



2018

ANNUAL REPORT

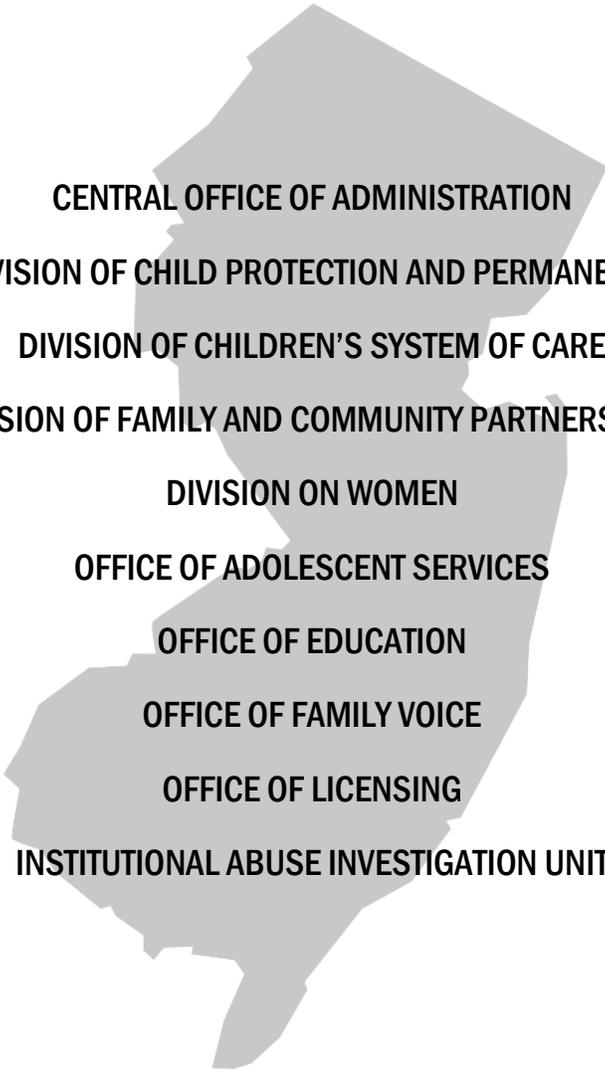
Safe, Healthy, & Connected

ABOUT DCF

The New Jersey Department of Children and Families was created in 2006. Over the last 12 years, the Department has stabilized, grown, and developed the infrastructure needed to take on the challenges of - and to take advantage of the opportunities associated with - serving children, women, men and families in the 21st Century. In the years since its creation, DCF's mandate expanded well beyond the protection of children to include: design and delivery of New Jersey's public behavioral health care service to children and families, provision of public services for children with intellectual and developmental disabilities and their families, and the administration of a network of services and coordinated supports aimed at strengthening families, prevention and interruption of child maltreatment, and promoting success of transition aged youth. In July 2012, DCF also proudly became the home of the Division on Women, New Jersey's pioneering State agency dedicated to the development, promotion and expansion of women's rights in the areas of poverty and welfare, employment and wages, work and family, the economic and social aspects of healthcare, violence against women, and women's civic and political participation in their communities. Each month, DCF serves over 100,000 constituents. DCF's 6,600 staff focus on assisting and empowering New Jersey's residents to be *safe, healthy, and connected*.

This is done with an array of family-centered programs and services delivered directly and through a network of community providers. Collectively, the DCF and its partners are working to: increase kinship placements and family connections; prevent maltreatment and promote strong families; integrate consumer voice in all programs and services; cultivate a culture of accountability; maximize federal revenue; provide an integrated and inclusive system of care for youth; safeguard staff and promote professional satisfaction.

