the Attorney General's office to provide a DAG so the cases scheduled for that day may proceed without delay.

- When the regularly scheduled "DYFS" day cannot accommodate all the required hearings in a week, a single "overflow" time (per month, if possible) should be set for all remaining non-emergent hearings.
- Court should not be scheduled on conference days (regularly scheduled days when DAGs have appointments to advise DYFS staff about the legal options available on pending and anticipated court cases).
- Proposed forms of court orders should be prepared prior to the commencement of a hearing to minimize time spent in court preparing orders.
- Fact-finding hearings and guardianship trials should be scheduled on consecutive days until they are completed to avoid repeated preparation and re-visiting of facts and issues already covered. Similarly, barring extraordinary circumstances, DAGs should not be required to begin a new hearing or trial before the same judge until a pending one is completed, as this leads to confusion and inefficient repeated preparation.
- An effective mechanism for prioritizing the scheduled cases on a particular day should be set up and adhered to. Often the DAG will know which case(s) are ready and can efficiently call cases in an appropriate order. Sheriff's officers and court staff often fulfill the same function when they check parties in.
- Consideration should be given to scheduling a pre-hearing conference several days in advance of a fact-finding to determine whether the case needs to go forward or a stipulation obviating the need for a hearing is anticipated. Similarly, in appropriate cases, a pre-trial conference should be scheduled about 30 days prior to a guardianship trial date, to determine whether a trial is needed or a surrender is anticipated. This would save considerable preparation time and would reserve blocks of court time presently left vacant when trials fold.
- Courts should utilize case management orders approved by AOC to promote timely distribution of court reports and pre-trial discovery.

Timeframe:

Local Children in Court Advisory Committees in every county were established to resolve local issues around the coordination of the activities of the agencies involved in the disposition of the children in court cases. Within six months of the effective date of this plan, each local Children in Court Advisory Committee will report to the CICIC on its progress in implementing the foregoing actions.

5. Deploy video-teleconferencing technology statewide in Family Courts and DYFS offices so attorneys, experts and caseworkers do not spend unnecessary time in court waiting for cases to be heard.

Rationale: Same as for strategy four.

Current Situation: Same as for strategy four.

Implementation Step: DYFS Video Conferencing Solutions

DYFS will implement over 24 months a plan to use Video Conferencing in each of its District Offices as well as computer training rooms. Video conferencing will:

- Improve the Division's ability to provide training to all DYFS staff so they will not always have to travel to attend training.
- Improve communication between all areas of DYFS and DHS, as employees could participate in meetings without the need to travel.
- Allow Division staff to make court appearances without making trips to courthouses.

The initial roll-out of video conferencing for court proceedings will be limited to two types of proceedings, pending a determination by the ICCF and the respective participants about whether to recommend expansion to other proceedings:

- Filing of new Complaints where parents are expected not to appear or to appear without counsel; and
- Regular PRS reviews or GSP case management conferences where the DAG has had an opportunity to conference the case with DYFS staff and a court report (PRS) or other required submissions (GSP) have been filed on time. It was felt that expansion beyond this might compromise the Division of Law's ability to effectively represent DYFS and was not recommended until an assessment of this concept is implemented.

Timeframe: Within 24 months, deployment statewide. The plan calls for a standard setup for each DYFS site that will allow videoconferencing with one other location, which would primarily be the courts. DYFS Central office, the Offices of the Child Advocate and training sites will also be equipped and linked so that multiple locations can be part of the same video conference. This would primarily be used for meetings and training.

6. Expedite the processing of abuse and neglect cases.

Rationale: To be in compliance with the ASFA mandate, there must be a judicial decision on reasonable efforts to finalize a permanency plan within 12 months of the child's entry into foster care, and prompt action to effect that placement. This time frame is not being met consistently.

Current Situation: In the processing of abuse and neglect cases, there are a number of places where delays occur. First, fact-finding – that is, an adjudication on the issue of abuse or neglect – is to be completed within 4 months when a child is placed out of the home. As of December 2003, 192 of these cases were not in compliance with this standard. Second, when a child is placed in a DYFS placement a permanency hearing must be held within 12 months. As of December 2003, there were 13,294 active cases with the child in placement, 386 of which were not in compliance with this standard.[128] Third, DYFS is required to make all out-of-home placements known to the court within five days. The court then calendars the case and tracks ASFA time frames. In December 2003, 503 placements were reported, only 184 within the five-day timeframe.

[128] All but 56 of these cases were in Essex County.

Implementation Steps:

- The CICIC will recommend a mechanism for electronic filing to the ICCF for implementation (within 24 months of the effective date of this plan).
- Interface court and DYFS data systems so that cases can be tracked and information shared efficiently (within 30 months of the effective date of this plan).
- The Department of Law and Public Safety will monthly receive data from the Administrative Office of the Courts tracking FC, FN and FG docket volume by county in order to deploy resources appropriately (immediately upon the effective date of this plan).
- A performance improvement plan for the Family Court in all vicinages to comply with the permanency hearing requirements will be monitored by the Administrative Office of the Courts to ensure that ASFA standards are met (immediately upon the effective date of this plan).

Time Frame: As stated above.

7. Eliminate Voluntary Placements.

Rationale: The utilization of Voluntary Placements deprives parents of legal representation in a judicial setting. When children are placed voluntarily into the care and custody of DYFS by a parent or guardian, they may languish in out-of-home placement longer than children who are involuntarily placed.

Current Situation: Of the children placed voluntarily, 1,306 children have been in placement longer than six months without an FN docket being opened, in violation of current state policy.

When voluntary placements are discontinued, it is assumed that the abuse and neglect docket will increase, requiring an expansion in judicial and attorney resources. It is impossible to know in advance what percentage of the current voluntary placement cases would enter the DYFS system as abuse and neglect cases, and what percentage would fall to a lower tier of the service continuum described in the prevention section of this plan and appropriately proceed without judicial oversight.

Implementation Steps:

- Starting October 2004, DYFS will begin a year-long program to phase out voluntary placements.
- The program will phase in the change vicinage by vicinage, in accordance with a schedule developed in consultation with the AOC and the Department of Law and Public Safety. Essex County will be in the first wave of implementation, starting October 2004.

- DYFS, the AOC and the Attorney General's Office will carefully monitor the effect of this policy change as it is phased in, and will adjust their respective staffs as necessary to end voluntary placements statewide by October 2005.[129]

Time Frame: As delineated above

8. Develop mechanisms for DYFS and Probation to collaborate, as appropriate, in cases where they are both involved.

Rationale and Current Situation: DYFS and Probation work with many of the same children and families, yet are often unaware of this fact and thus cannot develop coordinated case planning strategies. In those cases where DYFS and Probation are aware of one another's involvement in a given case and would like to exchange relevant information about the child and family, there are no protocols to permit them to do so in conformity with confidentiality requirements.

Implementation Steps:

- IT staffs at AOC and DYFS will work together to develop a mechanism for alerting DYFS of cases where there is Probation involvement and Probation of cases where there is DYFS involvement, consistent with existing statutes (by December 2004).
- If DYFS and Probation agree upon the need for additional information sharing which requires statutory change, statutory language to this effect will be proposed to the Legislature by no later than December 2004.
- Develop protocols, in conformity with confidentiality provisions, for the exchange of appropriate information between DYFS and Probation, and for a greater understanding of the roles each plays (June 2004).
- Develop strategies for Probation and DYFS to coordinate service delivery in cases involving the same child or family (October 2004).
- Develop Memorandum of Understanding between DYFS and Probation for information sharing purposes by April 2004, and for joint case management when appropriate by October 2004.

Timeframe: See above.

9. Improve the culture of the courts to better respond to the needs of children and families.

Rationale & Current Situation: Courts can be a confusing and unsettling place for children and families. Often parents do not fully understand the court process and what may be at stake, especially in regard to termination of parental rights. ASFA requires that foster parents must receive notice of, and have an opportunity to be heard at, proceedings regarding children in their care. This has been identified as an area of significant non-compliance in New Jersey's Children and Family Services Review.

[129] There will one narrow exception to this policy change: children given to DYFS for adoption at birth, whose mothers cannot legally relinquish them for adoption for three days, will continue to be accepted into the system voluntarily for this three-day period.

Implementation Steps:

- The CICIC will coordinate with the respective agencies involved in developing and instituting trainings for attorneys, judges, Resource Families, birth families and youth on how to assure that families understand, and feel respected, during the court process (roll out beginning March 2005).
- The CICIC will make recommendations which focus on ensuring that parents are notified promptly of the court hearing, especially the return date on the order to show cause, have counsel, and appear in court (by March 2005). The New Jersey Child Welfare Panel will decide whether and to what extent to incorporate these recommendations into this plan.
- The CICIC will make recommendations to ensure that foster parents receive notice of, and have an opportunity to be heard at, proceedings regarding children in their care. The New Jersey Child Welfare Panel will decide whether and to what extent to incorporate these recommendations into this plan. (December 2004)
- The CICIC will make recommendations to strengthen the role of resource families in the court process. (December 2004)
- The CICIC, in partnership with county-based local teams, will undertake in each vicinage an assessment of the larger picture of what parents and children experience in the court building. These will evaluate interactions with court officers, security staff and others, the length of time they wait, the extent to which anyone explains to them what is going on or why there is a delay, and whether there is a physical setting appropriate for children. A frank assessment of what families are experiencing now and what it will take to change that experience is essential. The CICIC will ensure the use of focus groups (children, biological parents, foster parents) as a means to gather information on the delivery of services and how to improve upon the same. (assessments completed for each vicinage by August 2005)
- The CICIC will make recommendations based on these assessments to the Director of the Administrative Office of the Courts, to improve the experience of children and parents in court (by January 2006). These recommendations will then be shared by the Director of the AOC to the other members of the ICCF.
- A plan to improve the culture and responsiveness of the courts for children and families will be presented by the ICCF to the New Jersey child welfare monitor (by March 2006).
- Training in all professional areas to insure cultural proficiency in dealing with DYFS-involved children and families.

10. Plan and operationalize alternative and innovative court models across the state.

Rationale: At the heart of many abuse and neglect cases are drug and alcohol problems. Yet parents often do not receive the drug treatment services necessary to address their addiction. In Family Drug Courts (FDC) – much as in criminal drug courts – a multidisciplinary team provides readily accessible treatment, therapeutic services and supervision.

Current Situation: Plans are underway to pilot a family drug court in the Morris/Sussex Vicinage for five families, in which substance abusing parents will be provided with treatment and wrap-around services. Upon favorable evaluation, the model will be expanded to more families and other counties.

Implementation Steps:

- The AOC will monitor and evaluate the results of the Morris/Sussex FDC pilot and, if appropriate, expansion in the number of families it serves.
- Determine whether continuation or expansion of the FDC pilot is appropriate.
- If appropriate, plan and roll out FDCs in identified counties based upon recommendations from the pilot evaluation.

Timeframe: Complete program evaluation by March 2006.

11. Take additional steps to ensure effective representation of children and parents in child welfare proceedings.

Rationale: In our adversarial system of justice, the best outcomes are achieved when all parties are represented by counsel who are well trained and supported, have reasonable caseloads and appropriate supervision, and are otherwise able to represent their clients effectively. The DAGs who represent DFYS were discussed previously. This section addresses the representation of children and parents.

Current Situation: Children are represented by the Law Guardian Unit of the state Office of the Public Defender (OPD), which has a large in-house staff. Parents are also represented by the OPD, which has a small in-house staff for this purpose (the parental representation unit, PRU, which mainly handles appeals, with almost all the trial level representation being handled by pool private sector attorneys paid on an hourly basis for this work.) This model raises several concerns. First, there is concern about the conflict of interest inherent in having both parents and children, who in a given case may have very opposing interests, represented by the same organization. Second is the fact that because most of the parental representation is not institutionalized, but handled by the individual pool attorneys, most parents are represented by counsel without reliable access to ongoing training, support (from paralegals, investigators, or the like) or supervision, which cannot but affect the quality of parental representation. Parents are often represented by different attorneys during the course of their cases, undermining both the quality of representation and the parents' confidence in the operation of the system as a whole, at a time of particular legal and emotional vulnerability.

Implementation Steps: To improve the legal representation of children and parents, the following steps will be taken:

- There will be an independent, expert assessment of and report on both (a) the quality of legal representation of parents, and (b) any legal conflicts of interest in the organizational structure, which report will also include recommendations for any changes deemed appropriate in either area (by February 2005).[130] The state will have 45 days from the

[130] To ensure requisite independence, the Child Welfare Panel will select the person or institution to conduct this analysis and will draft the scope of work by August 2004.

receipt of this report to develop a plan to address any and all issues the report may identify as warranting redress.[131]

- The implementation of recommendations from the report that create any changes to the structure or process by which parents or children are represented must attend to the quality of the resulting representation. Any restructuring of representation will ensure that attorneys work on child welfare cases exclusively; will be able to receive appropriate pre-service training; will have the benefit of professional camaraderie with more experienced attorneys in the same field; will have access to appropriate institutional supports such as paralegals and investigators; will have appropriate supervision; and will be housed in an organization dedicated to child welfare representation, with an institutional memory for such work and an obligation to keep current on all doctrinal developments bearing on it.
- The caseload target for the representation of children will be established by July 2004.
- The caseload target for the representation of parents will be established by July 2004.
- The CICIC will develop a process, for implementation by March 2005 to ensure the continuous representation of parents by the same attorney from the first judicial proceeding.[132]

[131] This plan will be subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

[132] The process will provide for representation of parents at the initial judicial proceeding by an attorney from the institution representing parents, with income eligibility for such public representation presumed. Should a parent be determined to be income ineligible for such representation, they will need to obtain their own counsel for subsequent proceedings. But a significant majority of parents in the child welfare system are eligible for public representation.

■ DEVELOPING THE NECESSARY CULTURE AND WORKFORCE

To meet the commitments in this plan, we must fundamentally transform New Jersey's child welfare system. We must become a new organization—a learning organization with the new goals articulated throughout this document. To accomplish this we must have:

- a newly trained, empowered and deployed workforce;
- new ways of communicating, reinforcing and building ownership of the reform process among our own staff, the families with whom we work, and our community partners;
- new cultural competencies;
- new collaborative ways of doing business with children, birth families, resource families, neighborhood organizations, service providers, other governmental agencies, and the courts;
- a new organizational structure, from Trenton to the District Offices;
- new ways of helping our staff to continuously improve their skills and enhance their careers; and
- a new institutional ability to honestly and regularly assess our progress, so both our successes and our failures contribute to our learning and improvement.

Learning organizations are reflective, constantly gathering information about how they're doing, assessing themselves with rigor, open to other perspectives and possibilities, always refining their ways of doing business in response to what works and what doesn't. Currently our organization is reactive and crisis-driven. We must transform it.

This will require enormous institutional change, by an agency with a high and important workload, low public support, and a staff reeling and demoralized from the events of the past year. It will not happen overnight. But it will happen.

We make the following **commitment:** We will build a learning organization by changing the culture of the agency, providing effective training to the workforce and partners, improving communication, and using a holistic approach to staff development that will enable the child welfare system to meet the needs of children and families in accordance with this plan.

To do this, we will employ five **strategies:**

1. **We will redefine and clarify the roles and expectations of our staff and our partners**. People cannot work effectively, particularly in a changing organization, without knowing exactly what is expected of them. We will clearly explain everyone's role. We will work with our partners – resource families, birth families, community collaboratives, service providers, and others – to develop common understandings of their roles in this new system and, importantly, of what they should expect of us. These messages will not be communicated just once; they will be regularly reiterated, discussed and reinforced.[133] Having appropriate degrees or experience prior to joining us will make our workforce more effective. We already have a preference for hiring front-line staff with MSWs, BSWs, or

[133] We will work with the Department of Personnel to revise the civil service examinations so they will better identify candidates with the skills necessary to child welfare work.

degrees in related fields.[134] By 2007, we will require that all front-line staff have either such a degree or a minimum amount of experience in a human service or related field. In accordance with our goal of becoming accredited, we will require that all supervisors hired or promoted in 2009 or later have MSWs or other advanced degrees consistent with accreditation standards.

2. **We will build a network of communication within the system and with its partners**. We will build a culture of open and frequent communication throughout the system. Too many members of our system, both public employees and private partners, feel isolated in their day-to-day activities, with no sense of common purpose or how their role fits into a broader strategy. This plan cannot succeed without fixing this. We must communicate our vision repeatedly, internally to our staff and externally to those we serve and to our partners, until the commitments of this plan become the air breathed by all the system's participants and partners. Through Web sites, e-mail, newsletters, town hall meetings in communities, letters to birth and resource families and adolescent foster children, op-ed submissions, and all other means at our disposal, we will strive to share our vision for the child welfare system, where we stand in the journey to achieve that vision, what needs to happen next, and what we're asking everyone to do in the next stage. We will ensure that these communications are two-way, and will actively seek consistent input from all quarters so our implementation strategies remain informed by reality.
3. **We will establish the New Jersey Child Welfare Training Academy to retrain current staff, and transform our pre-service and in-service training for our workforce and our partners.**[135] This plan calls for many new skills, new positions, and new ways of doing business with our clients and other partners. People cannot do what they do not know. We must create a new system and partnership with social work and child welfare educators and practitioners to ensure that our training and practice are on the cutting-edge and supportive of the commitments in this plan. We must retrain our existing workforce, and train all new employees, in accordance with our new approach. The training must encompass all levels of the system, from the front lines up the supervisory chain to management, with supervisors being trained before their reporting staff.[136]

   We will create and fill a new position in the Office of Children's Services: the Assistant Commissioner for Training, who will oversee the development of the training academy and other workforce development initiatives.

   The New Jersey Child Welfare Training Academy (NJCWTA) will be a new internal training academy under the OCS Assistant Commissioner for Training. Drawing upon the expertise of DHS, DYFS, training experts, child welfare leaders, and social work programs at

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[134] Of the 72 new caseworkers hired on April 19, 2004, 53, or 73%, have social work or related degrees (including psychology, guidance and counseling, or a related behavioral science area such as sociology or family and children's studies). Three have MSWs.

[135] The development of the Child Welfare Training Academy and the pre-service and in-service training curricula will be subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

[136] It is worth noting that police officers train full-time for many months before going out on patrol. Child welfare workers, whose work is also extremely difficult and also can involve potentially life-and-death decisions, typically train for far less time.

universities and colleges in the state, we will develop a range of new culturally competent curricula for various positions, informed by both clear delineations of the skills required for each position (as noted in strategy one, above) and a skills assessment program to determine our workforce's current abilities. We will draw on the expertise of leading national consultants in child welfare training to develop the soundest curricula and plan for their effective delivery. We will hire many new internal trainers to build our capacity to work with NJCWTA to meet the organization's training needs. We have already developed a new civil service training title, Educational Program Development Specialist. We will supplement our in-house training staff with highly qualified contracted trainers.

All new case carrying staff will receive a minimum of six weeks of training, including three weeks in the classroom and three weeks on the job. We will develop and implement a program of competency testing at the end of pre-service training, with continued employment contingent on demonstration of satisfactory knowledge and skills. The development of our information systems will include the capacity.

In developing the NJCWTA, we will seek supportive working partnerships with leading academic institutions in the state. The Office of Children's Services will retain the lead role in the development process, to ensure that the academy's priorities will be directly responsive to OCS's training needs.

In addition to helping to train our staff, NJCWTA will assist with training resource families and staff at contract agencies that provide services to our children and families. The NJCWTA will also help develop multimedia tools to inform other important parties – judges, law enforcement, doctors and nurses, law guardians, local government officials, staff at private service delivery organizations, community-based and religious organizations, our union partners, and others – of our new approach and how they can contribute to its success.

We will undertake a system-wide assessment of cultural competency – a concept that involves much more than the demographics of the system's frontline, supervisory and managerial staff – by illuminating every point of contact with families and communities, and determining whether we are knowledgeable about, and respectful of, the many different cultures and histories of our families and communities.[137] We will work with the Panel to identify an appropriate organization to conduct this assessment. The results of this assessment and ensuing recommendations will be woven into the training curricula, practice model, recruitment efforts for staff and resource families, and agency printed materials, and will otherwise be implemented as deemed appropriate (again, after consultation with the Panel).[138]

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[137] This assessment will include review of the system's ability appropriately to meet the needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. By June 2005, a comprehensive plan to address the unmet needs of this population – including cultural sensitivity, targeted resource family recruitment, development of requisite programming, and staff training – will be developed.

[138] Evidence suggests cause for concern regarding the system's cultural competency. Of the children discharged from out-of-home care in 2003, 28.1% of African-American children and 29.9% of Hispanic children were reunified with their families, compared with 36.7% of White children. Of the children in out-of-home placement on January 2, 2004, their mean length of time in care as of that date was 12.74 months for White children, 12.99 months for Hispanic children, and 18.5 months for African-American children. In 2002 (the last full year for which data are available), abuse and neglect reports were substantiated in 18.1% of cases involved White children, 21.4% involving Hispanic children, and 24.9% involving African-American children.

Given the size of our system, the training program will be a massive undertaking. We will prioritize by developing training curricula and skill development strategies in two areas of the new practice model: ensuring child safety, and engaging families and communities. This will involve training staff as quickly as possible, system-wide, on Structured Decision Making (SDM), Family Team Meetings, and protective service investigation skills. The rest of the identified training and skill-building will be delivered first to staff and partners in the communities of highest need, then rolled out statewide.

The SDM training will focus on using the forms as tools to help understand, evaluate and incorporate child safety, risk and well-being factors throughout the life of a case. It will be emphasized that SDM is only a set of tools, and that it neither substitutes for good social work practice nor formulaically determines all decisions about children and their families. The SDM training will incorporate an introduction to Family Team Meetings and how to use SDM in the context of joint decision-making and engaging children and families.

We will roll out the new case practice model starting with its central element, Family Team Meetings. We will begin by identifying and training a group of highly skilled staff to lead and model the use of Family Team Meetings, as full-time positions until other staff have been trained. In selecting staff, we will consider the following factors:

- Training staff in our communities of the highest need.
- Training caseworkers and their supervisors together whenever possible.
- Some staff are already familiar with joint decision making through family group conferencing and other team approaches.
- Developing leaders from all levels of the organization to provide peer and colleague support.