DCF's direct services are delivered by the following divisions and offices:



- CENTRAL OFFICE OF ADMINISTRATION**
- DIVISION OF CHILD PROTECTION AND PERMANENCY**
- DIVISION OF CHILDREN'S SYSTEM OF CARE**
- DIVISION OF FAMILY AND COMMUNITY PARTNERSHIPS**
- DIVISION ON WOMEN**
- OFFICE OF ADOLESCENT SERVICES**
- OFFICE OF EDUCATION**
- OFFICE OF FAMILY VOICE**
- OFFICE OF LICENSING**
- INSTITUTIONAL ABUSE INVESTIGATION UNIT**



TABLE OF CONTENTS

Executive Summary.....	1
Vision & Resources	3
Background: New Jersey Data Snapshot.....	7
2018 Impact.....	11
Service Design & Delivery Framework.....	17
Program & Service Descriptions.....	19
Part I: Prevention and Community Services	21
Family Success Centers	22
Kinship Navigator	23
Early Childhood Services.....	24
School-Based Services for Youth.....	25
Fatherhood Services.....	26
Employment & Training Services.....	27
Primary Prevention of Sexual Violence	28
Sexual Assault Direct Services.....	29
Domestic Violence Services.....	30
Plans of Safe Care.....	31
Part II: Children's System of Care	33
Network of Treatment & Support Services.....	34
Care Management.....	35
Family Support Organizations.....	36
Mobile Response & Stabilization Services.....	37
Part III: Child Protection & Permanency Services	39
State Central Registry.....	40
Child Protective Investigations.....	41
Case Management.....	42
Resource Family Care	43
Permanency: Reunification, Adoption, and Kinship Legal Guardianship	44
Coordination of Specialized Services	45
Family Preservation Services.....	46
Supportive Housing Services	47

Caregiver Substance Use Services	48
Services for CP&P-Involved Transition Age Youth & Young Adults.....	49
Part IV: Educational Services.....	51
Part V: Licensing	53
Part VI: Investigations of Institutional Abuse.....	57
Future Steps.....	59
Appendices.....	63
2018 Performance: Process and Caseload Measures	64
2018 Performance: Quality, Outcome and Annual Measures.....	66
Sustainability & Exit Plan Measure Definitions.....	68
2018 Sustainability and Exit Plan Performance.....	71
Endnotes	75

EXECUTIVE SUMMARY

2018 was a year of transition for the Department of Children and Families. With over 12 years as the state's first cabinet level agency dedicated to ensuring the safety, well-being and success of children, youth, families and communities, the Department is well positioned to advance Governor Murphy's vision for a stronger, fairer New Jersey by providing the programs and services integral to helping residents be/become *safe, healthy and connected* in the 21st Century.

The nomination and appointment of Christine Norbut Beyer eased the leadership transition and brought a national, progressive perspective to transforming child welfare in New Jersey. As an early years DCF alum, Commissioner Beyer was familiar with the state, the policies and the potential for progress. And, having spent over six years with Casey Family Programs, her expertise on promising and best practices brought a new vision and goals to the Department.

Immediately, she launched a Listening Tour to hear directly from constituents and held a series of Regional Forums to engage stakeholders across multiple systems. Together with staff, a new DCF model and mission was created.

At the same time, DCF continued its critical service to over 100,000 NJ constituents each month in 2018, including:

- Supporting family connection, safety and health in **7,000** families of infants and young children through evidence-based, statewide, home visiting services in partnership with the NJ Department of Health. Approximately **1,400** mothers were screened for depression and over **2,000** children received a developmental screen;
- Creating and implementing a best-practice model for ensuring plans of safe care for substance-exposed infants, which has drawn national attention for its strengths-based approach to engaging new parents in ensuring the safety and well-being of their infants and families;
- Expanding the Behavioral Health Collaborative statewide to build capacity among pediatric primary care providers to identify children and youth with mental health and substance use concerns and to support coordination of care among primary care and behavioral health providers;
- Providing treatment, services and supports to over **23,000** NJ children and their families each month, to support them in managing behavioral health and disability related needs;
- Launching a collaboration with NJ DMHAS to address underage drinking, marijuana use, and prescription medication/opioid misuse for youth, ages 9 to 20;
- Responding to over **165,000** calls to the state's child abuse hotline in 2018, including over **60,000** reports alleging serious maltreatment of almost **94,000** children, and almost **20,000** referrals for child welfare services for nearly **33,000** children;
- Successfully supporting, through case management and other services of the Division of Child Protection and Permanency, the families of over **21,500** children so that parents developed and strengthened skills needed to care safely for their children at home;