These leaders will help train and model the Family Team Meeting process across the system. They will begin facilitating meetings throughout the state. The Family Team Meeting immersion training schedule for the remaining workforce will focus on our communities of the highest need first.

Finally, we will prioritize the training and skill development necessary to ensure that our staff will conduct professional, standardized, culturally competent and collaborative investigations of child abuse and neglect. A new culture and way of doing business must be clear to children and families at their first interaction with the system—caring, engaging, helpful, knowledgeable, and fair staff working with the family and community to address allegations of abuse and neglect.

In short, the training program sequence will be:

- SDM training for the entire staff (existing and, as they arrive, new), over three months, focusing on child safety criteria and including a two-day introduction to family team meetings so everyone will be familiar with them;
- Training a cadre of family team meeting specialists who will facilitate family team meetings statewide, starting in the areas of high need, as the first element of the new practice model;
- Training on the entire new practice model, region by region, beginning with areas of highest need, including both frontline and supervisors trained together.

4. **We will develop a program of ongoing skill-building and career development for our staff.** As we've said repeatedly, child welfare work is very hard. While training is essential, as with all difficult things expertise is acquired only experientially and over time. When we lose experienced, talented staff, we lose an invaluable resource. In 2003 (a particularly challenging, tumultuous year), 12.4% of our case-carrying staff left the system, which extrapolates to a turnover rate greater than 37% every three years. This system needs to create a new culture, that is, shared experiences, common goals, institutional memory. Doing so is difficult with so many people leaving each year. So we must make the child welfare system a place where the staff are respected and want to stay. In the short term, we also must attend to the demoralization that now pervades the workforce as a result of the events of the past year.

   We will attend to our employees' mental health through staff support days, various incentive programs, and crisis response for staff involved in particularly difficult and disturbing cases. We will enhance our program of tuition reimbursement, so our employees can increase their knowledge by pursuing degrees relevant to their work.[139] We will have ongoing skill-building curricula. We will change the supervisory model, so supervisors will be mentors and coaches, identifying and helping to address supervisees' skill and knowledge gaps. We will make career paths clear and possible, explaining opportunities, what is required to take each step, and how the system will assist interested employees.[140] We will solicit employees' feedback on all this, and strive constantly to improve it.

   None of this is incompatible with the accountability critical to achieving necessary outcomes for children and families. Child welfare work is difficult and essential, and is not for everyone. At every level of the system, from top to front line, supervisors will be responsible for helping their supervisees to identify and fill the gaps in their skills and knowledge, while also documenting any deficiencies so that, consistent with the system's existing program of progressive discipline, those who cannot master the work can be moved to more suitable positions. We will implement a program of ongoing, competency-based evaluation for management and staff at all levels of the agency. This plan provides myriad new supports for staff – limited caseloads, necessary equipment, substantial retraining, support in career development, and more – and must, for the sake of the clients, expect that the staff at every level take up the new work with vigor and competency.

5. **We will utilize data, case situations, and critical incidents as learning tools.** Learning begins with information, which starts with data. We will develop regular data reports (ultimately from our SACWIS system, until then from the existing systems) to feed up and down the agency on key variables and trends. We will have case record reviews and other methods of garnering qualitative information.[141] We will have a data analysis unit dedicated to moving us from data to information to knowledge. We will seek out best

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[139] We will explore the possibility of granting salary increases to staff who attain such degrees, and of having the state fund (up front, not as reimbursement) a certain number of staff each year pursuing relevant advanced degrees (for example, through an executive MSW program).

[140] This commitment covers both our clerical and support staff, as well as our professional staff. We work with the state Department of Personnel to develop additional "bridge titles," through which qualified employees can transition from clerical or support positions to professional positions.

[141] Much of this is discussed in greater detail in the section of this plan on Continuous Quality Improvement.

practices and promising innovations from around the country.[142] We will develop systems and continuous feed-back loops to infuse the organization at all levels with the knowledge we develop, and to improve practice in response. We will use case situations, critical incidents and child fatalities as opportunities to learn, improve case practice, and identify training and skill building needs.

Implementation Steps

Clarifying Roles and Expectations

- We will hold meetings with union leadership to explain, review, and discuss this plan, and will develop a Task Force that includes union leadership to continue this partnership.
- We will have held at least one meeting in central office, each area office, and each District Office with every level of staff to explain, review, and discuss this plan. These open-discussion meetings with DYFS leadership will occur quarterly at every office, and will include union shop stewards. (April 2004 – September 2004).
- We will hold meetings with key stakeholders and community partners to explain, review, and discuss this plan. These meetings will include: court systems, contracted agencies, advisory groups, advocacy organizations, unions, etc. (January 2004 – June 2006).
- Working with staff and union representatives, we will clearly define the roles for all staff positions impacted or created by this plan, and will redraft job descriptions as necessary. (March 2004 – July 2005).
- We will distribute an initial letter to all birth and resource families involved with DYFS explaining the plan. (June 1, 2004 – June 15, 2004).
- We will submit all required paperwork to the Department of Personnel (DOP) and OMB for the approval of additional positions. (July 2004 – July 2005).

Building a Communications Network

- We will develop a transition monitoring team (TMT) comprised of 7 -12 people chosen from a wide cross-section of the organization to take a continual pulse of the organization in transition and facilitate dialogue both upward and downward. TMT will use a variety of methods to provide feedback, including staff surveys, suggestion boxes, talks with Director, etc. (July 2005 – August 2005).
- We will begin publication of a monthly electronic newsletter to all DYFS staff with information about progress on this plan and other important child welfare developments in the State. (July 2004 – October 2004).
- We will institute a policy requiring all management staff to hold bi-monthly informal discussions with direct reporting staff to answer questions regarding the progress on this plan and other issues. (September 2004 – September 2006).
- We will distribute a letter to all community partners involved with DYFS explaining the plan. (June 1, 2004 – June 15, 2004).

[142] The Child Welfare Panel and its technical assistance consultants will provide a valuable source of this information for the length of their involvement with our system. During this time, we will prepare for the Panel's eventual departure by exploring with the academic, non-profit and philanthropic communities the possibility of developing a permanent research entity on child welfare issues in New Jersey, to both help our system's continual learning process and contribute to the field nationally.

- We will hold a series of community forums to explain, review, and discuss the plan with families and community partners. These community forums will be held every six months across the state. (July 2004 – June 2006).

Training

- We will contract with consultants, child welfare experts and social work and other relevant programs at universities and colleges in the state to develop the New Jersey Child Welfare Training Academy. This Academy will be responsible for developing the full-range of training curricula (pre-service and in-service) for all staff positions and other training needs identified in the plan (e.g., resource families, family team meetings). The NJCWTA will focus on developing: (June 2004 – September 2006)
    - skills-based curriculum for new and ongoing caseworkers, supervisors, and management that addresses areas of substantive information but largely focuses on learning and practicing skills;
    - classroom training supported by integrated on-the-job training components;
    - minimum training hours and requirements for pre-service and in-service training for all staff positions and resource families;
    - a system to permit at a minimum annual assessments of the curricula to incorporate any needed changes;
    - sophisticated evaluation methods to measure and test skill acquisition and transfer of learning to DYFS staff, resource families, and other individuals receiving training;
    - infrastructure to support the capacity to provide effective training, evaluation and outcome measurement of the training program; and
    - skill assessment tools for each level of DYFS staff to be used for pre-service and annual skill assessments. These skill assessments will inform individualized annual training plans for each staff member.

- We will hire at least 5-10 expert trainers to help implement the training program needed for this plan and to serve as the core for the NJCWTA. These expert trainers will begin to assess and train existing DYFS trainers, and recruit more training staff selected for their ability to model and teach core competencies to build the foundation necessary for internal training capacity and the newly created County Trainer positions.[143] (September 2004 – December 2004)
- We will identify at least 50 staff to become leaders of the transition to Family Team Meetings, who will participate in intensive training.

[143] For a more detailed information about the units and staff that will support training efforts statewide and in local offices, see the section of this plan on "The DHS Office of Children's Services: Creating an Integrated System of Care for Children and Families." The County Trainers will be responsible for helping managers and supervisors in local offices identify and meet training needs based upon data, surveys and case reviews.

- We will identify a consultant to develop strategies to educate and inform community partners that require in-depth knowledge of the new case practice model, resource family system and organizational structure. These sessions will begin through classroom, CD-ROM, and video conferencing training sessions. The community partners requiring this type of training will include at a minimum: (September 2004 – December 2004)

    - Judges and court staff
    - DAGs
    - Law Guardians
    - Medical professionals
    - Hospital staff
    - Law enforcement
    - County and local government officials and agencies
    - State government officials and agencies
    - Transportation Aides
    - Nurses
    - Paralegals

- The SDM training curriculum will reflect the need to incorporate the use of SDM tools in the context of engaging children and families, and provide an introduction to the Family Team Meeting process. (July 2004)
- The revised SDM training for all staff will begin and will be included in the new worker training. (July 2004)
- We will develop and use the new training curriculum for Family Team Meetings for the identified staff who will lead the transition effort. The DYFS staff trained will help with training and model the process as the system wide training on Family Team Meetings occurs. The DYFS staff trained will also serve as expert facilitators. (October 2004)
- Training of all DYFS staff will begin on the Family Team Meeting process (with priority of supervisors trained before staff in communities of highest need). All DYFS staff will be trained. (October 2004 – October 2005)
- The new curriculum for the following DYFS staff positions incorporating the new practice model will be developed and training begun (with priority of supervisors trained before staff in communities of highest need): (October 2004 – October 2005)[144]

    - Caseworkers (pre-service and in-service for Child Protection Workers and Permanency Workers)
    - Supervisors (Child Protection Supervisors and Permanency Supervisors)
    - Casework supervisors
    - Management staff
    - Resource Family Trainer
    - Resource Family Recruiter
    - Resource Family Support Workers
    - Community Developers

[144] An assessment and evaluation of the curriculum in support of the implementation of this plan will be developed by October 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

- We will hire an expert in the field of assessing cultural competence of organizations to develop an instrument to assess and prepare a report by July 2004 evaluating how well the organization delivers services to culturally diverse populations. The recommendations from this assessment will be incorporated into the training, communications and operations of the system. (August 2004)
- We will work with contracted agencies to develop a joint-training plan that ensures staff at contracted agencies receive at least the same quality, amount and type of training provided to DYFS staff. This plan will involve at a minimum contracted agency staff attending DYFS training as well as revisions to internal training curricula for contracted agency staff. (July 2004)
- We will begin utilizing skill assessment tools to develop individualized annual training plans to focus on-going training on skill development. (September 2005 – September 2007)
- The new curriculum for Resource Families (pre-service and in-service) will be developed. This training will be delivered through local team training networks consistent with the phase-in plan. (January 2005 – July 2005)
- We will develop the curricula and begin training for the DYFS staff positions listed below. This training will be rolled-out first in our communities of highest need. (January 2005 – October 2005)
    - Adolescent Specialists
    - Adoption Workers
    - Substance Abuse Workers
    - Clerical
    - Litigation Specialists
    - Case Practice Specialists
    - Domestic Violence Workers
    - Community Developers
    - Case Aides
    - Transportation Aides
- The NJCWTA will be fully developed to support training capacity for all DYFS staff and community partners' training needs, utilizing both its own faculty and outside training experts. (July 2007)

Skill Building and Career Development

- We will work with union representatives and staff to develop clear policies to create monthly "Staff Support Days" for every DYFS office that will provide assistance and programs for staff to address quality of life and stress management issues. We will implement monthly "Staff Support Days." (June 2004 – July 2004)
- We will work with staff, union representatives, mental health experts and crisis management experts to develop policies for both mandatory and optional crisis response systems for DYFS staff statewide. This system will involve mandatory debriefing and therapeutic interventions for staff involved with certain types of crises, such as: child deaths, work place or work-related violence, colleague death, etc. The optional crisis

response program will address other critical incidents or situations where staff at any level will be able to utilize the response system. (July 2004 – December 2005)

- We will ensure that the training curriculum, job specifications and expectations for supervisory and management staff shift from primarily a monitoring function to reflect principles and skill development in coaching, mentoring, and behavior modeling. (July 2004 – July 2005).
- We will contract with a consultant to develop a comprehensive system and tools to measure staff satisfaction. This system will include, at a minimum, annual surveys and exit interviews. (August 2004 – October 2004)
- We will work with DOP, union representatives and staff to revise promotional requirements and procedures to reflect changes in staff positions and the promotional system. These revisions will include, at a minimum: (July 2004)
  - civil service tests that better evaluate skills needed for positions, and
  - current staff being able to attend training classes for promotional positions prior to applying.

- We will work with higher education institutions and community colleges to evaluate and redesign tuition reimbursement and incentive programs for educational and skill-building opportunities for all levels of staff. Over time, these opportunities will include: (September 2004)
  - MSW for supervisory staff
  - MSW and BSW for casework staff
  - BA, BS or Associate's Degree in relevant topics for clerical staff, case aides and transportation aides
  - Master's Degree in social work, administration, public policy for management staff
  - Certificate programs for casework staff in relevant topics, such as advocacy, adoption, adolescent transitions, family preservation, investigations, etc.
- We will revise and expand internship programs with higher education institutions in New Jersey that offer BSW and MSW programs, to offer eligible social work students both work experience and a stipend through the use of Title IV-E funding. (October 2004 – October 2005).
- We will work with DHS, staff and union representatives to develop a system to enhance career development by providing staff with 360° feedback on performance. This system will include feedback from colleagues, subordinates, families/clients, community partners, and supervisors that interact with the staff member. This system will be used for career development purposes only (not for salary, promotions, etc.). (July 2004 – June 2005).
- We will work with union representatives, DOP and staff to create and distribute to all DYFS staff a career development handbook to explain all educational programs, skill-building programs, and promotional opportunities and procedures. (October 2004 – October 2005).
- We will develop the capacity to track human resources data through web-based applications, including the number of staff at all levels by job title and job function to obtain baseline data and create strategies to improve career advancement where needed. (May 2004 – February 2005)

- We will work with DHS, staff, and union representatives to establish the capacity to provide a career counseling system for all levels of DYFS staff to explore promotional, lateral and educational opportunities. This career counseling system will be optional for staff, and available both in-person and on-line. (June 2005)

Utilization of data, case situations, and critical incidents as learning tools

- Begin collection of baseline data on: (April 2004)
    - Educational level of all staff
    - Retention
    - Best recruitment sources
- Begin collection of baseline data on: (November 04 – December 2004)
    - Employee satisfaction
    - Organizational/employee cultural competence
    - Resource family satisfaction

- DYFS leadership will begin the roll-out of discussions on the vision, mission, core beliefs and this plan. (March 2004)
- We will contract with a consultant with expertise in creating systems and processes to facilitate and manage major change in large organizations. This consultant will be responsible for helping DHS and DYFS leadership create strategies to implement changes and support staff during the difficult transitions. In addition, by June 2004, this consultant will design and implement a formal assessment tool to measure staff satisfaction and organizational climate. DYFS will utilize this assessment tool every June (June 2005-2008) to monitor progress on improving the level of staff satisfaction and organizational climate. (July 2004 – October 2004)
- We will establish a coalition with the Panel, Casey Strategic Consulting Group, foundations, and institutions of higher education to continuously assess and support the exploration of training expertise, information on best practices, successful organizational development interventions, etc. This coalition will develop into a research and best practice center, perhaps based at an institution of higher education that will continuously provide information about child welfare practices to DYFS and the public to ensure that the State remains at the cutting-edge of child welfare practice. (June 2004)
- We will implement a system and policy requiring weekly debriefing sessions at certain times (such as case closure, critical incidents, child fatalities, weekly, etc.) for units/teams to discuss and analyze data and both positive and negative case developments to ensure that staff members learn from case situations and each other. (December, 2004)

Topic and Content Areas for Child Protection Workers and Permanency Workers[145]

Core Competencies

- legal aspects of family-centered child protection
- family-centered child protective services
- case planning and family-centered casework
- effects of abuse and neglect on child development
- separation, placement, and reunification
- cultural competency
- community organizing and advocacy

Specialized Competencies (for certain types of positions or when indicated on individual training plans as a result of skill assessments)

- adoption and foster care
- working with adolescents
- sexual abuse identification
- intake and assessment of risk
- legal issues in child welfare
- services to single parents

Related Casework Practice (for certain types of positions or when indicated on individual training plans as a result of skill assessments)

- treatment strategies and interventions
- family systems theory and family therapy
- casework with children
- recognizing and assessing developmental delay and disability
- parenting skills
- adult psychopathology
- substance abuse
- time and Stress management; personal safety
- cultural competence
- collaborative interdisciplinary services to families
- family violence
- understanding psychological evaluations
- group work skills
- human sexuality
- writing skills for case documentation
- health and medical issues
- Other – sometimes in-service training is needed in areas that are not considered primary child welfare competency areas. Examples are self-awareness, social work values, and communication. These pre-service training issues are most appropriately addressed through pre-employment screening. However, where significant need is documented, in-service training may occasionally be considered a legitimate ancillary approach.

[145] We will refine the following lists of core competencies and skills for staff and resource families to reflect best practices and input from consultants, system partners, and the NJCWTA.

Topic and Content Areas for Child Protection and Permanency Supervisors

Core Skills Training

- supervising within a child and family serving system
- supervising work through other people - diversity in the workplace
- community organizing
- transfer of learning: the supervisor's role in developing staff
- supervising group performance: developing productive work teams

Specialized Child Welfare Supervision

- supervising case plan development and implementation
- supervising sexual abuse services
- supervising services to adolescents
- supervising adoption and foster care services
- supervising intake, risk assessment, and initial family assessments
- supervising in-home family services
- legal issues in child welfare

Related Practice

- planning and decision making
- effective use of power
- supervising for optimal job performance
- employee performance evaluation
- management of conflict
- public and community relations
- time and stress management
- team development and facilitation
- budgeting and fiscal operations
- staffing the agency
- employee relations and union partnerships
- supervising and managing change
- balancing accountability and continuous quality improvement principles
- culture and diversity
- improving practice by utilizing data and management information systems

Topic and Content Areas for Community Developers

Community Developers**:**

- community engagement
- community capacity building
- meeting facilitation
- problem solving
- organizing skills
- leadership modeling skills
- knowledge of child abuse/neglect
- leadership skills
- team building
- evaluation and assessment skills
- understanding the role and responsibilities of the resource family
- mediation skills
- group facilitation
- negotiation skills
- child development
- listening and observational skills
- cultural competence
- advocacy
- public speaking
- developing partnerships with the public and private sector
- grant writing

Resource Family Support Workers**:**

- evaluation skills
- assessment skills
- listening skills
- observational skills
- knowledge of child development
- knowledge of child abuse & neglect
- advocacy
- licensing requirements
- IAIU protocol
- coaching
- cultural competency
- sensitivity
- team building
- negotiation skills
- contracting skills
- mediation/conflict resolution skills
- group facilitation
- understand role and responsibility of resource families
- understanding the impact of separation and loss
- community organizing

Resource Family Recruiters**:**

- public speaking
- developing partnerships with the public/private sector
- team building
- leadership skills
- negotiation skills
- contracting skills
- cultural competency
- networking skills
- understand role and responsibility of resource families

Resource Family Trainers**:**

- public speaking
- group facilitation
- leadership training
- negotiation skills
- team building
- contracting skills
- cultural competency
- sensitivity
- coaching
- evaluation skills
- assessment skills
- listening skills
- observational skills
- understand role & responsibility of resource families
- child development
- IAIU protocols
- licensing requirements
- networking skills

Topic and Content Areas for Managers

Core Skills Training

- managing within a child and family serving system
- managing work through other people - diversity in the work place
- transfer of learning: the manager's role in developing staff
- managing group performance: developing productive work teams

Specialized Child Welfare Management

- managing case plan development and implementation
- managing sexual abuse services
- managing services to adolescents
- managing adoption and foster care services
- managing intake, risk assessment, and initial family assessments
- managing in-home family services
- legal issues in child welfare

Related Practice

- planning and decision making
- effective use of power
- managing for optimal job performance
- employee performance evaluation
- management of conflict
- public and community relations
- time and stress management
- team development and facilitation
- budgeting and fiscal operations
- staffing the agency
- employee relations and union partnerships
- managing change
- culture and diversity
- managing by utilizing data and management information systems
- balancing accountability and continuous quality improvement principles

■ PURSUING HIGH QUALITY, ACCOUNTABILITY & CONTINUOUS IMPROVEMENT

In child welfare systems, as in just about every other human endeavor, stasis is impossible. A system is constantly moving, either forward or backward. New Jersey's child welfare system is large, so its overall direction is not always self-evident; and it is complex, so some parts can be moving forward while others are slipping back. Without a sophisticated program to ensure continuous improvement across the system, this plan would risk being only aspirational ink on paper.

Our **commitment** is this:

- To ensure that New Jersey's child welfare system is continuously improving to meet the needs of children and families and the commitments in this plan, we will develop a robust program of continuous quality improvement (CQI) that will regularly evaluate all aspects of the system, both quantitatively and qualitatively, and this program will be institutionally positioned and operated in such a way that its findings lead directly to necessary programmatic improvements.

The **current situation** does not approach this standard. Although a Quality Assurance[146] (QA) unit has existed at DYFS for the past few years, it has focused on auditing case records to monitor and report on compliance with state and federal requirements. These reviews have helped to identify deficiencies in case practice, but little action has been taken to translate the findings into necessary improvements. Instead, QA reports have tended to collect dust. In addition, standards and benchmarks by which progress toward meaningful outcomes for children and families could be rigorously evaluated have been undeveloped. This is true for both the work the system does itself and the work for which it contracts with private providers. As a result:

- The system lacks a coherent, integrated quality improvement system that provides continuous feedback on performance.
- Change generally occurs in reaction to crises, not through an internally-generated, performance-driven process of evaluation and improvement.
- Data analyses are generally done for compliance evaluations, and rarely lead to program, practice or service changes.
- The system does not have the tools, skills, infrastructure or culture to monitor the outcome indicators and benchmarks in this plan.
- External stakeholders have no role in reviewing the system's performance across the state's 21 counties.
- There is no system for integrating the findings of QA reviews into programs for improved performance.
- There is little evidence whether services children and families receive through the child welfare system match their needs, or whether expenditures are producing results.

[146] "Quality assurance" has been the age-old term for this area, both in New Jersey and nationally. But "continuous quality improvement," which better captures the dynamism inherent in a successful program, is now the term of art.

- Service contracts with community providers are generally static from year to year, and in many cases do not contain specific performance measures.
- There is no link among QA, training and organizational development efforts, although all three need to work in partnership for the agency to improve.
- No consistent method exists to identify or ameliorate gaps in services to children and families.
- The service acquisition system has been organized to provide compensation for the delivery of inputs (e.g., staff hours or bed days) or capacity (e.g., availability of emergency services). It does not relate compensation to client achievements or outcomes, nor does it link financial incentives with state policy or child welfare reform objectives.
- Other than the panels that review child fatalities and near-fatalities, no outside perspectives are incorporated into the QA process.
- As a first step in turning this around, New Jersey plans to use the Program Improvement Plan (PIP) it develops through the federal Child and Family Service Review (CFSR) process to meet the national standards for safety, permanency and well-being. Many of these standards are referenced throughout this plan.

Strategies and Implementation Steps[147]

1. **Create a CQI culture within DYFS and the OCS**.

- By September 2004, hold a staff meeting with all senior level DYFS managers to declare that continuous quality improvement (CQI) will be a priority for practice across the agency. CQI will be discussed within the context of the overall Child Welfare Reform Plan and will set the stage for ongoing communication about quality improvement. Clear performance expectations and a timeline for creating a CQI structure within DYFS will be articulated.
- By November 2004, begin to engage staff at all levels in reviewing and designing data collection and reporting information.
- By November 2004, District Administrators and Area Managers will begin having monthly staff meetings with all supervisors to review the office's progress, respond to staff questions and brainstorm around problems.
- Beginning in the fall of 2004, we will publish quarterly and annual public reports on progress in implementing this plan, both statewide and, as the county offices come into being, at the county level, too (with the county level reports breaking down progress at the district office level).

[147] By July 2005, OCS will develop a more comprehensive plan regarding the phase-in of the OCS CQI culture. The plan will address the structure of CQI within OCS; will identify key functions, staffing and resources to meet CQI objectives; and will detail the CQI roll-out process, which will parallel the development of the new area and local offices to ensuring that the new CQI program focuses first on the areas of greatest need. This plan will be subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

2. Create, reorganize and integrate Continuous Quality Improvement functions at every major administrative level of DYFS and between DYFS, the OCS and DHS.

- By August 2004, rename DYFS's Central Office Quality Assurance Unit to the Continuous Quality Improvement Unit, to reinforce the newly established culture.
- By September 2004, identify the unique and overlapping functions of DHS's Office of Program Integrity and Accountability (OPIA) and DYFS's Central Office CQI Unit, and create a work plan to integrate their functions in a new, system-wide CQI office, under the OSC CQI Director. The Child Fatality and Near Fatality Review process also will be in this new office, to ensure that the findings from these incidents feed into the agency's improvement efforts. The OCS CQI office will be responsible for regularly monitoring the performance of all OCS Divisions, and also that of the private providers with whom any part of OCS contracts for services, whose contract renewal decisions will be based on performance reviews.
- By September 2004, move the Institutional Abuse Investigation Unit to the new OCS CQI/IAIU Office. The IAIU Corrective Action unit will be responsible for monitoring corrective action plans issued by IAIU. The CQI team will be responsible for identifying and addressing any systemic deficiencies revealed by the corrective action plans taken together. In the event an individual corrective action plan is not complied with, a meeting will be called including the IAIU Corrective Action staff responsible for monitoring the plan, staff from the licensing office, the permanency worker(s) for the child(ren) residing in the location at issue, and placement personnel (in case the children need to be moved). If the parties cannot agree whether to revoke the placement's license or move the children, the OCS Chief of Staff will make the decision. [148]
- By September 2004, hire a national expert on CQI to train selected DYFS Executive Management staff, Central Continuous Quality Improvement staff and DHS OPIA staff to be skilled custodians of the agency's CQI implementation and performance monitoring plan as well as trainers for CQI Specialists hired in the county and district field offices. Three additional training forums will occur during year one with the national expert to further improve staff's and the overall agency's CQI competencies.
- Hire and train a CQI Specialist for every Area Office, each of whom will: (Begin July 2004 and completed September 2005)
    - Work in a team with the DYFS field Trainers, Case Practice Specialist, MIS/Data Analysis Specialists, and Case Practice Supervisors to identify areas of strength as well as poor performance, and to plan, present, implement and monitor necessary improvement plans.
    - Direct and monitor the county's internal and external CQI activities.
    - Conduct small monthly case reviews, applying a standardized instrument that specifies the items to be reviewed, and provide feedback on the results to the caseworker and supervisor; coordinate a corrective action plan with the team.
    - Collaborate with District Administrators, Area Managers and existing county-based planning body chairs to create CQI Committees comprised of consumers and other

[148] A more refined implementation plan regarding improving the capacity of the IAIU and developing effective links between IAIU findings, corrective action plans, and the licensing process will be developed by September 2005, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

stakeholders who represent the diversity and leadership of the community; serve as a convener of and liaison to the Committees after its formation. (These bodies will be subcommittees of the County Child Welfare Planning Councils, and will have strong relationships with local Community Collaboratives – including overlapping membership – as they come into being.)
    - Collaborate four times per year with DYFS's Continuous Quality Improvement Unit and County CQI Committees to conduct a larger, more intensive Quality Service Review and issue a report to the DYFS Director and Area Manager for practice changes.
    - Create by-laws with the CQI Committee to identify the role and purpose of each Committee member as well as reporting mechanisms.
    - Provide continuous feedback to trainers and supervisors about outcome performance to strengthen workers' competencies.

- Hire and train six additional CQI Data/MIS Specialists to be housed in Central Office (begin June 2004 and complete hiring and training by June 2005), each of whom will collaborate with Data/MIS Specialists housed in the Area Offices, once they are hired.
- By August 2004, begin to hire and train a Data/MIS Specialist for each Area Office, each of whom will collaborate with CQI Specialists on data analysis, reporting and system-level corrective actions.
- By January 2007, begin conducting quarterly CQI roundtables to:
    - Discuss progress toward Child Welfare Reform Plan benchmarks
    - Create recommendations for systemic change based on findings from case reviews
    - Determine if any special studies are needed
    - Create recommendations regarding any identified service gaps
    - Determine if communication chains are clear and open and, if not, plan improvements
    - Discuss information being fed to DYFS from the State CQI or County CQI Committees
    - Route outcome-based information agreed upon by the group to trainers so it is incorporated into training curricula across the agency.

3. Engage community stakeholders in the CQI process to strengthen partnerships in support of improved child welfare outcomes.

- By January 2005, create at least four county-based CQI Committees (in conjunction with the roll-out of the new area offices) in collaboration with the Area Managers, District Administrators and chairs of existing county planning bodies. These local CQI Committees will be comprised of consumers, community leaders and other stakeholders who represent the diversity of the community, and will enable the community to assist in both the identification and amelioration of programmatic or practice limitations.[149] Each CQI Committee will:
    - Establish by-laws to govern their structure and duties

[149] These public CQI Committees will be rolled out in communities in coordination with the roll-out plan for community development discussed elsewhere in this plan. Consideration will be given to the possibility of forming these CQI committees as subcommittees of the County Child Welfare Planning Groups.

  - Conduct regular reviews of the county's child welfare data and outcomes, and the local delivery of services to children and families; conduct studies of issues of local concern
  - Participate in quarterly qualitative case reviews to determine the quality of services to children and families, and issue reports of findings
  - Advocate on behalf of DYFS consumers and providers on issues related to improving services, agency capacity or outcomes
  - Serve as a conduit of outcome information to the broader community
  - Be a resource for practice improvement recommendations, using the County CQI Specialist as the conduit for information back to DYFS

- By January 2005, create an independent State CQI, which will:
  - Monitor Child Welfare Reform Plan outcomes at a statewide level
  - Review data and other information related to child and family services
  - Participate in qualitative case reviews
  - Initiate special studies of particular areas of concern or interest, and issue reports of their findings and recommendations to DYFS and DHS

4. Develop and apply new tools for collecting and reporting outcome information.

- By October 2004, determine what DYFS data management information systems require re-tooling, replacement or additional capacity to support a fully automated child welfare system and adequately monitor DYFS's monthly progress in achieving the benchmarks and outcomes in this plan; by January 2005, issue the first quarterly progress reports using available data, while continuing to enhance the system's reporting capacity.
- By December 2004, make existing county monthly progress cards conform to the benchmarks and outcomes and in this plan.
- By August 2004, establish standards for the adopted case practice model and incorporate them into new case practice review tools.
- By January 2005, develop a Structured Decision Making supervisory case reading tool that checks case practice compliance with Safe Measures reporting; present findings at quarterly CQI roundtables.
- By July 2005, develop a new case review tool that captures appropriate qualitative information, and train relevant staff on its use and consistent application.
- By September 2005, develop a new instrument to consistently review all fatalities and near fatalities of children known to the system, with recommendations for systemic change.
- By June 2006, develop a new consumer satisfaction survey instrument that will be used periodically with families receiving services from DYFS and upon the closing of their cases.
- By September 2004, begin creating a CFSR Program Improvement Plan (PIP) protocol that is integrated with other data measures already tied to this plan.
- By January 2005, the DYFS Central Office Data/MIS Unit will begin geo-mapping data trends across the state; data pictures will be used to educate staff and community members about the functioning of the child welfare system in their area.

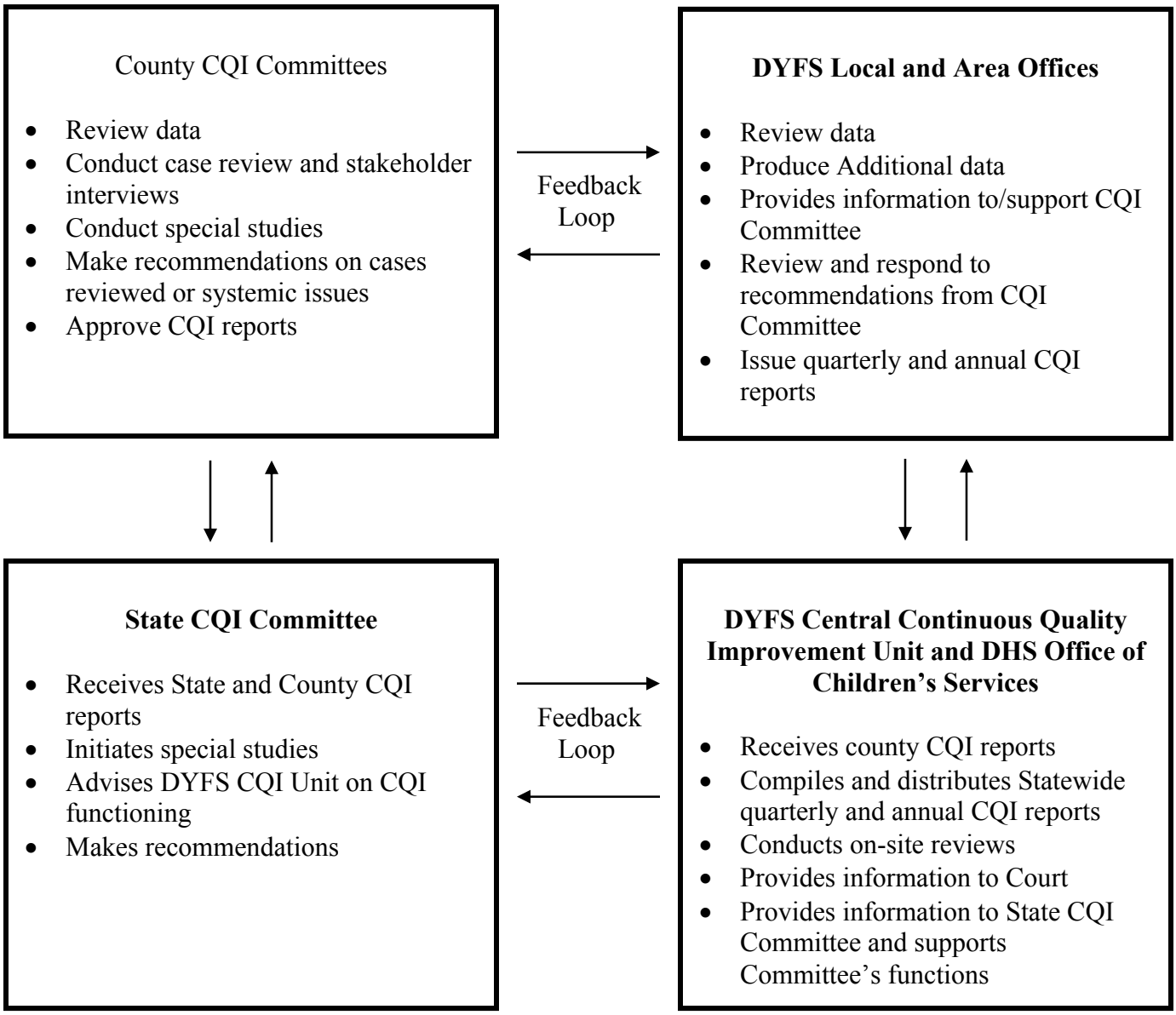
- Begin immediately to comply with as many as possible of the principles and practices necessary for COA accreditation, and formally start the process of COA accreditation by no later than 2009.

5. Create a performance-based contracting system connected to the commitments and benchmarks in this plan.[150]

- By March 2005, hire a national expert to help DHS design a state-of-the-art performance-based contracting program to incentivize the attainment of desired outcomes for children and families as defined throughout this plan.
- By September 2006, develop and enforce a "no reject, no eject" policy, carefully defining the type of client each contract agency must serve and prohibiting them from rejecting any such client (this to avoid the client "creaming" performance-based contracting will make tempting).
- By March 2006, develop a performance-based compensation methodology that provides fiscal incentives to the achievement of specific outcomes for children.
- By March 2006, develop and implement a transition plan that phases-in performance-based contracting with minimal disruption of services to clients and effectuates the major paradigm shift embodied in this plan; by July 2007, all contracts will be performance-based.
- By March 2006, develop an instrument to annually evaluate DHS' newly established performance-based contracting system and make necessary modifications.
- By September 2006, complete phase-in of all residential services contracts.
- By September 2007, complete all phase in of non-residential services contracts.
- By July 2009, complete first evaluation of performance based contracting.
- By July 2009, develop an instrument for contract staff to annually analyze community services, looking particularly at: existing community assets and strengths, current service array and gaps in service. The findings from this analysis will be used to develop the following year's service budget, until performance-based contracting is phased in.

[150] A more refined implementation plan regarding performance-based contracting will be developed by October 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

Continuous Quality Improvement Functions and Information Flow



♦ Creating a Research & Data Analysis Unit

Continuous quality improvement can only be real if there is information to base it on. So we commit to creating a research and data analysis unit in the Office of Children's Services, under the supervision of the OCS Director of Program Improvement and Accountability. The CQI program will also be under this Director, and the two will work very closely with each other.

The goal of the unit will be to create a knowledge management culture that enables DYFS and OCS to acquire and utilize information for planning, problem solving, decision-making, accountability and continuous improvement. This will require an investment in people, developing information technology infrastructures for the acquisition and distribution of data, and educating employees on the creation, sharing and use of information.

Knowledge management is not a technology-based concept but a way of doing business that can help an organization improve its effectiveness. It is a process through which an organization can generate value from its knowledge-based assets by sharing them among employees and departments to devise best practices. Knowledge management can foster innovation and help eliminate redundant or unnecessary processes. This is necessary because information resides in different units of the organization (e.g., human resources, fiscal, quality assurance, etc.), but often it is not integrated or coordinated. Technology creates large amounts of information, but producing information is not by itself gaining knowledge. A knowledge management approach attempts to organize this information in a meaningful way so that its full potential to effect organizational change can be realized.

To this end, this plan commits to:

- Creating a culture of evaluation throughout the agency;
- Monitoring improvement of the outcome indictors established in this plan, the settlement agreement, AFSA and CFSR;
- Defining what information is really important, and to whom, and developing systems to ensure that they receive it routinely;
- Ensuring that terms mean the same thing throughout the organization, and that confusion does not arise because of terminology, measurement or methodology;
- Transforming data into knowledge through analysis; and
- Encouraging sharing of relevant data and information among units within both DYFS and OCS.

Current Situation:

This plan calls for modifications that will coordinate data and information activities related to child welfare.

Existing data reporting consists mainly of a series of very detailed monthly reports. Even within DYFS, data reporting and analysis is not situated within one unit reporting to one manager. Instead, components of data reporting are housed in the Office of Information Systems (OIS), the Office of Policy, Planning and Support (OPPS), and the Office of Program Operations (OPO).

Information regarding the DYFS population also comes from other DHS divisions including Medicaid, the Division of Child Behavioral Health Services, Addictions Services and TANF. These sources do not necessarily share and connect their information, or even define their terms similarly. DYFS does not have internal Geographic Information Systems (GIS) mapping capacity.

Strategy:

Create a Research and Analysis Unit within OCS that consolidates data reporting and analysis functions into one unit reporting to one manager. This will:

- Reduce duplication of effort assuring that multiple units do not produce the same information.
- Assure consistency of information so that different units do not generate seemingly contradictory information because they use different definitions, samples or methods.
- Provide a clear organizational locus for data reporting and analysis.
- Channel the flow of information by creating a single conduit to management and staff.
- Provide access for management and staff to reliable information.

The Research and Analysis Unit's responsibilities will include:

- Developing uniform and consistent definitions for data reporting;
- Monitoring benchmarks in this plan and producing reports;
- Producing other reports to meet DYFS's information needs;
- Coordinating and sharing cross-cutting information with other Departments and Divisions (e.g., Addictions Services and Medicaid) and, where needed, developing common definitions and measures;
- Assuring that all units handling information (fiscal, licensing, quality assurance, human resources) have an understanding of the key principles of knowledge management; collect, analyze and report on information efficiently; and provide quality information for decision-making;
- Developing knowledge using the resources of the State Data Warehouse;
- Ensure that the culture of evaluation and analysis is reflected in DYFS information products;
- Educating staff on accessing information assets to improve their performance;
- Promoting a culture of knowledge management throughout DYFS.

Implementation Steps:

Create the OCS Research and Analysis Unit by hiring a director and new staff by October 2004.

Begin immediately to review plan benchmark grid to determine new information requirements.

Develop uniform and consistent definitions for all child welfare variables across OCS and the divisions by January 2006.

Develop templates for benchmark reporting by August 2004.

Produce baseline measures for monitoring benchmark changes by December 2004.

Monitor benchmark status on a monthly basis.

Develop job specifications for new positions by June 2004; begin new staff hiring by October 2004.

Evaluate staff training needs by October 2004; begin staff training by December 2004.

Begin developing a plan to educate DYFS staff in methods of accessing and using information by January 2005.

Create Monitoring and Analysis Group (MAG) and hold first meeting by May 2004.

Develop initial analysis of data quality and a quality improvement plan by July 2004.

Develop a process for the periodic internal review of data quality and identification and remediation of problems by September 2004.

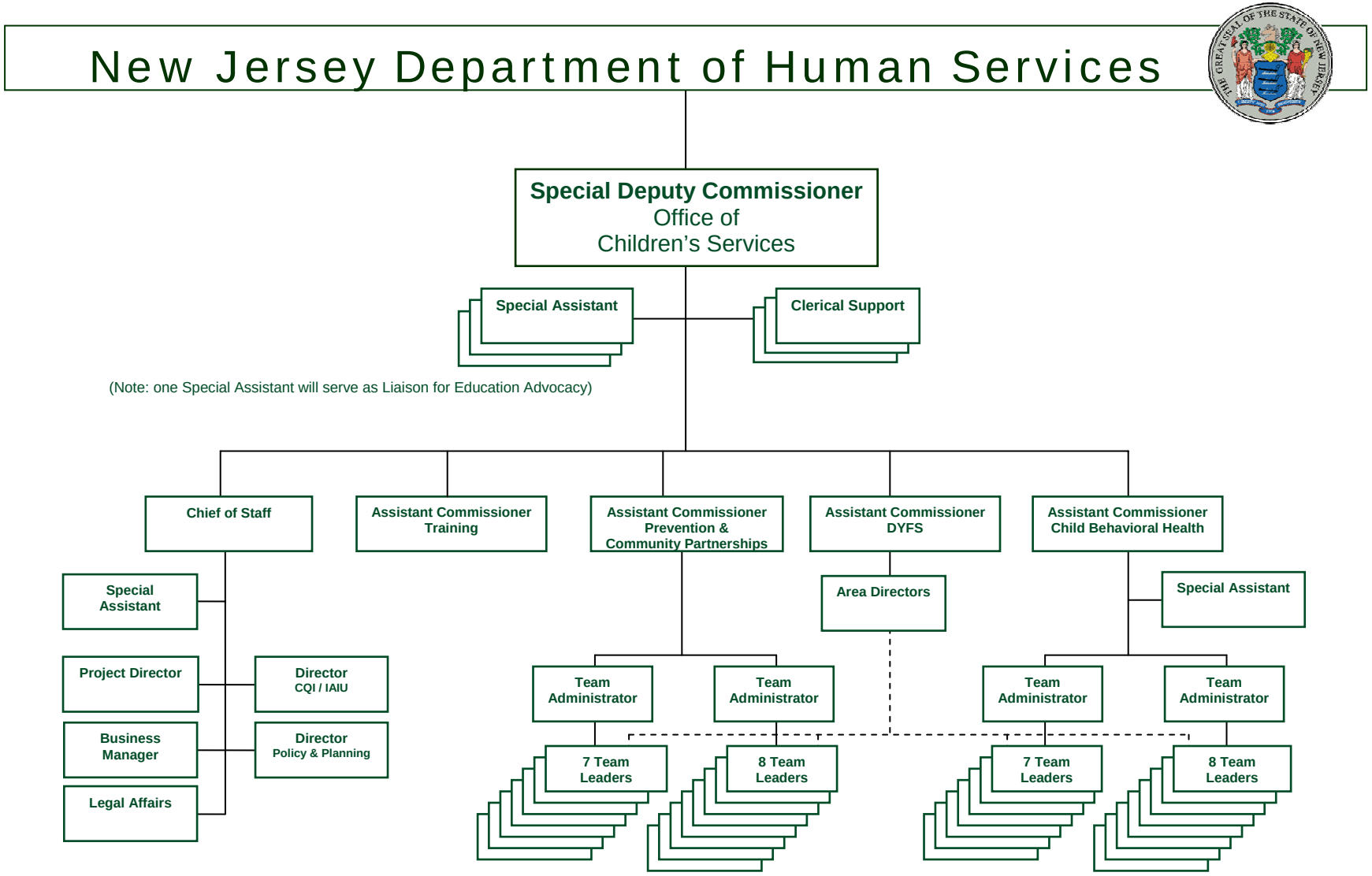
■ INFRASTRUCTURE AND RESOURCES

♦ The DHS Office of Children's Services: Creating an Integrated System of Care for Children and Families

To implement this plan, we must completely restructure the organization at every level, from DHS to the DYFS District Office.