- Reunifying over 2,200 children who had been placed into foster care, with their families;
- Facilitating the adoption of nearly 1,100 children for whom reunification was not possible;
- Safely reducing the number of children living in foster care by 10.8% from 2017 to 2018;
- Launching a peer recovery support program for child welfare involved parents, and providing supportive housing to preserve over 600 families as part of Governor Murphy's Opioid Initiative;
- Providing contracted programming and services to approximately 800 survivors of sexual violence each month;
- Supporting over 700 displaced homemakers each month by helping them to gain the knowledge, skills and networks needed to enter or re-enter the job market;
- In response to a series of infant abandonments, DCF refreshed New Jersey's Safe Haven Public Awareness campaign, modernizing the campaign to take advantage of targeted paid and organic social media ads, an enhanced, mobile-friendly website, and the production and dissemination through social media of a public service announcement;
- Creating the Office of Family Voice, to ensure that parents, youth, and kinship care providers have a seat at the table and input on the policies and practice that impact their lives.
- Revising the Department's ChildStat process, so that quality review processes in place within the Division of Child Protection and Permanency and Children's System of Care may be more closely aligned, informed by the Department's ongoing needs assessments, and responsive to federal and statewide improvement plans;
- Launching an effort to incorporate into the work of DCF the state-of-the-art safety science routines and practices, including human factors analysis, which are already in place in safety-conscious industries such as aviation, nuclear energy, and health care; and
- Promoting workforce well-being through the provision of remote and in-person supports available throughout the Department.

These accomplishments were achieved as a result of the dedicated work of 6,600 DCF staff, the partnership and support of Governor Murphy and the Judiciary, coordination with sister state agencies and collaboration among a network of direct service providers that work hand-in-hand with DCF every day. This report describes DCF's work, establishes our service delivery framework, and includes detailed descriptions of major service lines using that framework, serving to highlight areas of strength as well as areas in need of further development. The report concludes with a summary of the Department's intentions for future development.

As the assessment, reorganization and visioning of 2018 draws to a close, DCF looks forward to continued innovation, partnership, and effective practice to ensure that every New Jersey resident is safe, healthy and connected.



VISION & RESOURCES

1

The New Jersey Department of Children and Families was created in 2006. Over the last 12 years, the Department has stabilized, grown, and developed the infrastructure needed to take on the challenges of - and to take advantage of the opportunities associated with - serving children, women, men and families in the 21st Century. In the years since its creation, DCF's mandate expanded well beyond the protection of children to include: design and delivery of New Jersey's public behavioral health care service to children and families, provision of public services for children with intellectual and developmental disabilities and their families, and the administration of a network of services and coordinated supports aimed at strengthening of families, prevention and interruption of child maltreatment, and promoting success of transition aged youth. In July 2012, DCF also proudly became the home of the Division on Women, New Jersey's pioneering State agency dedicated to the development, promotion and expansion of women's rights in the areas of poverty and welfare, employment and wages, work and family, the economic and social aspects of healthcare, violence against women, and women's civic and political participation in their communities. Each month, DCF serves over 100,000 constituents.

A 21ST CENTURY VISION

With the advent of a new administration, DCF is prepared to move into the next phase of its evolution and positioned to work in support of a new vision: *that every resident of New Jersey is safe, healthy, and connected.*

This vision is informed first and foremost by the voices of New Jersey's children, youth, women, men and families, who shared their input through quality reviews, needs assessments, public forums, and a Listening Tour held by Commissioner Beyer in 2018. But it is also informed by decades of research into child maltreatment, intimate partner violence, individual and family protective factors, neuroscience, and the social determinants of health. It is a vision that embraces holistic wellness, and understands the fundamental interaction between individual, family and community strength.

Throughout 2018, DCF set a new course to achieve this vision. In tandem with the Commissioner's Listening Tour, a series of Regional Forums with professional stakeholders, labor/management meetings, and other interactions with constituents and system partners, DCF began the process of identifying the core components of an approach to realizing this vision:

Safe: free from physical and/or emotional harm and risk of harm

Healthy: physically, mentally, and emotionally well

Connected: bonded/tied together through biology, familiarity and/or community. The more connected people feel, the safer they feel, and this can positively impact their mental and emotional health

- **Race Equity:** DCF recognizes that it functions in a historical and social context of racial inequity. New Jersey residents deserve equitable treatment from the public systems it operates, contracts for and oversees, and DCF staff deserve equitable treatment in the workplace. DCF must continually assess whether its work has an equitable impact on families, regardless of race, and to take steps to change its work when equitable outcomes are not achieved.
- **Family Voice:** If services are to be truly responsive to children, youth, families, men and women, DCF must pro-actively include family voice to inform systems designs, policy development and quality improvement processes.
- **Protective Factors:** Department-wide, DCF will rely on the protective factors framework, a research-informed approach to increasing family strengths, enhancing child development, and reducing the likelihood of child abuse and neglect, to inform and drive system design, policies and practices.
- **Healing Centered Practice:** Many of the constituents DCF works with have survived or are actively experiencing trauma. DCF must ensure that its service network has the skillset and orientation to move beyond recognition of trauma to promote healing and resilience, across all services.
- **Collaborative Safety:** This is a model of behavior as much as it involves operations. DCF is incorporating techniques used in aviation, heavy industry, health care and other sectors so that we create a culture of safety, and do not merely respond to adverse events, but learn from them in such a way that we can reliably prevent future adverse events from happening.

DCF has historically operated within consecutive strategic planning cycles. The 2019-2021 strategic plan was finalized early in 2019 and includes the specific goals, strategies and activities that DCF will pursue to achieve this vision.

RESOURCED TO ACHIEVE THE VISION

DCF's strong infrastructure is continuously evaluated to ensure that best-in-class approaches to service delivery and design are in place to support work to achieve our vision.

Core components of DCF's infrastructure include:

Workforce

DCF's strongest asset is its people. DCF employs over 6,600 staff, including investigators, caseworkers, inspectors, regulators, trainers, evaluators, researchers, analysts and many others. DCF works hard to ensure that its staff are safe and well in the workplace. In 2018 DCF began working with Alia Innovations, a national non-profit dedicated to child welfare reform, to provide training to senior leaders and managers throughout the organization regarding trauma and resilience; to support 10 monthly workforce well-being groups; and to provide monthly micro-learnings available to all DCF staff. To ensure staff safety, DCF has robust security measures in place in all offices, and in 2018 piloted the use of state-of-the art mobile technology to safeguard staff in the field.

Training

DCF's Office of Training and Professional Development coordinates and oversees training for the Department and manages training certificate programs and partnerships with NJ schools of social work. OTPD delivers training directly and through two Statewide training partnerships. The New Jersey Child Welfare Training Partnership provides pre-service, foundational and elective training to staff in the Division of Child Protection and Permanency, and a partnership with Rutgers University Behavioral Health Care provides training and professional development for the network of service providers operating within the Children's System of Care. DCF also successfully invests in higher education for the child welfare workforce, partnering with schools of social work to recruit and train BSW candidates for employment at DCF and for staff to obtain a Master of Social Work degree while employed at DCF.

Strategy

DCF is guided by a multi-year strategic planning process, which builds on agency strengths and develops solutions to areas needing improvement. This strategic plan identifies departmental goals and organizes and prioritizes the strategies the department will pursue to achieve those goals. The strategic plan also provides the platform from which DCF develops major plans for federal funding streams, state investments, and performance management.