As was discussed in the section of this plan on services and prevention, DYFS has for too long tried to do too much for too many. Its mandate is to respond to allegations of abuse and neglect, and to provide protection and support – safety, permanency and well-being – when the allegations are substantiated. But because an open DYFS case has been the only way for many children and families to receive help, DYFS has understandably stretched itself thin in an attempt to provide as much assistance as possible. While understandable, perhaps even admirable, this has undermined DYFS's ability to address its core mission.

We will end this by providing an integrated continuum of services for children and families, unified within a newly organized Office of Children's Services, and allowing DYFS to focus only on cases involving child abuse and neglect. This new structure is reflected in the organizational chart on the following page.


New Jersey Department of Human Services
Special Deputy Commissioner
Office of
Children's Services
Special Assistant
Clerical Support
(Note: one Special Assistant will serve as Liaison for Education Advocacy)
Chief of Staff
Assistant Commissioner Training
Assistant Commissioner Prevention & Community Partnerships
Assistant Commissioner DYFS
Assistant Commissioner Child Behavioral Health
Special Assistant
Project Director
Director CQI / IAIU
Business Manager
Director Policy & Planning
Legal Affairs
Area Directors
Special Assistant
Team Administrator
Team Administrator
Team Administrator
Team Administrator
7 Team Leaders
8 Team Leaders
7 Team Leaders
8 Team Leaders

The Office of Children's Services (OCS) will be led by a Special Deputy Commissioner[151] who will report directly to the DHS Commissioner. The OCS will be organized as an "agency within an agency." It will have its own infrastructural supports, including information technology, training, human resources, data analysis, continuous quality improvement, policy and legislative affairs, communications, budget, planning, facilities and contracting. In the realm of children's services, the OCS will have decision-making authority. It will not have to compete with the numerous other important programs within DHS – including the Division of Family Development, the Division of Developmental Disabilities, Medicaid, the Division of Mental Health (adult behavioral health), the Commission for the Blind and Visually Impaired, and others – for the attention of the DHS-wide infrastructural personnel or resources.[152] Project managers will be hired (several are already on board) to oversee the implementation of various aspects of this plan, under the OCS Chief of Staff.[153] It is envisioned that once the plan has been sufficiently integrated into the agency's culture and practices, these positions will evolve into permanent features of the OCS infrastructure, to bring about the cross-division operational unity of children's services the plan calls for.

This infrastructure will support three substantive areas of work, each under the direction of its own Assistant Commissioner: the Division of Youth and Family Services (DYFS), responsible for child abuse and neglect; the Division of Child Behavioral Health Services (heretofore known as the Partnership for Children), responsible for children's mental health services; and the newly created Division of Prevention and Community Partnerships, responsible for developing the rich partnerships with communities statewide to serve both DYFS-involved families and families needing more primary prevention services. Another newly created Assistant Commissioner, the OCS Assistant Commissioner for Training, will lead the training effort across the Office of Children's Services, including development of the training academy discussed elsewhere in this plan.

These Divisions and supports cannot and will not operate in isolation from each other. For this to succeed, all the direct reports to the Special Deputy Commissioner must be highly qualified professionals who function as one team, planning and implementing a unified vision in partnership with each other. The system of children's services that emerges from this plan, once it is built up state-wide, will be a single system, not several systems reporting up through a common line to the Commissioner. The OCS Special Deputy Commissioner will be the person responsible for driving this vision, and all the commitments in this plan, forward to reality. The DHS Commissioner will be ultimately accountable, and will be responsible for carrying the work of OCS, in partnership with the Special Deputy Commissioner, to the Governor, the Cabinet, the Legislature, and the public. All of this work, to the degree it implicates children involved in the

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[151] The office is called *Special* Deputy Commissioner because DHS is legally limited to two Deputy Commissioners and this would be the third. We will work with the Legislature to revise this, institutionalizing the OCS under the leadership of a third DHS Deputy Commissioner.

[152] While OCS will have its own infrastructure, the institutional and political heft of DHS, the largest agency in state government, will be brought to bear in support of its success.

[153] A special assistant to the Special Deputy Commissioner will be responsible for coordinating efforts with the New Jersey Department of Education, local school districts, administrators, teachers, children and families to ensure that children under any OCS division receive appropriate educational services.

juvenile justice system, will be undertaken in partnership with the Juvenile Justice Commission.[154]

While OCS will be largely autonomous from the rest of DHS, there will be significant advantages to its being part of DHS. As is denoted by the dotted lines on the organizational chart, there will be a close relationship between OCS and the TANF and Medicaid programs, both of which will contribute significantly to the continuum of children's services from primary prevention through DYFS-involved cases. There will also be opportunities to ease the transition for children aging out of foster care and needing ongoing services, owing to the presence in DHS of the adult disability and mental health systems.[155]

The Division of Youth and Family Services[156]

Developing the continuum of services available through the OCS to children and families at various levels of risk will allow DYFS to focus exclusively on what should always have been its sole function: investigating allegations of child abuse and neglect, and when the allegations are substantiated, providing necessary services to ensure children's safety, permanency and well-being. DYFS must be restructured to enable it better to meet these core obligations.

The DYFS District Offices are too large and disconnected from the neighborhoods, communities, children and families they serve. To better connect, we will develop more offices, and will place them where the clients live. The District Offices, led by a District Administrator, will serve fewer families than the current districts. Cases will be divided among case work managers, each of whom will supervise three supervisors, each of whom will supervise 5 child protection or permanency workers and 1 case aide. We will implement a capital expansion program to increase the number of district offices until each is approximately this size. The first fifteen area offices under this model will open in January 2005, with the rest to follow in July 2005 and January 2006.[157] District offices will be placed in areas of high service need, based on geo-mapping analyses, and in consideration of both natural neighborhood boundaries and public transportation routes. Their exact locations will be determined in partnership with our

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[154] The essential operational partnership between OCS and JJC will be pursued in several ways. An interagency agreement will be developed, detailing how OCS services needed by children in the juvenile justice system will be provided and accessed. The Executive Director of the JJC will be a contributor to the OCS senior leadership team, invited and encouraged to participate in the development and implementation of policy and practice regarding children whose issues overlap OCS and JJC.

[155] Two joint planning efforts – between OCS and (a) the Division of Mental Health Services, and (b) the Division of Developmental Disabilities – will seek to integrate services for families involved with both these systems and the child welfare system, and how these systems can contribute their resources and expertise to the goals of child safety, permanency and well-being, and family stability. The Division of Family Development's Abbott pre-school extension program also serves many children who are either DYFS-involved or at risk of DYFS involvement, creating an opportunity for productive partnership.

[156] Mindful that while names do not of themselves change underlining realities they do have associative power, to signal the new era for children that this plan embodies we intend to rename the Division of Youth and Family Services, after consultation with key stakeholders including Division staff.

[157] It is certain that we will end up with many more District Offices than we have now. The exact number is impossible to predict because at the same time we are expanding the offices the reforms throughout this plan should be reducing the DYFS caseload. Where these two lines – increasing District Offices and decreasing cases – will meet cannot now be known. We will monitor the caseload trends carefully while implementing the district expansion plan.

employees from the area and with community members, as will decisions on whether to outstation any of a district's employees or units in schools, CBOs or other local institutions. To ensure effective management, each district office will have at least two at-will management employees.

Within the district offices, staff will be geographically assigned so they can become deeply familiar with the local institutions, civic organizations, formal and informal leaders, business community, services and supports, schools, religious institutions, and everything else that will help them work in partnership with the families from the community. Staff – including child protection workers, permanency workers, supervisors, resource family support workers, casework support workers (including adolescent specialists, adoption workers, substance abuse workers and domestic abuse workers) will work in teams, all assigned to the same areas. Some teams will be sited in the community – in a school, YMCA, housing project, or other local organization – to be even closer to their clients. Resources and authority will as much as possible be pushed down the organization to the districts, where they can directly benefit clients.

The four regional offices, the middle level of the DYFS organization between the districts and headquarters in Trenton, will be phased out by December 2005. The state and its child welfare caseload are too large to permit meaningful management in one-fourth regions. Instead, we will have 15 OCS area offices, which will provide support to the districts and house personnel and functions that cannot be provided on the district level. Our overall goal is to reassign staff and relocate decision-making authority, on both the district and area levels, to as close to the clients as possible. The first four area offices will open in January 2005, in the highest need counties, with the remainder following in two waves, in July 2005 and January 2006.[158] The jurisdiction of these offices will be based on New Jersey's 21 counties, with the division of the 21 counties among the 15 offices paralleling both the vicinage structure of the Administrative Office of the Courts and the county-based structure of the children's behavioral health system.[159] Since DYFS works in close partnership with both of these entities, the parallel structure will allow for joint planning and programming.[160] The area directors will be responsible, among other things, for interfacing on behalf of DYFS with the various existing planning bodies in the counties to ensure that child welfare services are coordinated most advantageously for clients.[161]

"Team Leaders" from the Division of Child Behavioral Health Services and the Division of Prevention and Community Partnerships also will work out of each of the area offices, so they can partner with the DYFS Area Director to plan and manage an integrated continuum of

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[158] A steering committee with both management and union representation will be formed to develop a detailed plan for redeploying staff from both the regional offices and the adoption resource centers (ARCs) to area and district offices.

[159] Under this structure, each county will constitute its own area with the following exceptions: Atlantic/Cape May, Morris/Sussex, Somerset/Hunterdon/Warren, Gloucester/Cumberland/Salem.

[160] While the advantage of paralleling the geographic structure of the court and mental health systems is the ability to plan together, the disadvantage is it results in areas with widely disparate child welfare workloads, most notably Essex County's, the caseload of which dwarfs the second busiest area's. This will be addressed by staffing the area offices more robustly in the areas of heaviest demand.

[161] The area directors will be linchpins of our new structure, essential to the successful implementation of this plan. We will seek highly qualified people for these positions, searching both within and beyond our existing workforce. As with our other staffing efforts, we will maintain a commitment to staff diversity in making these important appointments.

children's services responsive to conditions in their county/ies.[162] This planning will be undertaken in partnership with the county child welfare planning councils and local collaboratives discussed elsewhere in this plan, as they come into being. Each OCS county office will have substantial autonomy to allocate resources – including human, fiscal, and service – in light of local needs.

The Division of Child Behavioral Health Services

Within DHS, children's behavioral health services historically have been provided through multiple divisions and initiatives, including the Division of Mental Health Services (DMHS), DYFS (which was responsible for the residential placement of most children needing mental or behavioral health treatment, even when there were no abuse or neglect issues), and others. Few resources were developed in the community to prevent the need for, or transition children from, acute care or residential placement. The Division of Child Behavioral Health Services (DCBHS), which began in three counties in 2001, was designed to make mental and behavioral health services available, along a single continuum, for children involved in the child welfare, mental health and juvenile justice systems. In November 2003, the traditional mental health services for children operated by the DMHS transitioned to the DCBHS. Now, to bring the vision of a single children's mental and behavioral health system further into being, these services need to come under one authority, and their allocation needs to prioritize children abused or neglected or involved in the juvenile justice system.

This plan creates the Division of Child Behavioral Health (DCBH) to accomplish this, replacing the DCBHS, and places it under the same authority – the Office of Children's Services – to ensure coordination and prioritization of the neediest children. The Division brings together the traditional components of child mental health in New Jersey[163] with more recent community-based strategies[164] to form a single system of behavioral health care for children with emotional or behavioral health care needs and their families. This will reduce fragmentation and avoid the need for children to enter the DYFS system to receive these services.

The provision of children's behavioral health services has been weighted too heavily toward residential and institutional care which, when not essential to children's needs, both harms children and wastes money. Over the next 18 months, the entire continuum of children's behavioral health services will be evaluated and, as necessary, reallocated, to improve the system's achievement of the following goals:

- Improved clinical outcomes and emotional/behavioral stability
- Improved permanency in community placements
- Reduced inappropriate use of residential/congregate care
- Reduced lengths of stay in residential care
- Reduced readmissions to acute psychiatric hospitals

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[162] Each OCS area office will thus have at least two at-will management positions in addition to the area director.

[163] These include Brisbane, Children in Crisis Intervention Services (CCIS) and Children's Intermediate Units, Hospital Screening for Children, Partial Care Programs, Out-patient Services, Psychiatric Community Residences and other Residential Facilities.

[164] These include Uniform Assessment, Mobile Response, Intensive In-Community Services, Behavioral Assistance, Youth Case Management, Care Management Organizations, and Family Support Organizations.

- Improved crisis management and stability in living environments for families and caregivers

Our ultimate goal is the development of a flexible array of mental and behavioral health services that can be tailored to meet the individual needs of all the children and families requiring them.[165]

The Division of Prevention and Community Partnerships

The Division of Prevention and Community Partnerships (DPCP), created by this plan, will be responsible for forming and working with the child welfare planning councils in each county; for state-wide development of community partnerships; for developing community collaboratives; and for working with these entities to map the services being provided and assets in their areas. All of this will be done – as the Division's name denotes – in close partnership with the communities, who will be approached as equal partners the government exists to support, not control. The community development resource specialists in each District Office and the community developers in each area office will be part of this Division.

The county- and community-wide planning processes will have ambitious goals, and will be undertaken in dialogue with existing state- and county-level planning and service bodies, some of which may eventually be consolidated into the child welfare planning councils. These will be data-driven processes, responsive to local strengths and needs, and should identify areas where state, county and local government can coordinate funding in support of the resultant plans. It is essential that clients, local leaders and other community members have strong voices in these planning efforts, and it will be the responsibility of the DPCP to help create the contexts in which this will occur.

Because adolescents' needs have been so poorly met, and because adolescents are particularly vulnerable to being passed like hot potatoes among systems (child welfare, behavioral health,

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[165] Three areas that will receive the immediate attention of the DCBH are:

1. Care Management Organizations (CMOs): This intensive case management tool was designed to reduce the length of, or obviate the need for, residential care. The percentage of CMO clients using residential care varies widely by county; the reasons for this will be carefully evaluated. CMOs employ a caseload standard of 1:10 (case manager: children), with the expectation that children would "step down" to Youth Case Management as they stabilized and needed less intensive support. In accord with this plan's embrace of the One Family/One Worker practice model, the Division of Child Behavioral Health Services will develop a strategy to adjust CMO caseloads through the assignment of mixed caseloads including children with various levels of need.
2. Contracted Systems Administrator (CSA): This contract was designed to provide child-specific and systemic data analysis on all children in the Division of Child Behavioral Health Services. There have been numerous setbacks during the implementation process. An in-depth analysis of the program deliverables is ongoing, and likely to result in contract changes and amendments going forward.
3. Arthur Brisbane Child Treatment Center: This facility continues to struggle to meet child safety requirements. Some of the struggle relates directly to the physical plant, which was not designed for the current population. An ongoing analysis will guide future planning for children who require its intensive level of care.

juvenile justice), this Division will have an office devoted to planning for the particular needs of adolescents and youth transitioning out of the system.

Because resource families are the essential community partners, and because there is a significant need to recruit many resource families for both DYFS and DCBH, the resource family development and support function will be elevated into the Office of Children's Services and housed in this Division.

This Division also will include the Office of Prevention Services (OPS), which will coordinate and develop the network of primary prevention services statewide, and those that emerge from the community collaborative processes in the areas of highest need. Because many of these services will be funded through the state's TANF and Medicaid programs, this Division will be the interface between them and the Office and Children's Services.

New Jersey, through the Task Force on Child Abuse and Neglect, recently developed Standards for Prevention Programs. The OPS will allocate the state and federal resources within its control in accordance with these standards.

♦ Information Technology

Phased Approach to the Statewide Automated Child Welfare Information System (SACWIS)

Implementation of the new State Automated Child Welfare Information System (SACWIS) is currently scheduled to be completed in three major phases, referred to as "releases." Phased implementation allows for earlier introduction of technology solutions for casework and management staff while other system applications are being completed. DYFS IT staff are currently confirming the over 840 requirements in the SACWIS RFP while also developing new requirements based upon both changes in practice since the RFP was published and changes called for by this plan. Many of these changes have already been incorporated into Release One, which covers Centralized Screening (see table below). Detailed IT requirements will need to be developed and implemented to support numerous other areas of this plan, as well as the overall enhanced reporting and CQI functions essential to its successful implementation.

This section will first summarize the IT capacities that will be in place to support the agency's work and implementation of this plan at each time period: pre-SACWIS and at each of the SACWIS "releases." It will then set forth the agency's goals and plans in this area in somewhat greater detail.[166]

[166] A more refined plan regarding interim IT solutions in support of the implementation of this plan will be developed by September 2004, subject to the review and approval of the Child Welfare Panel, which may designate elements of it legally enforceable. Failure to develop this plan will constitute substantial non-compliance with the settlement agreement.

Pre-SACWIS Interim Applications/Solutions (Interim Web-based Applications):

A number of information technology solutions to support case practice reform will occur prior to the full implementation of SACWIS. These include the following:

Recording the collection of information for all screening calls being captured by the new State Central Registry:

The Division of Youth and Family Services (DYFS) will begin implementing a centralized screening system in July 2004, permitting all reports of suspected child abuse or neglect to go to one centralized telephone hotline that operates 24 hours a day, seven days a week. While all the details have not yet been resolved, this new centralized system will provide electronic tracking and transmission of all referrals to appropriate field offices for response. The new system will also enable the generation of reports tabulating the number of cases accepted for child abuse and neglect investigations and the number resolved by various sorts of referrals. Reports will also be generated showing the response time for all referrals, including the frequency of home visits to children. This will be used to monitor compliance with Monthly Visitation Requirements (MVRs). These reports will be capable of "drill down," allowing the tabulation and review of, for example, cases assigned to a particular caseworker or office. The call center phone system to be deployed will provide statistical reporting on all calls made to the hotline including length of call, number of dropped calls, total call volume, etc.

Development of the SAFE Measures Reporting Tools for Management and Supervisory staff:

The SAFE Measures Reporting tools will provide reports on Structured Decision Making practices, including reports that will detail all children who are determined to be at risk and whether a valid safety plan for each at-risk child is being implemented. Among other management reports, SAFE Measures will also provide reports on the frequency of contact between caseworkers and their clients. Management reports will identify any instances where contact with at-risk children was not provided immediately or within 24 hours, where required under new case practice procedures. Reports with this type of information can be run on the regional, office, unit and worker levels. The initial SAFE Measures reports will be available by July 15, 2004, with additional reports designed and developed thereafter.

Deployment of Video Conferencing in all DYFS locations:

The Division will deploy video conferencing in each of our sites. This new technology will help support training initiatives and improve communication among offices, programs and agencies. Video conferencing will also be employed in those courts that support caseworkers testifying via video conferencing. Implementation of the video conferencing initiative began in December 2003 in offices in Middlesex County, the Central office in Trenton and DYFS training locations. These set-ups are being updated to conform with a standardized model as a result of a new initiative with Verizon so the same video conferencing platform will be deployed statewide. Full implementation of video conferencing for all DYFS locations, as well as creating partnerships with the courts to utilize this technology more widely, is scheduled to be completed by June 2006.

Pre-SACWIS Production Applications (Case Book):

DYFS will continue to modify and support all interim Web-based applications currently employed by the various Divisions providing child-related services. These applications include providing an electronic "journal" for caseworkers to record detailed narrative descriptions of all contacts with clients, recording information and key data concerning children in out-of-home placement to ensure good case practice and enhance our Title IV-E support by the Federal Government. The applications also will record tasks and information about all resource family applicants, and will allow access to historical records of prior child abuse and neglect investigations on all protective service cases.

Wireless Access Pilot:

DYFS will explore the feasibility of wireless technology for caseworkers by testing, on a pilot basis, the use of a laptop computer or similar device provided with connection capability to the Interim Web-based applications. This pilot will inform the development of wireless or disconnected access to SACWIS by caseworkers in the field. The pilot is scheduled to start in October 2004, with an initial assessment in February 2005.

Increased Board Rates for Resource Homes

Significant changes to legacy systems will need to be made to support the increase of board rates for Resource Homes. This work has begun, and will be completed by December 2004, in time for the first scheduled rate increase in January 2005.

SACWIS Deployment Schedule

Dates	Activities and System Functions
November 2004	**Release 1 – New System Functions** • Screening of cases received through the SCR 24-hour hotline • Searches to determine if case/child is known to DYFS • Preliminary assessment of safety of the child(ren) in the report • Classification of reports into Child Abuse/ Neglect (CAN), Child Welfare Services (CWS), Information and Referral (I&R) or Information Only (IO) categories • Assignment of CAN cases to investigative units in district offices (business hours) or Special Response Unit (SPRU) investigators after hours • Referral of CWS cases to appropriate district office or other service • Referral of I&R cases to appropriate community services • Provision of information to callers (IO) • Limited access (read only) of investigators to SACWIS system to read reported allegations of abuse or neglect
September 2005	**Release 2 – Major Case Management Activities** • Automated safety and risk assessment • Case recording and improved case tracking • Case investigation results • Electronic reminders for major casework activities • Improved ability for supervisors to manage caseworkers through electronic tracking capabilities • Improved monitoring of caseworker caseloads through electronic tracking capabilities • Automation of placement selection, payment and monitoring • Improved automation of other financial functions, e.g. payment to Resource Families • Automation of licensing functions • New automated contract system linking resources to clients served, performance, and payments expended • Access to automated resource directory • Improved automation of required court reviews • Improved federal claims procedures and fiscal accountability • Reduction in redundant work through use of shared data • Extensive reporting and tracking ability implemented statewide Implementation of case practice changes from Child Welfare Reform Plan including Family Team meetings, Resource Families, increased reliance on reporting to assist with management, sharing of Institutional Abuse Investigation Unit (IAIU) and Licensing Data, and Structured Decision Making

Dates	Activities and System Functions
April 2006	**Release 3 – New System Functions** • Statewide tracking of employee training and competencies • System to track planned expenditures for contracted services • Exchange of information between and among courts, other service providers and divisions within the DHS • Any additional Child Welfare Reform Plan Case Practice changes
May 2006-February 2008	**Post-Implementation Support** • System corrections, refinements and enhancements • Maintenance and termination of contracts with vendors

Goals:

- Pre-SACWIS: Integrate resources and systems in place
- Pre-SACWIS: Build IT capacity including field staff
- Pre-SACWIS: Create processes for timely and appropriate data collection
- SACWIS: Build IT Capacity including field staff
- SACWIS: Integrate Data Sources
- SACWIS: Develop information exchange protocols with State departments and DHS Divisions
- SACWIS: Develop a method to reduce duplication of data and allow for more efficient case practice process
- SACWIS: Plan for Equipment Upgrade

1. Commitment:

Pre-SACWIS

- Pre-SACWIS applications
  - Essential: Require all DYFS staff to use Pre-SACWIS applications
  - Complete testing and deployment of the Foster Care Children Picture Database System and identify it as a new Pre-SACWIS application.
  - Complete all CRC automated assessments and their incorporation into the DYFS Pre-SACWIS casebook.
  - Develop and deploy a DYFS Centralized Screening application for the new Centralized Screening process, scheduled to begin in July 2004.
  - Integrate essential elements to support the Resource Family requirements.
  - During the latter stages of the SACWIS solution, after there has been user acceptance; analyze the impact on workers and management of providing field electronic data collection devices.
  - Establish a Management Team to work with IT to determine if any critical data elements or reports need to be added to the Pre-SACWIS applications and to oversee deployment of DYFS Pre-SACWIS applications.
- Complete DYFS infrastructures upgrades and strengthen the PC and Server configurations.
- Provide sufficient and appropriate training of staff to ensure every DYFS employee who needs to, knows how to use the applications.
- Utilize Medicaid and SIS data for policy and program decision-making.

- Implement Phase 2 of the Video Conferencing equipment deployment with the additional equipment and infrastructure to support training, change management, and court processing at all District Offices.
- Evaluate, purchase, install, & test middle tier application server to support mobile computing platforms.
- Deploy and evaluate the appropriateness of a variety of mobile computing form factors in pilot sites in preparation for supporting SACWIS mobile computing solutions.

SACWIS

- SACWIS Development
  - Commit all necessary staff and fiscal resources
  - Commit to staff that SACWIS will be a user friendly and intuitive tool
  - Commit to staff that SACWIS will provide multiple access methods allowing them to maximize their time when providing protective services.
  - Build Web Services as part of the SACWIS interface effort to ensure efficient and timely integration of data sources
  - Continue & Expand current progress toward establishment of data exchange protocols with other Departments and Divisions.
  - Closely examine/update functional requirements in SACWIS to ensure appropriate attention is given to eliminating duplicate data entry as it applies to New Jersey DYFS processes.
  - Closely examine/update functional requirements to ensure support for new data, business process, and reporting requirements needed to implement the Child Welfare Plan.
- District Office Super User, Trainer, and IT Support Person Team for each office
  - Train these teams and incorporate them into the SACWIS change management process
- Department level Data Management Team (IT and Program Staff) to manage this effort
  - Establish team with IT and program staff
  - Coordinate information exchange needs for all the new major development efforts including SACWIS, ACSES, and CASS as well as the case management development that will be initiated for the other DHS divisions
- Equipment Replacement Plan
  - Develop, through the IT Steering Committee, a Department wide, phased in approach for the periodic replacement of PCs and other major infrastructure components.
- Staffing Levels Assessment
  - Analyze and select the appropriate vendor to conduct a DYFS Staffing Assessment. It will be used to determine if DYFS is operating at appropriate levels to support the SACWIS/DYFS computing infrastructure.
- Ensure SACWIS system components are developed in coordination with DYFS Policy Unit.

2. Rationale:

Pre-SACWIS

- The Pre-SACWIS applications are, by design, business process improvement methodologies. In addition to the Permanency Tracking, Home Provider Tracking, and Minimum Visitation Requirement applications already completed, the Picture Database System will permit DYFS workers to capture and store digital images of all foster children in their care. The photographs will be collected, electronically filed and serve to document the well-being of each foster child. The Centralized Screening application will ensure timely and auditable delivery of referral to District Offices for action. Providing training to all DYFS staff will make the use of these new applications part of the new business process. Sharing data between the Division of Medicaid and DYFS will assist the Division in identifying the quality of medical care provided to many children under supervision as well as determine if children have been seen for abuse and neglect related medical reasons. The careful analysis and application of Medicaid, SIS, and Pre-SACWIS data has the potential to reveal service delivery gaps and assist management in redirecting service, fiscal and staffing resources, in addition to providing information that could guide the tuning of SACWIS functional requirements for business process, data, and reporting.

SACWIS

- New IT requirements and major business process issues/changes need to be addressed in relationship to the development of SACWIS. If addressed separately they may jeopardize the development of SACWIS by diverting limited staff and fiscal resources.

3. Current Situation:

Pre-SACWIS

- Program management has to be an integral part of the team for the development and deployment of DYFS Pre-SACWIS applications.
- Pre-SACWIS application data are essential to meet current information and reporting requirements.
- The quality and accuracy of SIS data needs to continue to improve in order to improve the quality of the legacy data that will be loaded into the new SACWIS applications.

SACWIS

- Actively recruiting District Office Super User staff.
- VV&T and Implementation vendors are in the joint planning stage.
- Recruiting and hiring State Subject Matter Experts.
- The American Management Systems, Inc. was awarded the NJ SACWIS contract. Their proposal clearly demonstrated:
  - An intuitive and user friendly Graphical Use Interface that supports both Federal and State requirements

- A workflow driven system that will assist enforcing Division processes (i.e. ensuring timely Minimum Visitation Requirements, Safety Assessments, Court Processing and Documentation).
- The collection of mandatory data required for NCANDS and AFCAR reporting
- Capabilities to be accessed using mobile solutions as were required in our RFP.

4. Strategies:

Pre-SACWIS

- Maintain development and deployment of Pre-SACWIS applications
- Incorporate program management participation
- Add key elements to the Pre-SACWIS suite of applications without impacting the deployment of the new SACWIS
- Continue to make use of SIS data in web-based pre-SACWIS applications so that staff can take steps to correct inaccurate data.
- Evaluate mobile computing form factors.
- Implement video education portals.

SACWIS

- Finalize SACWIS requirements utilizing focus groups and the Department's IT Steering Committee
  - Ensure requirements are finalized by all levels of the Division.
  - Ensure all the requirements are in line with the Division's goals and objectives.
- Maintain SACWIS development effort
- Expand DHS-CO IT and Program support resources
- Establish Central Data Management team

5. Implementation Steps:

Pre-SACWIS

- Establish Pre-SACWIS Management Team:
  - By February 2004, establish team
  - By February 2004, complete initial review of data and reporting requirements
  - By March 2004, complete addition of data elements and reports to applications
  - Meet bi-weekly for on-going evaluation
- Foster Care Picture Database Application:
  - By February 2004, complete development
  - By April 2004, complete training and deployment
- Maintain the CRC Applications development efforts
  - By March 2004, vendor estimates training to be completed
  - By June 2004, vendor estimates full deployment
- Centralized Screening:
  - By February 2004, determine if automated system required
  - By March 2004, complete vision, scope, and business requirements
  - By April 2004, deploy pilot

  - By May 2004, production
- Resource Families:
  - By March 2004, determine all functional requires and establish implementation plan.
  - By May 2004, deploy pilot application system & process
  - By May 2004, production
- Phase 2 Video Conferencing:
  - By March 2004, determine all additional site requirements & submit purchase of additional resources
  - By June 2004, complete deployment.
- Mobile Computing
  - By July 2004, install and test middle tier mobile computing server
  - By November 2004, complete evaluation of mobile computing platforms

SACWIS

- By February 2004, establish Central Data Management team
- By February 2004, state SACWIS Core Team in place.
- By March 2004, submit APDUs for SACWIS and CASS and ACSES that would allow for the addition of IT and Program Support staff in DHS-CO.
- By March 2004, establish DO change management teams and incorporate them into the SACWIS development and change management plan
- SACWIS Phased in Release Schedule:
  - By November 2004 - Release 1 – Intake and Associated Functionality (Resource Family requirements would be support directly or through integration with the Pre-SACWIS process/application.)
  - By October 2005 - Release 2 – Full SACWIS Functionality
    - Service Management
    - Provider Management
    - Financial Management
    - Staff Management
    - Common Functionality
    - Critical Interfaces
  - By May 2006 - Release 3 – Remaining Interfaces

6. Necessary Resources:

Pre-SACWIS

- Pre-SACWIS Management Team:
  - Two Executive level DYFS Program staff
  - DYFS Pre-SACWIS Application Development manager and lead programmer
  - DHS-CO Application Development Manager
- DYFS Training Unit
- DYFS staff involved in the development of SDM and DYFS policy
- Centralize Screening management staff
- DYFS application development staff

- DHS-CO IT Managers and staff

SACWIS

- Existing SACWIS staffing plan
- DHS-CO IT and Program Planning Staff
  - Should consider the establishment of additional federally funded positions at the Department level to assist DYFS and DFD in all of these areas, including the management of a larger and more complex infrastructure and the development of web services to support the efficient and timely exchange of data with other Departments and Divisions.

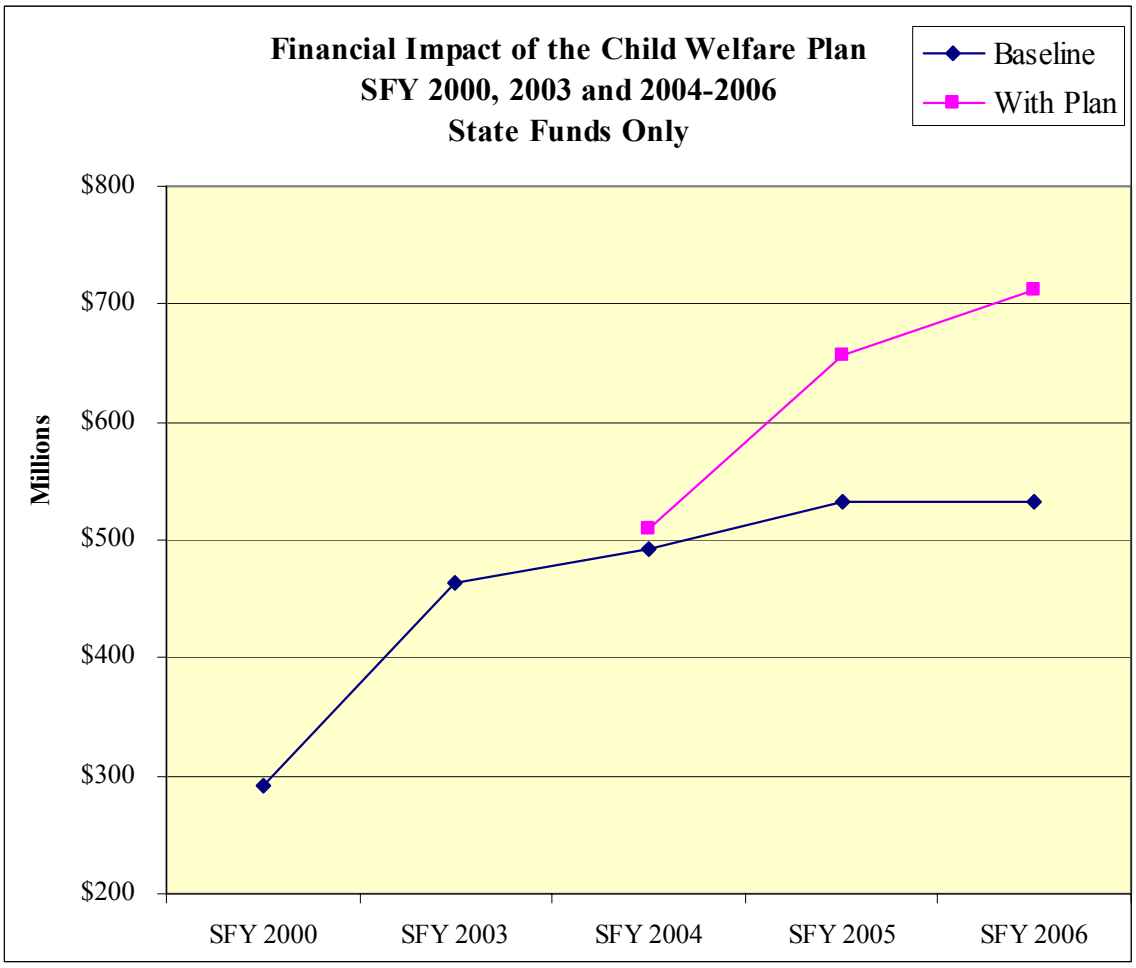
♦ Budget

Implementation of this plan will require the following additional resources in the first several years:[167]

Department of Human Services Child Welfare Plan Fiscal Summary Total Need by Year			
	FY2004	**FY2005**	**FY2006**
Additional State Need[168]	$15,000,000	$125,000,000	$180,000,000

[167] We note with gratitude the Legislature's April supplemental appropriation for FY 2004 in the amount of $15 million, which enabled us to begin the implementation process. Implementation of this plan will not be complete, even under the rosiest projections, by FY 2006. But developing budgets for later years now would be unduly speculative, subject to too many intervening variables. We can, however, make this commitment now: we will conduct annual statewide needs assessments covering all aspects of this plan – including but not limited to staffing, training, prevention, supportive services and residential placements – will base our planning on these assessments, will insure that future years' budgets identify all necessary resources, and will seek to secure resources to address identified needs.

[168] As discussed in the next section of this plan, we also will vigorously pursue federal funds, which are essential to the successful implementation of this plan. It is anticipated that the additional state funds in this chart will enable us to draw down additional federal funds in the amounts of $3.4M in FY 2004, $62.1M in FY 2005, and $81.5M in FY 2006.


Financial Impact of the Child Welfare Plan
SFY 2000, 2003 and 2004-2006
State Funds Only
Baseline
With Plan
Millions
$800
$700
$600
$500
$400
$300
$200
SFY 2000
SFY 2003
SFY 2004
SFY 2005
SFY 2006

- **Maximizing Federal Financial Participation (FFP)**

The Department of Human Services relies heavily on federal funding to meet its child and family service goals and is taking proactive steps to maximize federal financial participation (FFP). Aggressive pursuit of federal reimbursement requires interdivisional and interdepartmental coordination and cooperation and adherence to strict claiming requirements. The primary funding streams[169] used to generate FFP are: Medicaid, Temporary Assistance to Needy Families (TANF), and Title IV-E.

Medicaid Reimbursement for DYFS Children

- Federal EPSDT compliance is being aggressively pursued for children in out-of-home placement under DYFS supervision. The Department's goal is to increase EPSDT screening rates for children in foster care by 10 percent by January 2005. DYFS and DMAHS are establishing a baseline to monitor EPSDT compliance. Resources will be devoted to timely processing and review of claims to minimize and correct errors. Internal data systems must be upgraded to improve utilization rates.
- DYFS and DMAHS are collaborating to draw down federal funding for foster care pre-placement examinations, required under New Jersey Statute and DYFS policy. Initially, Medicaid fee-for-service will be used to cover the cost of these exams but ultimately managed care could be the vehicle for payment. Contract amendment would be necessary, however. Utilization of fee-for-service will preempt the need to utilize District Office bank account funds[170] and enable FFP potential to increase.
- In an effort to improve health outcomes for children in foster care, DYFS and DMAHS will initiate a comprehensive health assessment for all children within the first 30 days of their initial out-of-home placement. The health assessment package carries the components of EPSDT, with a focus on preventive health care. An enhanced rate has been developed and is potentially claimable through a state plan amendment. Treatment and service needs identified through the exam will be billable under EPSDT.
- By June 2004, 25 percent of DYFS children in foster care will be enrolled in Medicaid managed care through the New Jersey Care 2000+ program. It is expected that all children for whom managed care is appropriate will be enrolled by mid-2005. Service outcomes under managed care improve as a result of higher utilization rates and opportunities for federal claiming at an enhanced match of 65 percent.

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[169] The major dedicated child welfare federal funding sources are Title IV-B and Title IV-E of the Social Security Act. Title IV-B represents only a small portion of the federal funding available; however, New Jersey will be reexamining the use of IV-B funds through the Child Welfare Services Program and Safe and Stable Families Program to claim services and expenditures for training and services related to expanded reunification and prevention efforts through Family Team Meetings and other changes in the practice model and service delivery system.
The three major non-dedicated federal funding streams are: Medicaid, Temporary Assistance to Needy Families (TANF), and Social Services Block Grant (SSBG).

[170] DYFS District Offices are provided discretionary funds to supplement expenses or uncovered services for families and staff. These funds are distributed and maintained in "DO bank accounts."

- All eligible DYFS aging out youth, ages 18-21, will be linked with the appropriate health coverage option. As greater numbers of young adults receive FFP-eligible services, claiming opportunities increase concomitantly.
- Under certain circumstances, DYFS pays health and mental health providers for services utilizing DO bank account/cost reimbursement funds. In other situations, Medicaid fee-for-service is used for the same types of services without follow-up FFP claiming activity. Opportunities exist to identify those services currently paid with 100 percent state funds and develop a strategy to access Medicaid reimbursement and subsequent FFP. Additional potential exists for DYFS to identify and process claims that meet FFP guidelines.
- In many of the aforementioned areas, the DYFS and DMAHS Program Development Offices will implement and coordinate the FFP claiming process. They will establish the appropriate billing procedures and implement required system changes to effectuate any new procedure codes with descriptions and fees required for FFP. Concurrently, DMAHS will submit state plan amendments required for the Center for Medicare and Medicaid Services' approval as well as propose and promulgate any needed Medicaid regulations.

Efforts to Maximize Federal Financial Participation (FFP) in the Cost of Division of Child Behavioral Health Services (DCBHS) Services

A New Jersey Medicaid State Plan amendment enables the Division of Child Behavioral Health Services (DCBHS) to maximize federal financial participation (FFP) for children's behavioral health services and their administrative overhead. Beneficiaries of the Medicaid rehabilitation option include Medicaid and NJ Family Care Plan--A recipients and children under DYFS supervision.

Once Medicaid State Plan services were approved by the Centers for Medicare and Medicaid (CMS), the DCBHS took full advantage of federal revenue claiming opportunities by initiating retroactive claims back to 2001, the original amendment's effective date. Services provided in New Jersey under the Medicaid rehabilitation plan are:

- **Residential Treatment Centers (RTCs),** funded as optional services under the "Inpatient Psychiatric Services for Individuals Under Age 21" portion of Medicaid. Changes in billing rates last year created a one-time increase of $10 million and will generate approximately $3 million annually prospectively.
- **Group Homes** and **Treatment Homes**, funded through the "Diagnostic, Screening, Preventive and Rehabilitative Services" Medicaid rehabilitation option. Room and board for DYFS clients, which is ineligible for FFP under Medicaid, is claimed through Title IV-E.
- **Care Management Organization (CMO**) and **Youth Case Management (YCM)** services, funded under Medicaid "Targeted Case Management."

- **Behavioral Assistance (BA), Intensive In-Community (IIC) and Mobile Response (MR)** services, funded under the Medicaid "Diagnostic, Screening, Preventive and Rehabilitative Services" option.

Administrative costs associated with the Contract System Administrator, DCBHS administrative salaries and associated costs are now earning FFP, according to a Medicaid-approved cost allocation plan.

In addition to billing for all claimable Medicaid services, New Jersey is poised to further maximize FFP through the following actions:

- Expand the number and type of providers who are authorized to perform presumptive eligibility determinations for clients they are currently serving with state dollars. Once enrolled in Medicaid, the DCBHS will increase intensive in-home and behavioral assistance service consumption rates from their current low of 45%.
- Develop a quality assurance protocol to assure that presumptive eligibility applications are pursued to completion.
- Tighten policy and outreach efforts to ensure all families entering care provide the information and documentation necessary for accurate eligibility determination and subsequent claiming.
- Amend the SCHIP State Plan to provide coverage for services to DCBHS clients, presently covered only under Medicaid and NJ Family Care Plan A.
- Review all rate-setting methodologies to ensure that all claimable services are billed. For example, group homes and treatment home services presently characterized as non-claimable room and board should be built into treatment rates.
- Investigate the ability to further amend the Medicaid State Plan and NJ FamilyCare benefits packages to provide coverage for substance abuse services. This includes the development of a more comprehensive continuum of substance abuse services for a greater number of people than are being served now and in an integrated fashion with mental health services.

Temporary Assistance to Needy Families (TANF)

New Jersey receives approximately $404 million in federal TANF funds annually, which represents the maximum amount available. Currently, the Division of Family Development (DFD), which serves as the conduit for TANF funds, provides approximately $32 million in TANF funding to DYFS for the following services: the Healthy Families program, relative caregivers, Emergency Assistance (EA), foster care, TANF to Social Services Block Grant transfer, and independent living services.

A total of about $33 million is available within DFD to provide substance abuse services and priority child care slots to families with protective services issues. Despite the fact that TANF funds are maximized, DFD proposes to fund an additional $10 million in substance abuse services. In cases where DYFS and the Division of Family Development (DFD) have mutual

clients (currently, approximately 33% of DYFS-active families are also TANF-active), the TANF funds will be used rather than DYFS State-only funds to pay for substance abuse services.