Financial Management

DCF's budget for SFY2017-18 was \$1.83 billion, \$616 million of which comprised federal funds. DCF continually looks to maximize federal revenue and to manage innovative and financially responsible programs that maximize the State's investment.

Facilities and Equipment

DCF maintains 46 DCP local offices, 9 area offices, 18 schools, and a state-of-the art training and professional development center in addition to its Trenton headquarters. DCF's fleet of vehicles supports investigations, inspections and casework/service activities, and its IT and telephonic infrastructure ensures that staff are able to take advantage of mobile and office-based technological supports to maximize efficiency and effectiveness of their work.

Data Infrastructure

DCF uses data to inform policy, strengthen standard operation procedures, and maintain its focus on continuous improvement. DCF maintains New Jersey's Comprehensive Child Welfare Information System, NJSPIRIT, and contracts for the maintenance of NJ CYBER in the Children's System of Care. DCF is in the process of developing consistent data collection methods for services delivered through other parts of its contracted service network. State of the art reporting tools such as Safe Measures put quality management reports directly into the hands of child welfare staff. Data is routinely made available to the public at large through a data portal created in partnership with Rutgers University (<https://njchilddata.rutgers.edu/>), and monthly performance and descriptive reports that are published to DCF's website (<https://www.state.nj.us/dcf/>).

Analytics

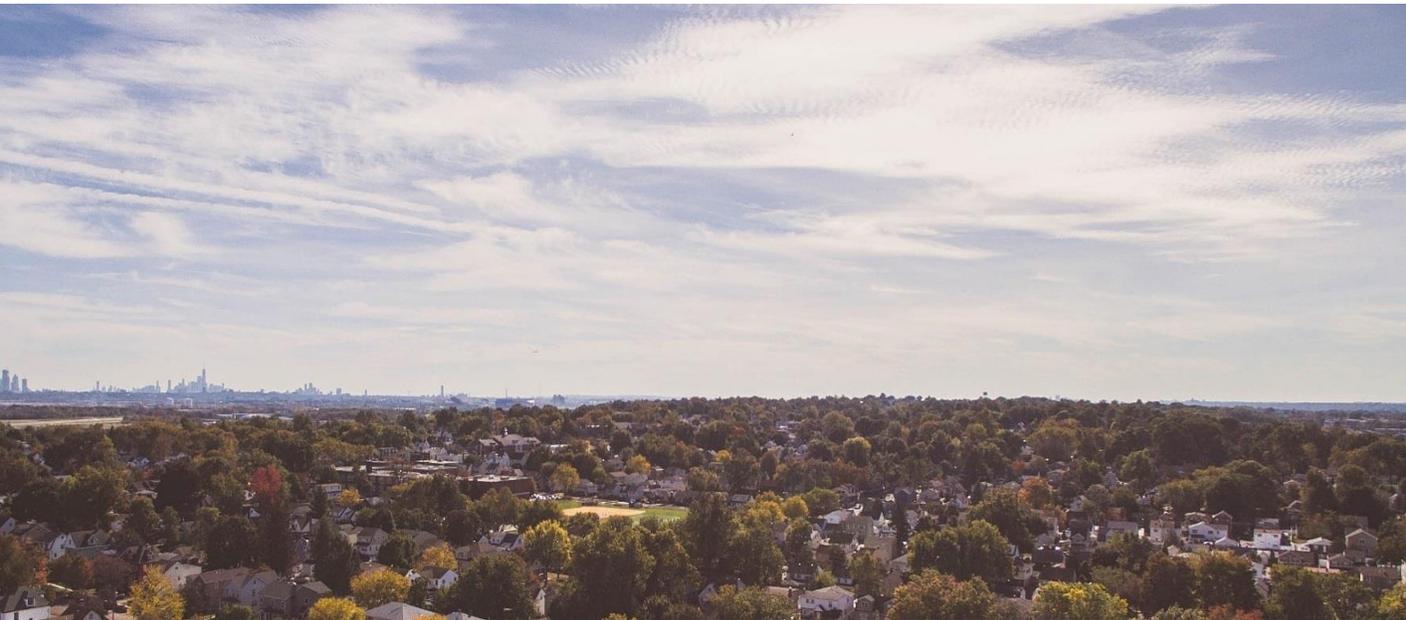
DCF measures community need, organizational performance as well as child and family outcomes across the entire DCF service array and publishes a variety of descriptive and statistical reports summarizing key metrics (e.g. Commissioner's Monthly Report). DCF strives to understand the risk factors related to child welfare involvement and protective factors that promote safe, healthy and connected children, youth, men, women and families. DCF maintains partnerships with national experts to promote data transparency, including the partnership with Rutgers's University for the New Jersey Child Welfare Data Hub, a data portal through which the public can access the State's child welfare data. DCF is currently launching a new body of work using predictive geospatial analytics to identify neighborhoods in greatest need of prevention approaches.