- Through a recently developed information systems match among DYFS, DFD and Medicaid, children and parents currently participating in programs within the three Divisions will be identified. This will further improve access to federally-reimbursable services, including Title IV-E, NJ FamilyCare, Medicaid, and TANF-related services.
- In situations where DYFS/TANF families need emergency assistance, TANF EA funds will be used rather than DYFS District Office funds.
- As part of an overall prevention strategy, new mothers on TANF will be provided with skills training in parenting, nutrition and related life skills; $6 million of combined TANF and Food Stamp funding will be used to support this initiative.
- TANF funds also will support access to a Mental Health Initiative for mutual DYFS TANF or General Assistance (GA) services. Intensive case management services will be available to mutual DFD and DYFS families who may be at risk of losing public assistance benefits due to time limits or identified chronic conditions.

Title IV-E

The FY 2004 budget for the Division of Youth and Family Services is $520.6 million, of which $179.2 million is federal funding for foster care, adoption, Chafee foster care independence, support services, and miscellaneous services. Title IV-E programs, funded by the Administration for Children and Families (ACF), are intended to assist states with foster care and adoption related services and comprise a large percentage of the federal funding to DYFS.

Within the past year DYFS has taken bold steps toward maximizing IV-E funding. It has:

- Restructured the Title IV-E Eligibility Determination Unit to assure that all eligible children in foster care and subsidized adoption are properly categorized for billing under IV-E. Structural improvements include the hiring of an administrator to oversee and coordinate daily operations, personnel and policy issues and track billing performance. Additional staff have been hired to oversee quality assurance and documentation compliance, and provide better training and supervision of field staff making eligibility determinations.
- Trained all Title IV-E staff to ensure that determinations and re-determinations are completed according to federal regulations.
- Developed a Title IV-E monitoring system to track more detailed information on eligibility than is currently available through the DYFS SIS system. Trends in ineligibility are now tracked statewide, regionally and by District Office, allowing for intervention and improvement of eligibility rates. The monitoring system also provides the IV-E Unit with a management tool to track and improve productivity and accuracy of staff.

- Contracted with MAXIMUS, a private consultant, to improve DYFS's in-house capacity to train and technically support IV-E operations statewide.
- Proposed amendments to the IV-E State Plan to implement provisions stemming from the Ninth Circuit's Rosales v. Thompson decision. This decision held that a child may be determined Title IV-E eligible based upon his eligibility for Aid to Families with Dependent Children (as it was in effect on July 16, 1996) in the home from which he is removed or in the home of some other specified relative with whom he lived at some point during the six months prior to removal. The Division is awaiting a written response from ACF on this matter.

Proposed Title IV-E initiatives to maximize FFP are as follows:

- Revise the IV-E Cost Allocation Plan (CAP) to incorporate new claiming opportunities as they emerge and are approved by ACF.
- Revise the Random Moment Survey (RMS), one of the primary CAP statistics required for the filing of accurate administrative claims.
- Review the Law Guardian Claim that covers expenditures made by the Office of the Public Defender for the representation of DYFS children and parents and retroactively bill for recently approved work.
- Increase participation in ACF Demonstration Waiver Projects on an on-going basis. A recently submitted waiver application would fund children placed with relatives who are in, or who enter the DYFS Relative Care Permanency Support Program as well as children who have been in the same foster care placement for two or more years but for whom adoption or reunification has been ruled out. If the results achieved at the end of the demonstration are as favorable as expected, programs regarding the two groups of children previously mentioned may be permanently incorporated into Title IV-E claiming.

■ STATUTORY, REGULATORY AND POLICY & PROCEDURE REFORM

The myriad interrelated reforms called for throughout this plan have a variety of legal and policy implications, only some of which have been delineated. This important work will begin comprehensively now.

Under the direction of the DHS Special Deputy Commissioner for Legal, Legislative and Regulatory Affairs, a team will analyze all the changes necessary in either statute or regulation to support this plan's implementation by. The regulatory changes will be implemented as soon thereafter as possible under New Jersey administrative law; the emergency regulatory process will be employed if needed. The agency will work with the Governor's Office to bring forward the proposed statutory changes during the spring 2004 legislative session.

A second team, under the same Special Deputy Commissioner,[171] will review the agency's policies and procedures and will, by December 2004, draft all changes necessary to comport with this plan.

There will thereafter be annual reviews of any statutory, regulatory, or policy changes necessary to facilitate the continuing implementation of this plan, and all efforts made (working, as necessary, with the Governor's Office and Legislature) to effect any such changes promptly. Responsibility for this work will lie with the OCS Office of Legal Affairs.

[171] This task may become the responsibility of the OCS Office of Legal Affairs, depending on when that office is staffed up.

■ GETTING FROM HERE TO THERE

Throughout this plan, we have strived to paint an honest picture of where we are – and describe the vision of where we want to go. But there is obviously a long and arduous journey we will need to take to get from here to there. Rarely has a reform of this magnitude been attempted in such a wholesale way – and the task, as the sum of all of these parts, is formidable.

So how will we get there? We cannot do all these things all at once. We need to be strategic about rolling out the reforms in such a way that our already fragile system does not break under their weight. We need to build our capacity and our resources, while we work hard all along the way to keep children safe and deliver services to families. We cannot put the system on hold or hit the pause button – get all of our staff trained all at once – and then resume our work. We will have to do it in tandem – reform and continue to deliver safety and services at the same time.

There are some things we need to do immediately to build momentum and to start to build hope both externally and internally that we can do what we are setting out to do.

Our theory of change is that a very public process of reform serves us – and the children and families in our care – best. We need the public to participate in shaping the reforms, in stepping up to help us deliver them, and in holding us accountable. Our failures have been very public – as they should have been. We need to make the process of remedying our short-comings just as public – and step up to the challenge of delivering concrete results that people can see – and know – are real.

We will start to build public trust and support by creating as transparent a process as possible as we move along to reform – so that people know what we are doing and they can give us feedback. We have already begun this process. We will post this plan on our website – along with the reports from the public work groups so people can compare and contrast what they asked for and what we have promised to deliver. In the plan, we believe we have done what they asked us to do – but we want them to have an opportunity to tell us. As another move to transparency and accountability, we will start posting the key statistics about our performance on the web as well so that everyone can see how we are doing. Our Commissioner will continue to hold regular press conferences as another way to get our message out to the public – and have the public hold us accountable.

We have to start with child safety. We will make that commitment concrete to the public and to our staff by opening our 24/7 Hotline by this summer. We will have our number – ONE number – posted everywhere and we will vigorously encourage people to call us. And the Hotline includes the capacity for rapid transmission for investigations – so that even as we are retraining and reorganizing our investigative staff, we will keep the pedal down on instituting investigations and making sure we see children quickly to see if they are all right and to help them if they are not. We will monitor our investigations closely – the Hotline gives us the opportunity for the first time to track all of the calls that come into us. We are rolling out to our workforce an unprecedented level of guidance on how to check for risk – and respond. We have imported the best practices from around the country to shape a very specific and research-driven set of protocols. And we will very publicly ask people to hold our feet to the fire to tell us how

we are doing in delivering on all the commitments in this plan, particularly the most important: keeping the children of New Jersey safe.
As for case practice, the changes that we want to make represent a revolution. And many people will have to see it to believe it. To that end, we will roll out our first four area offices and fifteen prototype model district offices by January 2005. We cannot institute the case practice changes we propose piecemeal – we have to deliver all the parts as a whole. Again, we will concentrate our management attention and resources and assemble a strong team of supervisors and frontline staff to take this model and make it real. We will pick communities of high need – and we will start partnering with them from the very beginning. We will bring in the best expertise and the best practices we can find – from around the state, around the country, and around the world. We have committed to family team meetings as our primary vehicle for reorienting our agency to listen and deliver based on what our families and children tell us they need. Again, while we plan to train everyone on delivering family team meetings, we know that this is a tool that requires quite a bit of training and support to deliver well. At the start of the summer, as we open our training academy, we will begin by training a cadre of family team meeting experts – who will fan out across the state, but starting with our prototype model District Offices, to support the family team meeting model throughout the state. We want to get a buzz going about family team meetings. As families and children and resource families and community partners start to experience family team meetings – we will ask them to help spread the word to others, particularly our own staff, on the virtues of family team meetings.

We know we need resource families desperately. We have already begun a vigorous process of recruitment, one that we will continue to step up over the next several months. In just a few months, we will launch a very prominent campaign to ask the citizens of New Jersey to help us with this very important task – and agree to become resource parents. We will reach out to experts and resources to help us deliver. We will use community members and our current resource families and others to reach out through all of their networks – professional, faith, civic, corporate, and others – to spread the word that we need YOU – or more importantly, the most vulnerable children of New Jersey need you. We will focus on recruiting resource families in our areas of highest need – so that we can start delivering neighborhood-based placement from the beginning. We have set aggressive targets for recruitment – and we will do some specialized recruitment campaigns to develop families who come to us wanting to take older children, wanting to take special needs children, wanting to take large sibling groups. We will take licensing seriously – we will not compromise safety by failing to scrutinize the families who want to help – but we can do that briskly and respectfully. We have already begun to streamline that process. We are also concentrating management support and putting some of our best people on the task of revising resource family training – and developing resource family supports. We want to do more than get families to sign on – we need them to have a good experience with us from the very beginning – and if they have a good experience, they will stay with us and with our children – and they will spread the word so that others want to join.

We will start the community mapping process soon so that we can begin identifying existing services, formal and informal supports, overlaps and gaps in need. That process will help our services contract process rolling – while grounding it in the principles of commitment to community based services, starting with the communities of highest need.

In this plan, we have made an unprecedented commitment to adolescents in our system. They will no longer be the step-children of our system. We have made it a priority to move them out of inappropriate and wastefully expensive group facilities that do not meet their needs. As we stated above, we are targeting recruitment of resource families for older children – and so we will develop homes for them to go to. We are also moving young children out of our congregate care settings, because the research and practice tells us those setting are inappropriate for young children. We will place a priority on placing those younger children in family-like settings. We are expanding treatment beds for those who will need them but we also suspect that some of our children in institutions will flourish in well supported resource and kinship family homes. We will make it a priority to deliver support to those homes to make it possible for our children to adjust and settle in.

We will open New Jersey's first child welfare training academy by this summer. We have set aside the resources to hire experts to develop our curriculum and get our training quickly and vigorously off the ground. As is evident from the training section of this plan, we want to give our staff much more support and much more training. To do that, we must have deep and broad and consistent internal capacity – as only our own training academy can deliver.

By the end of this year, the public – and our children and families – and our staff – should start to see and hear and feel the difference in how we do what we do. And they should start to hope that we mean what we say. As we go into 2006, we will work to build on that momentum. We will have new and more staff on board. We will have worked with our managers and supervisors and existing frontline staff to review our open cases – and close all those we can close safely and appropriately. And our staff should start to experience an easing of case workloads – and our families and children should start to feel the increase in attention. We will be frontloading the engagement and training of our supervisors. We know that they are critical to bringing and reinforcing our messages about this new way of business to the frontlines. We need them to support the new staff we hire so that they get off on the right foot – and we need them to guide and support our existing staff to make the changes they need to make to bring our vision of case practice into reality.

We have committed to introducing unprecedented resources and energy and attention to New Jersey's child welfare system. We cannot do it all alone. We need the support of the public and advocates and providers and legislators and our colleagues in other agencies and many, many others in order to move forward. In this first year, we must deliver the beginnings of reform very publicly in order to garner the further resources and energy and attention that we will need to keep moving along on our journey towards change – and to deliver to the children and families of New Jersey the child welfare system they need and deserve.

Summary of the First Fifteen Months

The approach delineated above represents our overall approach to this multi-year reform effort. Much more detail will obviously be essential to our implementation efforts as we move forward. It would not be responsible, however, to explicate these details on a multi-year basis now, because future years' details will depend on developments and progress in the first stage. What follows is a summary of the steps we intend to take from April 2004 through June 2005.

Reforming Case Practice

- In creating a Centralized Child Abuse Hotline a single 800 number for calls will be established. A new plan will be designed and implemented and a community awareness/marketing plan will be rolled out to publicize that number.
  - Hotline protocols which standardize the criteria for screening and assessing which reports meet the threshold for suspected child abuse or neglect will be created.
  - The process for referring cases meeting that threshold to protective services or IAIU will be established.
  - IAIU screening function and staff will be integrated and relocated/reassigned into State Central Registry
- SACWIS will be made to accommodate the automated transmission of reports to District Offices, IAIU, and the OCA as appropriate. This automated system should also track calls, investigation time frames, and referrals and allow for analysis of the calls.
- IAIU will revise the investigative practices, protocols and procedures to ensure consistency with in-home forensic investigations.
- Human Services Police Officers will be hired and assigned to each District Office and IAIU unit to assist with criminal investigations and coordinate the process of receiving police reports in a timelier manner.
- Improved support to Child Victims and Coordination Among Law Enforcement, Medical and Child Protection Staff in Cases of Severe Maltreatment.
- Structured Decision Making will be developed to support DYFS, IAIU OPIA staff in delineating between levels of risk and development of safety plans that can keep children safely in their homes. SDM tools will be modified to include minimum review every six months, review at key change points, opening of case, change in household composition, change in placement, and return home, increased visitation requirements.
- A placement support unit will be established to find appropriate placements for placing children who need out-of-home settings like those who may be medically fragile, LGBTQ, etc.
- Voluntary placements, a.k.a. informed consent, will be phased out beginning in October 2004.
- A community-based approach will be important when assigning cases. Considerations of geography will be taken into account so that caseloads will reflect the one-worker, one-case model.
- A community awareness campaign for staff, consumers and stakeholders will be developed related to the concept of family team meetings. Training will also be a critical part of the process.

- A detailed blueprint will be developed for ensuring adoption expertise throughout the agency as a precursor to the ARC phase-out. All elements of adoption case practice will be incorporated into the district offices and case practice protocols to integrate adoption functions with ongoing casework, i.e., concurrent planning. New Jersey will also take all necessary steps to become a member of the Interstate Compact on Adoption Medical Assistance (ICAMA).

Recruiting, Retaining & Supporting Resource Families

- Develop statewide resource family work plan with short- and long-term recruitment goals ensuring that 1,000 new resource families are recruited by June 2005. Specific recruitment targets will be developed, following a data analysis, based on where the children come from.
- New Resource Family training initiatives will encompass relatives, foster parents and adoptive parents. There will be a new 24 hour pre-service training curriculum implemented in July 2005. Resource families will be licensed and approved within 90 days of application.
- Plans to adopt uniform licensing standards for resource families, unifying regulations governing adoptive, kinship and foster homes will be carried out. Plans include rate equalization for relative care and kinship legal guardianship rates and become effective 7/1/04 and increases in board rates for resource families beginning 1/1/05. The equalization will close the gap between current board rates and the full USDA rate.
- Partnerships with resource families will be enhanced through a variety of recognition events designed to recognize that partnership and those between staff and resource families, each quarter.
- Licensing regulations will be changed to reflect CWLA standards for capacity.

Adolescents and Youth

- A new state-of-the-art youth development training curriculum in consultation with national best practice will be developed and will include a review of the curriculum used by the National Resource Center to train child welfare staff. Particular attention will be paid to those sections that identify New Jersey-specific policies and procedures related to adolescents, aging out youth, and Lesbian, Gay, Bisexual, Transgender, and Questioning Youth, making them more applicable.
- A request will be made to the Legislature to amend kinship legal guardianship statute so that it may be incorporated as a permanency planning case goal for youth who may have previously had long term foster care as their alternative permanent placement.
- A Request for Proposals will be issued to select community and faith-based organizations in order to recruit, hire, and supervise 500 adult mentors statewide. The mentors will be paired with youth ages 13+ who are in out-of-home placement.
- OCS will work with the Department of Labor and Workforce Development to develop linkages for youth transitioning to adulthood who require career counseling, job training, apprenticeships, and Youth Corp participation.
- Life skills training for youth will be expanded for youth in out-of-home placement. A review of the current process for independent living skills services to determine if it's

currently implemented in the most effective and efficient way. Many sources, including a survey of youth will be used to obtain this information.

- Strategies for building life long adult/family connections for teens are support activities in the plan and important when helping prepare adolescents to live as healthy and productive adults. These efforts will be supported by developing strategies to incorporate independent living skills. Higher education and vocational training scholarship applications will be issued to all youth in DYFS out-of-home placement, including homeless youth programs, schools and community-based agencies to increase the number of youth who enroll in post-secondary education.
- A Request for Proposal will be issued to create 40 new transitional living beds for approximately 55 youth who have aged out of the foster care system but for whom permanency with a family is not an option.

Substance Abuse & DYFS

- Since many DYFS clients are also served by the Division of Addiction Services, DAS is now under the umbrella of DHS—yielding greater efficiency and improved coordination of substance abuse services within DHS as well as enhanced opportunities for federal reimbursement.
- Treatment capacity for DYFS families will be expanded and enhanced.
    - DAS will expand services to integrate adolescent Mental Health services into a Substance Abuse program using the federal (SAMHSA) model and create 750 slots over five years.
    - $3 million will be spent in FY 04 to specifically meet the adult treatment needs of DYFS families.
- DYFS workers will receive substance abuse related training, including information, policies, and procedural protocols so the substance abusers may be identified and have their treatment facilitated.
- OCS and DAS will work with DMAHS to review and identify potential Federal Financial Participation (FFP) and any subsequent State Plan Amendments.
- Primary, secondary, and tertiary prevention services will be expanded to reduce substance use by adolescents and youth. These activities, such as prevention marketing campaigns, will help to create a continuum of prevention services that break the chains of substance abuse and addiction and promote healthy lifestyles.
- Funding and training will be provided to community-based agencies to implement nationally recognized substance abuse prevention programs that best meet the needs of the community.

Reducing Inappropriate Reliance on Institutional Settings

- Provide behavioral health services based upon a common assessment tool which will be used across service systems.
- Expand community-based services that reflect a service continuum statewide, such as:
    - Mobile response and crisis stabilization services
    - Youth case management
    - Intensive in-community services

  - Behavioral assistance
  - Clinical in home therapy
- The expansion of new treatment homes to provide additional community-based capacity for children returning to the community.
- The expansion of the Family Support Organization (FSO) to four new communities
- Expansion of Care Management Organization (CMO) capacity to four new communities will provide additional behavioral health services and family supports.
- OCS, in collaboration with JJC leadership will develop and implement protocols that will ensure access to behavioral health services including out-of-home placement for youth involved with the juvenile justice system. An MOU will be developed to define the process and integrate planning for OCS involved youth served by the Juvenile Justice System.
- A plan to assess and develop system capacity will be developed and implemented that meets the needs of children with behavioral health needs. In order to minimize the use of out-of-home group settings, policies and procedures will be developed for children under 6 (including boarder babies), children 6 to 12, and young children with special needs.
- Children in group homes, residential treatment centers, and or psychiatric community residences will be assigned an appropriate level of case management.
- All children referred to shelter care by DYFS, will be registered upon admission with the Contracted System Administrator (CSA). Arrangements will be made for an assessment of every child whose current assessment is older than 90 days or for whom there is no assessment. When appropriate, children will be moved to a less restrictive environment.
- Children in shelters or detention waiting for an out of home treatment setting must be assigned a case manager who will oversee any necessary evaluations and will identify an appropriate placement and transition the child to that placement.

Unifying the System/Community

Domestic Violence

- Children and families involved with DYFS will benefit from the continued use of the successful "Peace: A Learned Solution (PALS)" project. Having expanded statewide over the past five years, the program is designed to help children heal from the effects of domestic violence. Expansion will include two additional high risk areas.
- A public awareness campaign to develop, implement, surface, and help eradicate domestic violence. A broad-based advisory committee will be created to shape this campaign and contribute its expertise and efficacy. DCA will provide housing assistance to women transitioning from domestic violence shelters to permanent living arrangements.
- District Offices will have access to Domestic Violence experts to inform case practice.

Health/Medical

- A Medical Director will be hired and will develop an interdisciplinary support team of medical consultants including specialists in psychiatry, psychology, licensed clinical social work, licensed certified alcohol and drug abuse, as well as the American Society of Addiction Medicine.

- A plan will be developed within 6 months of the hiring of the Medical Director that includes research based practice and standards for both physical and mental health assessments. Training opportunities will be outlined in the plan for physicians/medical personnel who are partners with the child welfare system.
- A policy to ensure annual physicals and dental exams for children in out-of-home placements will be implemented. Pre-placement exams for each child entering foster care will be completed using a community provider or contracted nurse-practitioner.
- The Training Academy coordinates with managed care providers to assure educational sessions for staff, resource parents and other community providers that focus on the health needs of children in the system.

Housing

- An interdepartmental team will be formed to coordinate housing service activities under the plan with DCA, OCS, HMFA, and DHS.
- DCA will assist with respect to three programs:
    - $2 million in a federal subsidy program for permanent rental housing funding available in the first year, and $800,000 annually for the next four years. These monies will create up to 40 affordable rental housing units.
    - $1.5 million available over 5 years in Neighborhood Preservation funds. These funds will be used to rehabilitate neighborhoods that include resource family homes. Program operating guidelines and protocols will be jointly developed between DCA and DYFS.
    - $1 million available annually for 5 years to rehabilitate 250 homes for resource families to ensure safety and accessibility for licensure.
- The Home Ownership Permanency Program (HOPP) operated by HMFA will be expanded to provide more than $5 million in loans to assist 250 resource families who are in the final stages of adopting a child or becoming the child's legal guardian.
- To mitigate the possible DYFS involvement of children and families at risk, Emergency Shelter Homeless provider agencies will be encouraged to apply to become non-profit housing developers to create additional permanent housing slots for the DYFS population transitioning from emergency or transitional placements into more stable living environments.

Prevention and Community Development

- School Based Youth Services Program will be expanded to high schools and middle schools with Abbott Districts having priority. An RFP will be issued.
- Home Visitation Program for TANF mothers of children from birth to 12 months is being piloted in Camden County.
- Creation of Community Case Management according to the phase-in plan.
- Development of Community Collaboratives in 6 high-risk communities.
- Identification of Community Developers for all DYFS offices.

Striving for Safety & Permanency in the Courts

- The Inter-agency Council for Children and Families (ICCF) is established to oversee and implement strategies related to safety and permanency in the courts. To that end, the council will develop monitoring tools that measure the progress of these strategies. Public reports will be issued every 6 months.
- In order to support child welfare reform in the courts, legal resources will be identified.
- Reorganize the Department of Law and Public Safety's Division of Law to ensure that attorneys representing DYFS in Family Court are specialists in this area of law, are well trained, and are rigorously supervised for practice.
- Expedite the processing of abuse and neglect cases.
- Eliminate Voluntary Placements (informed consent)
- Develop mechanisms for DYFS and Probation to collaborate, as appropriate, in cases where they are both involved.
- Improve the culture of the courts to better respond to the needs of children and families.

Developing the Necessary Culture & Workforce

- Begin recruitment of leadership positions at the county/ local office level.
- Recruit senior leadership team for the OCS including a sufficient number of managers with the expertise, talent and experience to execute all components of the reform.
- Begin recruitment of leadership positions at the county/ local office level.
- Align hiring and promotional opportunities with new structure.
    - Require front line staff to have BSWs or degrees in identified fields or have a minimum number of hours of work experience in human services or related fields.
    - Immediately incorporate into hiring procedures a preference for MSWs or related degree consistent with accreditation standards.
- Development of a career ladder for clerical and support staff, including development, and promotional opportunities.
- Develop a transition monitoring team (TMT) comprised of 7 -12 people chosen from a wide cross-section of the organization to take a continual pulse of the organization in transition and facilitate dialogue both upward and downward.
- Establish the New Jersey Child Welfare Training Academy.
    - Implement an information system that will track individual participation and completion of training for all levels of staff and resource parents as well as completion of competency testing.
- Contract with consultants, child welfare experts and social work and other relevant programs at universities and county colleges in the state to deliver training.
- Integrate elements of new case practice model into the existing DYFS core training curriculum.
- Make other related graduate programs available to staff by expansion of the tuition reimbursement program, and/or development of contracts with educational institutions.
- Establish Union leadership/Management Task Force to address reform activity.
- Staff Retention Activities
    - Implement monthly "Staff Support Days."
- Utilization of data, case situations, and critical incidents as learning tools.

Accountability

- We will create a CQI culture within OCS that creates, reorganizes and integrates Continuous Quality Improvement functions at every major administrative level of DYFS, DCBH, DPCD, and OCS, and between OCS and all of DHS.
- Develop local capacity for CQI that includes management reports.
- Develop benchmarks and standards to evaluate the new case practice model.
- Engage community stakeholders in the CQI process to strengthen partnerships in support of improved child welfare outcomes.
- Develop and apply new tools for collecting and reporting outcome information.
- Create the capacity to monitor the Child Welfare Reform Plan benchmarks and outcomes and build and/or expand data analysis and reporting capacity within the divisions of the OCS.
- Create a performance-based contracting system connected to the commitments and benchmarks in this plan.
- Develop a process for the comprehensive review and feedback of Fatalities and Near Fatalities of children known to the child welfare system. Lessons learned will inform future policy and planning.

Infrastructure and Resources

- SACWIS development will be informed by the reform plan and be integrated with IT within DYFS, Child Behavioral Health and the new Division of Prevention and Community Partnership.
- Data will be shared between DFD, Medicaid and OCS Divisions in order to better integrate services for families.
- A commitment to integrate and analyze data will reveal service delivery gaps and assist management in decisions regarding staffing, fiscal and services.
- The Office of Children's Services will coordinate, manage and advance the reform goals. By July 2004, leadership within the OCS will be in place. Infrastructure supports including IT, training, human resources, data analysis, budget, planning and policy development will be built to support the work of its 3 Divisions.
- A Special Deputy Commissioner will be recruited to provide the leadership of the newly created OCS.

- **MEASURING PROGRESS**

There can be no accountability without clear expectations. We present here some of the numerous standards to which we intend to hold ourselves. We will report on our progress regularly, as will the Child Welfare Panel during its existence.

Key Child Welfare Outcomes and Indicators

The litigation Settlement Agreement includes, in Section IV, a set of 11 "Improved Outcomes for Children" that are to be measured regularly. The New Jersey Child Welfare Panel is required to "…set specific numerical measures and timeframes for each of these outcomes…" and is authorized "…if it deems it appropriate, [to] establish other outcomes and set numerical measures and timeframes for those outcomes" (the Panel has added three). Accordingly, the Panel, in consultation with the State and Plaintiffs, has established specific indicators to be used in evaluating progress for each of the outcomes listed in the Settlement Agreement. Baseline data (i.e. current system performance) will be available for virtually all of these indicators in the near future. The Panel, in consultation with the parties, will establish target levels of performance at a later date.

The indicators listed below are necessarily broad in scope, and it will be essential to look at critical breakdowns of the data to better understand how the system is working. For example, in certain instances it will make sense to look at the data by demographic characteristics (e.g. age and race); administrative characteristics (e.g. first entry into foster care vs. re-entry); and by region and/or district office.

In virtually all instances, data will be analyzed for "entry cohorts" – that is, all of the children who enter care in a particular time period, typically a calendar year. This methodology is unanimously recommended by the experts consulted because it provides a view of the experience of all the children who experience out-of-home care, not just those who remain in care on a given date. However, cohort information has been supplemented with a cross-sectional view in a few instances where this specific analysis is important.

A. Decrease the length of time in care for children with a goal of reunification.
B. Decrease the length of time in care for children with a goal of adoption.

Indicator 1: Length of stay for all children by entry cohort, measured at the 25th percentile, median, and 75th percentile.

Indicator 2: Probability of a permanency exit (reunification, adoption, or legal guardianship) within 12, 24, and 36 months of entry to care.

Indicator 3: Probability of a non-permanency exit (by entry cohort).

Indicator 4: An additional indicator, not yet defined, will measure the system's performance in achieving permanency for children who have already been in care for a long period of time.

C. Increase the proportion of siblings in foster care who are placed together.[172]

Indicator 5: The percentage of sibling groups, *entering care* at the same time, in which all siblings were placed together.

Indicator 6: The percentage of children in sibling groups, *currently in care*, in which all siblings are placed together.

D. Increase the proportion of children in foster care who are appropriately placed with relatives.

Indicator 7: Percentage of children entering care whose first placement[173] was with a relative, for the most recent entry cohort.

E. Increase the proportion of children in foster care who are placed in their home neighborhoods.[174]

Indicator 8: Percent of children entering care whose first placement was within ten miles of their home.

Indicator 9: Percent of children entering care whose first placement was in the same county as their home (for children from rural areas) or the same city as their home (for children from urban areas).

Indicator 10: Percent of children entering care whose first placement was within the same school district.

F. Decrease the incidence of abuse and neglect in out-of-home care.

Indicator 11: Percentage of children in out-of-home care who experience a substantiated instance of abuse or neglect during the reporting period (i.e. a calendar year).[175]

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[172] These indicators will be broken down to show the differences between smaller sibling groups (3 or fewer) and larger groups (4 or more).

[173] For this indicator, "first placement" will be defined to include children who were moved to a placement with a relative within seven days after an initial placement with a stranger or in congregate care. We will use breakdowns of some of the other variables to address the question of appropriateness; for example, we will examine levels of placement stability and rates of abuse and neglect in relative homes compared to those in other foster homes. We may add data drawn from qualitative reviews at a later date.

[174] All of this data will be broken down by level of care, so we can distinguish the experience of children being placed with foster families from that of children going to congregate settings.

[175] This indicator counts all substantiated abuse or neglect during an out-of-home care episode, including the relatively small number of incidents perpetrated by the parent on a home visit.

G. Decrease the proportion of children in out-of-home care who are placed in congregate settings.[176]

Indicator 12: Percentage of children *(by entry cohort*) whose predominant placement[177] was in a congregate setting.

Indicator 13: Percentage of children *currently in care* whose current placement is in a congregate setting.

Indicator 14: Percentage of children (by entry cohort) whose initial placement was in shelter care.

H. Decrease the average number of placement moves experienced by children while in out-of-home care.

Indicator 15: Percentage of children *(by entry cohort*) who have experienced two or more placement moves.

Indicator 16: Percentage of children *currently in care* who have experienced two or more placement moves.

I. Increase the proportion of children in care, and their families, who receive the services they need.

We cannot extract this information from existing data systems and will develop indicators and a methodology for obtaining the data at a later date.

J. Decrease the rate of re-entries into out-of-home care.

Indicator 17: Percentage of children (*by exit cohort*) who have returned to care within twelve months of exit.

K. Reduce the number of adoptive and pre-adoptive placements that disrupt.

We do not yet have a reliable source of data for this information and will develop indicators and a methodology for obtaining the data at a later date.

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[176] Each of these indicators will be broken down by age group, so we can separately examine the experience of children 12 and under and that of children 13 or older.

[177] "Predominant placement" is the setting in which the child has spent the largest part of her placement experience.

Additional Outcome Indicators

The New Jersey Child Welfare Panel has established three additional outcomes:

L. Reduce the proportion of children entering out-of-home care.

Indicator 18: The number of children entering care per 1,000 children in the general population.

Indicator 19: The number of children entering care per 1,000 children, in those communities from which placement rates have historically been highest.[178]

M. Reduce the recurrence of maltreatment for children who have been abused or neglected.

Indicator 20: The percentage of children with *substantiated* allegations of abuse or neglect in the most recent year, excluding those placed in out-of-home care following the substantiation, who have a second substantiated case within twelve months.

Indicator 21: The percentage of children with an *unsubstantiated* allegation of abuse or neglect in the most recent year who have a new, substantiated allegation within the following twelve months.

Indicator 22: The percentage of children who have a *substantiated* allegation of abuse or neglect within twelve months of exit from out-of-home care to reunification with parent(s) or relative(s).

N. Improve outcomes for African-American and Hispanic children in New Jersey's child welfare system.

Specific indicators will be developed through further discussion between the state, the panel, and the plaintiffs to measure outcomes for children in these groups that have historically had the poorest outcomes. These indicators will most likely include rates of entry into out-of-home care; median length likelihood of a permanent exit from out-of-home care; and the likelihood of reentry into out-of-home care after discharge.

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[178] Chapin Hall is currently identifying the specific communities to be included for this Indicator; they will certainly include Newark and Camden.

Benchmarks

In creating *A New Beginning*, we have developed many data measures that will provide us the means of tracking progress and holding ourselves accountable. The major outcomes for children and families that we intend our reform plan to improve were included in the litigation settlement and appear in the preceding section of this plan.

In addition to those overarching Outcome Indicators, however, many other measurements are needed to track our progress in meeting the commitments we make in this plan. These are presented here, under the corresponding chapter headings from earlier in the plan.[179] The Final Targets represent our ultimate goals, when we have achieved comprehensive reform. At that point, for most of our measures, we expect to meet our commitments at least 95 percent of the time. For measures directly related to the safety of children, we hold ourselves to the higher standard of 98 percent compliance.

We are well aware that much work needs to be done to reach these high standards. When it is available, we include baseline data to tell us where we are starting. We have also set interim targets, which match, where possible, to dates when the New Jersey Child Welfare Panel will issue monitoring reports. These interim targets represent the level of change we will regard as evidencing successful, timely progress toward our ultimate goals.

For many of these benchmarks we do not yet have baseline data, without which we cannot establish interim targets. We are working on developing these, and will complete this task before the end of the first monitoring period, in partnership with the Child Welfare Panel. For now, the "Methodology" identifies how, or the data source with which, we will measure a benchmark. For many items, the precise method of measurement will also be developed during the course of the first monitoring period.

We expect to supplement *A New Beginning* with additional, detailed implementation plans as our implementation process moves forward. As these plans are developed, we will, as appropriate, add related benchmarks and timeframes, in partnership with the Panel.[180]

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[179] The Key Outcome Indicators each involves at least one, and in many cases several, of the programmatic areas of this plan, but will not be repeated here.

[180] For example, in the coming month, we will work the New Jersey Child Welfare Panel to determine the court-enforceable terms of the plan, a process which is likely to generate additional benchmarks. These will then be incorporated into this plan.

REFORMING CASE PRACTICE – A NEW WAY OF DOING BUSINESS

Calls to the Centralized Hotline will receive a complete, timely response.

Benchmark 1. For reports falling below the threshold for abuse/neglect (i.e., child welfare issues), increase the percent that are referred to and accepted by other state or community agencies.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: SACWIS Release 2.

Reports of child abuse or neglect will be investigated in a complete, timely manner.

Benchmark 2. Increase the percentage of investigations with face-to-face contact between the investigator and the child (and any other children in the household) within 24 hours of report.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: SACWIS Release 2 and/or Safe Measures

Benchmark 3. Increase the percentage of investigations completed within 60 days of report

Baseline: By July 2004, TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: SACWIS 2

The safety of children with open child protection cases will be regularly assessed.

Benchmark 4. Increase the percentage of in-home cases where safety assessments have been completed at the specified intervals for children in home.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: Safe Measures; Point-in-time measure

Children will have pre-placement physicals in emergency rooms only when medically necessary.

Benchmark 5. Increase the percentage of children who receive pre-placement physicals.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: Hand-count of all

Benchmark 6. Decrease the percentage of children who receive pre-placement physicals using hospital emergency rooms.

Baseline: TBD
Interim Target:
Final Target: By [DATE],
Methodology: Hand-count of all

Visits between children, siblings, families, and workers will be frequent and timely.

Benchmark 7. Increase the percentage of children in placement who have a minimum of one monthly visit from their permanency worker.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: Baseline from case record reviews of a sample or hand-count of all. Interim applications to be developed. Point-in-time measure

Benchmark 8. As caseload size decreases, increase the percentage of children in placement who have a minimum of bi-weekly visits from their permanency worker.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: Baseline from case record reviews of a sample or hand-count of all. Interim applications to be developed. Point-in-time measure

Benchmark 9. For children in placement with a goal of reunification, increase the percentage of birth families who have received a minimum of one visit by the permanency worker in the last month.

Baseline: TBD/Note: Expect frequency of visits to increase as caseloads decrease.
Interim Target:
Final Target: By [DATE], 95%
Methodology: Baseline from case record reviews of a sample or hand-count of all. Interim applications to be developed. Point-in-time measure

Benchmark 10. For children in placement with a goal of reunification, increase the percentage who have weekly visit with their family.

Baseline: TBD
Interim Target: TBD
Final Target: By [DATE], 95% of families with weekly visits.
Methodology: Baseline from case record reviews of a sample or hand-count of all. Interim applications to be developed. Point-in-time measure

Benchmark 11. For children in placement who are separated from their siblings, increase the percentage who have weekly visits with their siblings.

Baseline: TBD
Interim Target: By [DATE], ____% of siblings with bi-weekly visits.
Final Target: By [DATE], 95% of siblings with weekly visits.
Methodology: Baseline from case record reviews of a sample or hand-count of all. Later, interim applications to developed. Point-in-time measure

Child welfare efforts will be focused around communities.

Benchmark 12. TBD regarding geographic assignment of workers.

Children and families will experience continuity in their relationships with permanency workers.

Benchmark 13. Decrease the average number of permanency workers assigned to a child and/or family from the time a case is opened until discharge.

Baseline: TBD
Interim Target:
Final Target: By [Date], ____
Methodology: Interim application to be developed or SACWIS Release 2. Cohort analysis

Benchmark 14. Of all cases transferred, increase the percentage that occur at a family team meeting with the family, former permanency worker and new permanency worker.

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Interim application to be developed or hand count.

Family Team Meetings will be a regular element of case practice

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Benchmark 15. Increase the percentage of cases where a family team meeting precedes a child's removal from home.

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Interim application to be developed or hand count.

Benchmark 16. Increase the percentage of cases in which a family team meeting occurs within 72 hours of an emergency removal.

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Interim application to be developed or hand count.

Benchmark 17. Increase the percentage of cases where a family team meeting is used to introduce birth families to resource families.

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Interim application to be developed or hand count.

Families will be involved in creating a timely, individualized and coordinated case plan.

Benchmark 18. Increase the percentage of case plans developed in a family team meeting

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Interim application to be developed or hand count.

Benchmark 19. Increase the percentage of child and family functional assessments completed within 30 days from case opening.

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Interim application to be developed or hand count.

Benchmark 20. Increase the percentage of case plans that incorporate findings from the functional assessment of child and family, clearly identifying strengths and needs.

Baseline: None (0%)
Interim Target:
Final Target: By [DATE], 95%
Methodology: Quality Service Reviews

Benchmark 21. Increase consumer satisfaction

Baseline: None (0%)
Interim Target:
Final Target:
Methodology: Qualitative measure to be developed.

RECRUITING, RETAINING & SUPPORTING RESOURCE FAMILIES

Resource families will be well-trained and supported in their roles.

Benchmark 22. Increase the percentage of resource families who have a Resource Family Support Worker (RFSW) assigned to them.

Baseline: None (0%)
Interim Target: By July 2005, at least ____ of the resource families will have a RFSW assigned to them
Interim Target: By July 2006, at least ____ of the resource families will have a RFSW assigned to them
Final Target: By July 2007, 95% of the resource families will have a RFSW assigned to them
Methodology: Interim application to be developed.

Benchmark 23. Increase the percentage of resource families who feel the system is adequately supporting them.

Baseline: TBD by April 2005
Interim Target: Set by June 2005
Final Target: By July 2005
Methodology: Qualitative measure to be developed.

Benchmark 24. Increase the percentage of existing resource families who have annually received the requisite 10 hours of in-service training in the new resource family model, 10 hours in 2005, 15 hours in 2006, TBD thereafter.

Baseline: None (0%)
Final Target: By June 2006, 95% (and annually, thereafter)
Methodology: Interim application to be developed.

Resource families will experience a streamlined, simple licensing process.

Benchmark 25. Increase the proportion of resource family applicants who complete the licensing process.

Baseline: Establish a baseline by September 2004
Interim Target:
Final Target: By [DATE], ___%
Methodology: Interim application to be developed. The measurements should be able to identify which elements of the licensing process are generating exits (i.e., training, references).

Benchmark 26. Decrease the time required for prospective families to become licensed resource families (timeframe is from time of application to approval).

Baseline:	TBD
Interim Target:	By July 2005, 33% of families in under 90 days
Interim Target:	By July 2006, 66% of families in under 90 days
Final Target:	By July 2007, 95% of families in under 90 days
Methodology:	Interim application to be developed. Measurement should target specific time intervals (i.e., percent licensed within 90 days, 180 days, etc)

More resource families will be available.

Benchmark 27. Decrease the percentage of foster families who exit the system (excluding foster families who exit due to adoption or move out of state).

Baseline:	TBD/November 2004
Interim Target:	
Final Target:	By [DATE], ___%
Methodology:	Interim application to be developed. Measurement should target specific time intervals (i.e.; percentage who exit within one year, within two years, etc.)

Benchmark 28. License an adequate number of new resource families.

Baseline:	310 from January 2004 to May 2004
Interim Target:	
Final Target:	By June 2005, 1,000 new families will be licensed (subsequent targets set thereafter).
Methodology:	Interim application to be developed.

ADOLESCENTS & YOUTH TRANSITIONING OUT OF THE SYSTEM

Adolescents and youth will grow up, whenever possible, in a home or other family-based setting

Benchmark 29. Increase the percentage of youth ages 13 and older living in family-based settings.

Baseline: TBD
Interim Target:
Final Target: By [DATE], ___%
Methodology: Chapin Hall Outcomes

Benchmark 30. Increase the percentage of adolescents for whom reunification is no longer a viable permanency goal who are adopted.

Baseline: TBD
Interim Target:
Final Target:
Methodology: Chapin Hall Outcomes and annual point in time measure

Child welfare practice goals for adolescents and youth will change to better meet permanency needs

Benchmark 31. Increase the percentage of adolescents for whom reunification has been ruled out as viable permanency goal who obtain permanency through legal guardianship.

Baseline: TBD
Interim Target:
Final Target: By [DATE], ____
Methodology: Chapin Hall Outcomes and annual point in time measure

Benchmark 32. Decrease the number of youth who have long term foster care as their permanency goal.

Baseline: As of 5/7/04, 593 children
Interim Target:
Final Target: By [DATE], 0%
Methodology: Interim application to be developed.

Benchmark 33. Decrease the number of youth in DYFS custody who have independent living as their permanency goal.

Baseline: As of 5/26/04, 789 children (2 children under age 12; 286 between 13 and 17)
Interim Target:
Final Target:
Methodology: Interim application to be developed.

Adolescents and youth will be adequately prepared and supported for the transition to adulthood.

Benchmark 34. Increase the percentage of youth in DYFS custody who graduate from high school with a high school diploma.

Baseline: TBD
Interim Target:
Final Target:
Methodology: Quality Service Reviews.

Benchmark 35. Increase the percentage of youth in DYFS custody who obtain a GED (excluding those who are in high school and/or have already received high school diploma)

Baseline: TBD
Interim Target:
Final Target:
Methodology: Quality Service Reviews.

Benchmark 36. Increase the percentage of eligible youth in care at age 14 or older who receive life skills training

Baseline: TBD
Interim Target: By January 2005, 60%
Interim Target: By January 2006, 70%
Final Target: By January 2007, 95%
Methodology: Interim application to be developed or SACWIS Release 2.

Benchmark 37. Decrease the number of youth in DYFS custody who do not have a goal of permanency whose cases are closed at the age of 18.

Baseline: As of CY 2003, 4,271 children
Interim Target:
Final Target: By [DATE], ____
Methodology: SIS. Cohort analysis.

Benchmark 38. Increase the percentage of youth ages 18 and older who exit the system with employment or are enrolled in further education or job training.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 95%
Methodology: TBD

Benchmark 39. Increase the percentage of youth ages 18 and older who exit the system with housing.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 95%
Methodology: TBD

Benchmark 40. Increase the percentage of youth ages 18 and older who exit the system with a connection to one adult who will assist them with the transition.

Baseline: TBD
Interim Target:
Final Target:
Methodology: QSR

Adolescents and youth outcomes will be enhanced through connections to housing and health supports

Benchmark 41. Increase the percentage of children in care on or after their 18th birthday who are enrolled in the Chafee Medicaid Program.

Baseline: TBD
Interim Target:
Final Target:
Methodology: Interim application to be developed or SACWIS Release 2.

Benchmark 42. Increase the number of transitional housing units for adolescents.