Policy Development

DCF strives to maintain clear, concise and accessible policies. The entire DCF policy manual is available to the public, accessible online at https://www.nj.gov/dcf/policy_manuals/toc.shtml.

Continuous Quality Improvement (CQI) Infrastructure

DCF employs systems that support its ability to self-monitor performance, analyze practice, and self-correct. The goals of CQI at DCF are to: (1) Create a continuous learning environment to improve future outcomes; (2) Ensure sustainability of DCF'S case practice model and reform efforts; (3) Improve agency processes, procedures, and quality of services by using data to guide fiscal and programmatic decision-making; and (4) Sustain and enhance DCF's ability to self-monitor. DCF uses multiple mechanisms to collect and analyze the qualitative and quantitative data that informs CQI processes, including internal and external evaluations of purchased services, use of frontline reporting tools focused on DCF case work and service, and qualitative case reviews. Each month, the DCF leadership spends a full day examining its direct child-serving work in one county at a time through a participatory ChildStat process modeled after the New York Police Department's CompStat.



BACKGROUND: New Jersey Data Snapshot

2

New Jersey is the most densely populated state and 11th most populous, overall in the nation, home to over 8.9 million people. Across New Jersey's 7,504 square miles of land, its residents are largely concentrated in urban and suburban areas; while 60% of the state's land is rural, only 5% of residents live in a rural community.¹ New Jersey's vibrant population experiences a wide range of successes and challenges, including:

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Diversity

The population of NJ is increasingly diverse. Although the majority of NJ's adults are non-Hispanic white (58%), the state's children are primarily non-white and represent a variety of racial and ethnic backgrounds including Hispanic (27%), African American (13%), Asian/Pacific Islander (9%) and multiple-race (4%).² Approximately one-third (31%) of NJ residents speak a language other than English at home and 41% of all babies born in NJ are born to foreign-born mothers.³

Socioeconomics

Ninety-four percent of NJ adults aged 25-34 hold a high school diploma or GED, compared to 91% nationwide.⁴ New Jersey's median household income is \$76,475,⁵ and 10% of residents are living in poverty. Among families with children, NJ has the second highest median household income of all states in the nation;⁶ however New Jersey ranks among the top 13 states for unemployment and income inequality.⁷ Racial inequities in child poverty in particular, persist: approximately 23% of Hispanic or Latino and 26% of Black or African American children live in poverty compared to 8% of white children.⁸

Families

Over 1.9 million families are raising children in New Jersey.⁹ Twenty-nine percent of NJ's children live in single-parent households and 3% are in the care of grandparents.¹⁰ 4.6 per 10,000 NJ family households are homeless¹¹, and 12.1 per 1,000 live births are to teen mothers between the age of 15-19.¹² 18.1% of NJ children have been exposed to one or more Adverse Childhood Experiences.¹³