Baseline: 48 units
Interim Target: Develop 40 additional units per year, for five years.
Final Target: By July 2009, total of 248 units.
Methodology: Hand count.

REDUCING INAPPROPRIATE RELIANCE ON INSTITUTIONAL SETTINGS

Children in or waiting for congregate care will receive timely, appropriate and routine assessments.

Benchmark 43. Increase the percentage of children in or waiting for a congregate placement who receive an assessment within two weeks of admission into DFYS custody.

Baseline: TBD
Interim Target:
Final Target: By January 2005, 95% will have assessment within two weeks of admission.
Methodology: Absolute Report Application

Benchmark 44. Increase the percentage of children in or waiting for a congregate placement who have a current assessment (i.e., one every 90 days).

Baseline: TBD
Interim Target:
Final Target: By January 2005, 95%
Methodology: Absolute Report Application

Child welfare practice in congregate settings will include family team meetings.

Benchmark 45. Increase the percentage of children in a congregate placement who participate in a family team meeting before they are transferred or discharged.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 95%
Methodology: Absolute Report Application

Children identified for step down are assigned appropriate case management

Benchmark 46. Increase the percentage of children in congregate settings who are assigned case managers to assist them in the transition to a community-based setting.

Baseline:
Interim Target:
Final Target: By January 2005, 95% of children
Methodology: Absolute Report Application

The use of congregate care will be minimized for babies and young children.

Benchmark 47. Decrease the number of "boarder babies" who remain in hospitals for more than five days beyond the point of medical clearance.

Baseline:
Interim Target:
Final Target: By [DATE], none (0)
Methodology: Interim application to be developed or hand count.

Benchmark 48. Decrease the number of children under age 6 who are in congregate settings.

Baseline: As of 5/7/04, 72 children
Interim Target:
Final Target: By February 2005, none (0) children under age 6, except cases where there is a medical necessity.
Methodology: Chapin Hall Outcomes and annual point in time measure

Benchmark 49. Decrease the number of children under age 10 who are in congregate settings.

Baseline: As of 5/7/04, 155 children
Interim Target:
Interim Target:
Final Target: By [DATE], none (0) except cases where there is a medical necessity
Methodology: Chapin Hall Outcomes and annual point in time measure

Benchmark 50. Decrease the number of children under age 12 who are in congregate settings

Baseline: As of 5/7/04, 428 children
Interim Target:
Interim Target:
Final Target: By [DATE], none (0) except cases where there is a medical necessity
Methodology: Chapin Hall Outcomes and annual point in time data

Neighborhood and home-based settings and services will be utilized and expanded for children in or at risk of placement in congregate care.

Benchmark 51. Increase the number of children transferred from in-state congregate placements to family-based settings.

Baseline: TBD
Interim Target: By December 2004, transfer 150 children to family setting.
Interim Target: By December 2005, transfer additional 150 children to family setting.
Interim Target: By December 2006, transfer additional 150 children to family setting.
Final Target: By [DATE], percentage of total population in congregate settings will be ____
Methodology: Absolute Report Application

Benchmark 52. Decrease the number of children in out-of-state placements.

Baseline:	As of January 2004, 282 children in out-of-state congregate care
Interim Target:	By December 2004, move 25% in-state
Interim Target:	By December 2005, move additional 25% in-state
Interim Target:	By December 2006, move additional 30% in-state
Final Target:	By [DATE], none (0)
Methodology:	Absolute Report Application.

Benchmark 53. Decrease the number of DYFS children in shelter placements.

Baseline:	TBD
Interim Target:	
Final Target:	By [DATE], none (0)
Methodology:	Interim application to be developed or hand count.

Benchmark 54. Decrease the number of DYS children inappropriately placed in detention facilities.

Baseline:	TBD
Interim Target:	
Final Target:	By [DATE], none (0)
Methodology:	Interim application to be developed or hand count.

Benchmark 55. Increase the number of community-based treatment homes and emergency treatment homes

Baseline:	TBD
Interim Target:	By July 2005, additional 75 treatment homes and 40 emergency treatment homes (set target annually, thereafter.)
Final Target:	By [DATE], ____
Methodology:	Absolute Report Application

Benchmark 56. Increase the capacity of in-home community based services and supports

Baseline:	TBD
Interim Target:	
Final Target:	By July 2006, 95% of children identified through an assessment as in need of in-home services will have access to them.
Methodology:	TBD. Note that this benchmark needs to track expansion of mobile response, youth case management services and other relevant supports/services.

The quality of congregate care will be improved and regularly evaluated.

Benchmark 57. Increase the percentage of congregate settings that receive timely licensing and facility assessments.

Baseline:
Interim Target:
Final Target: By [DATE], 98%
Methodology: Interim application to be developed or hand count.

Benchmark 58. Increase the percentage of congregate settings that are evaluated on congregate care report card.

Baseline: None (0%)
Interim Target:
Final Target: [DATE], 98%
Methodology: Interim application to be developed or hand count. Expectation that score card will include data on child outcomes, e.g., percentage of youth who were the subject of substantiated critical incident report, percentage of youth AWOL, etc.

Benchmark 59. Increase the percentage of children in or at risk of placement in congregate care who are placed appropriately and receive services to meet their individual needs.

Baseline: None (0)
Methodology: Quality Service Reviews

Benchmark 60. Close Arthur Brisbane Child Treatment Center

Interim Target: By September 2004 admission of children age 11 through 13 to ABCTC will cease.
Interim Target: From October 2004 through December 2004 children age 11 through 13 receiving care at ABCTC will be transitioned to alternative treatment settings.
Interim Target: By January 2005 admission of adjudicated violent offenders to ABCTC for treatment will cease
Interim Target: From January through February 2005 adjudicated violent offenders receiving treatment at ABCTC will be transitioned to an alternative treatment setting.
Interim Target: By May 2005 step down treatment beds will be available for children and youth that no longer need in patient psychiatric care
Interim Target: Beginning in October of 2005 youth age 14-18 will begin transitioning from ABCTC to alternative settings.
Final Target: By the end of December 2005 Arthur Brisbane Child Treatment Center will close.

UNIFYING THE SYSTEM, PARTNERING WITH COMMUNITIES, AND DEVELOPING A NETWORK OF PREVENTION

Office of Children's Services will build private/public partnerships with communities.

Benchmark 61. Increase the number of Community Collaboratives

Baseline:	None (0)
Interim Target:	By 2005, 6
Interim Target:	By 2006, 6 additional (12 total)
Final Target:	6 additional every six months until no further need
Methodology:	Hand count

Benchmark 62. Increase the number of Child Welfare Planning Councils.

Baseline:	None (0)
Interim Target:	
Final Target:	By June 2006, 15 (one for every area/county)
Methodology:	Hand count

Benchmark 63. Increase capacity for community case management

Baseline:	None (0)
Interim Target:	By April 2005, ___
Final Target:	
Methodology:	Interim application to be developed or hand count.

Benchmark 64. Continuously increase the impact of community partnership and prevention effort.

Baseline:	TBD
Interim Target:	
Final Target:	
Methodology:	Qualitative measure to be developed.

Domestic Violence

Benchmark 65. TBD

Parents with children in the child welfare system will be able to access mental health services.

Benchmark 66. Increase the number of counties with an adult DFD Mental Health Initiative as well as the number of people served.

Baseline:
Interim Target: By December 2005, 7 additional counties and 150 additional persons per month
Final Target:
Methodology: Interim application to be developed or hand count, in collaboration with DFD

Children and families will receive appropriate child behavioral health services.

Benchmark 67. Increase the number of counties that have an adequate CMO/FSO capacity to fully meet the need in that area.

Baseline:
Interim Target: By June 2005, expand to 4 new counties
Final Target:
Methodology: Hand count

Benchmark 68. Increase the numbers of providers and the level of expenditures for Intensive in-community services

Baseline:
Interim Target:
Final Target:
Methodology: Hand count; fiscal analysis

Children in the child welfare system will have consistent, coherent medical plans.

Benchmark 69. Increase the percentage of children in care who have up-to-date physicals.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: SIS/collaboration with Medicaid. Utilization reports presently issued to district offices

Benchmark 70. Increase the percentage of children in care who have up-to-date immunizations.

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: SIS/collaboration with Medicaid. Utilization reports presently issued to district offices

Benchmark 71. Increase the percentage of children who have a full EPSDT screen and follow up identified treatment (including dental care).

Baseline: TBD
Interim Target:
Final Target: By [DATE], 98%
Methodology: SIS/collaboration with Medicaid. Utilization reports presently issued to district offices

Children and families in care will have increased access to affordable housing

Benchmark 72. Increase the percent of referred applicants who meet with DCA staff to determine level of assistance

Baseline:
Interim Target: By [DATE], 300 short-term and 100 long-term
Final Target: By [DATE], ___
Methodology: Interim application to be developed or hand count, in collaboration with DCA.

Benchmark 73. Increase the availability of DCA funds ($1M annually) to rehabilitate homes for resource families.

Baseline:
Interim Target: By September 2004, DCA opens intake and selects 50 participants for the first year
Final Target: 250 rehabilitated homes for resource families over 5 years
Methodology: Hand count and fiscal analysis.

Benchmark 74. Increase the availability of The Home Ownership Permanency Program (HOPP) operated by HMFA to assist families who are in the final stages of adopting a child or becoming the child's legal guardian.

Baseline:
Interim Target: By July 2004, HMFA initiates loans to 20 eligible participants for the first year
Final Target: 250 families receiving $5 million in loans over 5 years
Methodology: Interim application to be developed or hand count and fiscal analysis.

Benchmark 75. Increase the availability of housing for children and families at risk of DYFS involvement

Baseline:
Interim Target: By [DATE], ___ units
Final Target: 160 units over 5 years
Methodology: Hand count

Children and families will have access to substance abuse services

Benchmark 76. Increase the percentage of children and youth who receive substance abuse services

Baseline: TBD
Interim Target:
Final Target:
Methodology: QSR

Benchmark 77. Increase the capacity of substance abuse services to ensure that parents and youth who need services can access and obtain them.

Baseline:
Interim Target: By July 2004, an additional treatment capacity of 102 slots, serving 306 women and 612 children under DYFS supervision.
Interim Target: By June 2005, 125 new adolescent substance abuse treatment slots (including 25 residential slots) serving 300 youth.
Final Target: By July 2006, assuming a 60% prevalence rate, 2602 slots across various treatment modalities.
Methodology: Interim application to be developed or SACWIS Release 2.

Adolescents and youth will have access to school-based prevention and intervention services

Benchmark 78. Increase the percentage of adolescents and youth who obtain school-based prevention and intervention services

Baseline: TBD
Interim Target: By January 2005, the School Based Youth Services Program (SBYSP) will expand to at least 16 new schools and be available to 13,000 additional students
Interim Target: By January 2006, the SBYSP will expand to an additional 16 schools and be available to 13,000 more students
Final Target: By January 2008, the SBYSP will be in 110 schools, serving 100,000 students
Methodology: TBD.

STRIVING FOR SAFETY AND PERMANENCY IN THE COURTS

Note: The ICCF will monitor the action steps and strategies in this section.

Children will not enter care or remain in on a voluntary placement agreement.

Benchmark 79. Decrease the number of children currently in care on a voluntary placement agreement

Baseline: TBD
Interim Target: TBD
Final Target: By April 2006, none (0)
Methodology: Interim application to be developed or hand count.

The legal rights of children, families and resource families involved in child welfare proceedings will be effectively protected.

Benchmark 80. Increase the percentage of new placements made known to the court within 5 days of placement.

Baseline: In December 2003, 34.8% of cases.
Interim Target: By July 2005, __% of cases
Final Target: By July 2006, 95%
Methodology: Interim application to be developed or collaboration with courts.

Benchmark 81. TBD Regarding notice to, and attendance of, birth parents, resource parents and other relevant stakeholders to relevant legal proceedings

Legal proceedings involving children and families will be timely and respectful of all parties.

Benchmark 82. Increase the percentage of termination of parental rights cases with a disposition within six months from the filing date.

Baseline: TBD
Interim Target: By July 2005, __% of cases
Final Target: By July 2006, 95% of cases
Methodology: Interim application to be developed or collaboration with courts.

Benchmark 83. Increase the percentage of cases that have had a permanency hearing within legally mandated timeframes.

Baseline: TBD
Interim Target: By July 2005, ___% of cases
Final Target: By July 2006, 95% of cases
Methodology: Interim application to be developed or collaboration with courts.

Benchmark 84. Increase the percentage of cases that have timely fact-finding hearings.

Baseline:	According to AOC, in April 2004, 25% of active FN cases statewide had fact-finding hearings that occurred beyond the time goals or that had not occurred.
Interim Target:	TBD
Final Target:	TBD
Methodology:	Interim application to be developed or collaboration with courts. Methodology will need to separate in-home cases (6 month timeline), and out of home cases (4 month timeline).

All parties will have the benefit of well-qualified counsel.

Benchmark 85. Decrease caseload of Deputy Attorneys General who represent DYFS

Baseline:	TBD
Interim Target:	By June 2005, decrease caseloads to 75 PRS (protective) or 25 GSP (guardianship) or 55 OAL (administrative) cases._
Final Target:	By September 2005, decrease caseload size to 70 PRS or 20 GSP or 50 OAL
Methodology:	Interim application to be developed or collaboration with courts.

Benchmark 86. TBD decreasing caseload of Law Guardians

Consolidate the Family Court case calendar so parents, attorneys and caseworkers do not spend unnecessary time in court waiting for their case to be heard.

Benchmark 87. TBD regarding decreasing time waiting in court

DEVELOPING THE NECESSARY CULTURE AND WORKFORCE

Existing staff will be supported and authorized to best meet the needs of children and families.

Benchmark 88. Increase retention rate for caseload carrying staff

Baseline: As of 2003, 87.6%
Interim Target: TBD
Final Target: By July 2008, TBD
Methodology: Existing data application

Benchmark 89. Increase retention rate for supervisory staff.

Baseline: As of 2003, 91.6%
Interim Target: TBD
Final Target: By July 2008, TBD
Methodology: Existing data application

Hiring and promotion standards will be consistent with goals of reform.

Benchmark 90. Increase percentage of newly hired front line staff with a BSW, MSW or degree in a related field, or a minimum amount of experience in a human service or related field.

Baseline: TBD (as of 2004 hiring)
Interim Target: By July 2005, 78%
Interim Target: By July 2006, 86%
Final Target: By July 2007, 100%
Methodology: Existing data application

Benchmark 91. Increase percentage of supervisors (SFSS) hired or promoted in FY 2005 or later with MSWs or other advanced degree consistent with accreditation standards.

Baseline: TBD (as of 2004 hiring)
Interim Target: By July 2006, 15%
Interim Target: By July 2006, 30%
Interim Target: By July 2007, 50%
Interim Target: By July 2008, 75%
Final Target: By July 2009, 100%
Methodology: Existing data application

Staff will have manageable workloads that best serve the needs of children and families.

Benchmark 92. Reduce caseload size for intake protection workers **statewide**.

Interim Target: By October, 2004 95% of protection workers will have no more than 14 new cases and 21 pending cases per month. The average new cases statewide will be 9 with a total of 18 pending cases per month.

Interim Target: By March, 2005 95% of protection workers will have no more than 12 new cases and 18 pending cases per month. The average new cases statewide will be 9 with a total of 17 pending cases per month.

Final Target: By August, 2005 95% of protection workers will have no more than 8 new cases and 12 pending cases per month.

Benchmark 93. Reduce caseload size for child permanency caseworkers.

Interim Target: By January 2005 95% of permanency workers in Phase 1 areas (Essex, Camden, Mercer and Passaic) will have 20 or fewer cases, the average caseload in Phase 2 counties (Cumberland, Gloucester, Hudson, Middlesex, Monmouth, Ocean and Salem) will be 19 families with 80% of caseworkers having 30 cases or fewer and the average caseload for Phase 3 counties (Atlantic, Bergen, Burlington, Cape May, Hunterdon, Morris, Somerset, Sussex, Union and Warren) will be 22 with 80% of caseworkers having 30 or fewer cases.

Interim Target: By March 2005 95% of permanency workers in Phase 1 areas will have 17 or fewer cases, the average caseload in Phase 2 counties will be 17 families with 80% of caseworkers having 30 or fewer cases and the average caseload size in Phase 3 counties will be 19 families with 80% of caseworkers having 30 or fewer cases.

Interim Target: By April 2005 95% of caseworkers in Phase 1 areas will have 17 or fewer cases, 95% of caseworkers in Phase 2 areas will have 20 or fewer cases and the average caseload for Phase 3 will be 15 families with 80% of caseworkers having 30 or fewer cases.

Interim Target: By June 2005 95% of permanency workers in Phase 1 areas will have 15 or fewer cases, 95% of permanency workers in Phase 2 areas will have 17 or fewer cases and the average caseload for Phase 3 counties will be 14 families with 80% of permanency workers having 25 or fewer cases.

Interim Target: By August 2005 95% of permanency workers in Phase 1 will have 15 or fewer cases, 95% of Phase 2 caseworkers will have 17 or fewer cases and 95% of Phase 3 areas will have 20 or fewer cases.

Interim Target: By September 2005 95% of permanency workers in Phase 1 and 2 areas will have 15 or fewer cases and permanency workers in Phase 3 areas will have 20 or fewer cases.

Interim Target: By October 2005 95% of permanency workers in Phase 1 and 2 areas will have 15 or fewer cases and 95% of Phase 3 areas will have 17 or fewer cases.

Final Target: By January 2006 95% of permanency workers statewide will have 15 or fewer cases.

Benchmark 94. Adolescent Specialist caseload TBD

Benchmark 95. Adoption Specialist caseload TBD

Benchmark 96. Reduce the number of employees supervised by casework supervisors to 5 caseworkers and one case aide for each supervisor.

Interim Target: TBD

Staff will be trained well.

Benchmark 97. Increase the percentage of new staff who receive the requisite pre-service training before carrying a caseload

Baseline: TBD
Interim Target:
Final Target: By [DATE], 95%
Methodology: Hand count

Benchmark 98. Increase the percentage of new supervisors who receive the requisite pre-service training before carrying a caseload

Baseline: TBD
Interim Target:
Final Target: By [DATE], 95%
Methodology: Hand count

Benchmark 99. Increase the percentage of staff (in identified positions) who meet their individualized training

Baseline:
Interim Target:
Final Target: By [DATE], 95%
Methodology: Hand count

PURSUING HIGH QUALITY, ACCOUNTABILITY & CONTINUOUS IMPROVEMENT

The Office of Children's Services will work continuously to improve the quality of its work.

Benchmark 100. Increase involvement in the CQI process by developing active CQI committees of consumers, staff, and stakeholders.

Baseline:	None (0)
Interim Target:	By January 2005, 4 area offices
Interim Target:	By July 2005, 5 additional area offices (9 total)
Final Target:	By January 2006 remaining area offices; actively meeting CQI Committees in all 15 area offices
Methodology:	Hand count

Benchmark 101. Increase the level and diversity of participation in the local CQI Committees

Baseline:	TBD
Interim Target:	
Interim Target:	
Final Target:	
Methodology:	Qualitative measure to be developed. Conduct an evaluation in 4 area offices by January 2005, 5 additional area offices by July 2005, and 6 remaining area offices by January 2006

Benchmark 102. TBD regarding increasing the cultural competency of staff

Benchmark 103. Increase the proportion of cases where there is an adequate array of services and supports in response to the identified needs of the children and families

Baseline:	TBD
Interim Target:	
Interim Target:	
Final Target:	
Methodology:	QSR

Create a CQI culture

Benchmark 104. Increase OCS' ability to understand and target improvements to the quality of case practice in all 15 area offices by conducting Quality Service Reviews.

Focus minimally on the following aspects of case practice/systems: Screening, Investigations, Multi-Disciplinary teams (MDT), Structured Decision Making (SDM), Safety Assessments, Minimum Visitation Requirements (MVR), Family Team Meetings (FTM), case practice model (One Worker-One Family), community supports, post-adoption services and retention of resource families.

Target cases for review with at least the following specific populations and topics: aging out youth and adolescents, and substance abuse, child behavioral health, domestic violence, and physical health needs.

Baseline:	Sporadic QSRs, linked to the CFSR process
Interim Target:	By July 2005, record baselines in 4 area offices
Interim Target:	By January 2006, record baselines in an additional 5 area offices
Interim Target:	By July 2006, record baselines in the remaining 6 area offices
Final Target:	Conduct Quality Service Reviews (QSRs) on a minimum of TBD cases in each area office and repeat annually.
Methodology:	

Benchmark 105. Increase performance and improve programs in areas identified areas by annual QSRs and quarterly record reviews.

Baseline:	TBD by first round of QSRs and record reviews
Interim Target:	By July 2006, conduct a second round of QSRs in 4 area offices
Interim Target:	By January 2007, conduct a second round of QSRs in an additional 5 area offices
Interim Target:	By July 2007, conduct a second round of QSRs in the remaining 6 area offices
Final Target:	Conduct Quality Service Reviews (QSRs) on a minimum of TBD cases in each area office and repeat annually.
Methodology:	Improvement on CFSR outcomes within recommended guidelines measured every two years

Benchmark 106. Increase the consistency and quality of record reviews in area and local offices as a CQI technique.

Baseline:	TBD by first round of QSRs and record reviews
Interim Target:	
Final Target:	CQI units complete record reviews on a quarterly basis in each area office including sub-populations and report the number of cases reviewed and findings
Methodology:	

Use Performance-Based Contracting to assure providers are delivering appropriate, high-quality and cost-efficient services.

Benchmark 107. Increase the number of contracts being evaluated on a performance-based system.

Baseline:
Interim Target: TBD
Interim Target: TBD
Final Target: TBD
Methodology: Hand count

Benchmark 108. Increase the percent of contractors whose service provision is consistent with their contract commitment.

Baseline:
Interim Target: TBD
Interim Target: TBD
Final Target: TBD
Methodology: Hand count; qualitative measure to be developed.

Benchmark 109. TBD Increase RFP competition and development of resources

Baseline:
Interim Target: TBD
Interim Target: TBD
Final Target: TBD
Methodology: Hand count number of RFPs, number of bidders, and number of providers. Qualitative measure to be developed—survey or interview providers to obtain feedback regarding the new process.