Women

In New Jersey, women have slightly higher educational attainment than men; 11% of females and 13% of males do not have a high school diploma, while 33% of females and 31% of males have a bachelor's degree or above.¹⁴ However, Statewide women's earnings for all occupations overall are 71.2% of a man's earnings.¹⁵ Women own 20% of firms across all industries in New Jersey, while 70% are owned by men and 10% are equally male-/female-owned.¹⁶

Community Safety

New Jersey experiences low rates of violent crime compared to the national average; however, variation exists across the state. Statewide, there are 253 violent crimes per 100,000 residents and county rates range from 42 in Hunterdon County to 606 in Essex County.¹⁷ New Jersey holds one of the lowest overall rates of death due to gun violence in the United States (5.3 per 100,000), but this rate more than doubles in Essex and Camden, NJ's largest urban areas.¹⁸ Caregivers of 7% of NJ children report that their child is unsafe in their neighborhood.¹⁹ In New Jersey, 37.5% of women and 16.0% of men have experienced contact sexual violence in their lifetime (which includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact), compared to 36.3% of women and 17.1% of men nationally.²⁰

Family and Intimate Partner Safety

Three of every 1,000 children in NJ are confirmed victims of abuse or neglect, compared with a national rate of 9.1 per 1,000 children.^{21, 22} In 2017, the last year for which national data are available, NJ's rate of child fatalities due to maltreatment (0.66 per 100,000) was less than a third of the national average (2.32 per 100,000).²³ More than one in three (35.8%) women in NJ report having experienced intimate partner violence across their lifetime compared to 37.3% nationally, and 1.5% of New Jersey women with a recent live birth report having experienced violence by their husband or partner during pregnancy versus 2.1% nationally.²⁴

Health

The health of NJ's residents generally meets or exceeds national averages. Only 17% of NJ adults report fair or poor health compared to 16% nationwide.²⁵ New Jersey's premature death rate is lower than the national average as is its prevalence of health risk factors including smoking, excessive drinking, and obesity.²⁶ However, NJ's rate of drug overdose deaths is greater than the national average.²⁷ And, while the state has made progress in improving or maintaining health in areas such as reducing overall infant mortality and improving rates of childhood immunization,²⁸ specific health challenges such as increased rates of adult obesity and health disparities based on race and ethnicity persist. For example, the prevalence of low birthweight babies and teen birth rates are consistently higher among Black and Hispanic residents compared to whites.²⁹ And while New Jersey's infant mortality rate is among the lowest in the nation, with 4.7 deaths per 1,000 live births, compared to national rate of 5.9 death per 1,000 live births, there is a disparity between white (3.0 per 1,000 births) and black infants (9.7 per 1,000 births). Maternal mortality, the number of deaths related to pregnancy, is higher in New Jersey (38.1 per 100,000 live births) than nationally (20.7 per 100,000 live births)³⁰.

With respect to health access, 88% of adults and 96% of children in NJ have health insurance.³¹ Additionally, 94% of NJ residents have access to exercise opportunities and 96% have access to healthy foods.³² While the state has more primary care physicians and dentists than the national average, NJ has a much lower availability of mental health professionals.³³

Social and Community Connections

In 2018, 60% of New Jersey parents reported feeling that they live in neighborhoods where people help each other out, watch out for each other's children and know where to go for help in the community.³⁴ NJ has a slightly lower rate of membership associations than the national average and ranks 46th of all states for percentage of residents who volunteer.^{35,36} Sixty-six percent of the voting eligible population in the state voted in the 2016 general election.³⁷ Six percent of NJ youth are neither working nor in school.³⁸

While the overall social and economic picture for New Jersey is bright, DCF's review of findings from needs assessments, quality and performance reviews, and the 2018 Commissioner's Listening Tour makes clear that constituents served by DCF share a set of common challenges. These are primarily challenges associated with poverty, social infrastructure, and availability of and access to targeted services. The day to day trade-offs that low-income constituents face can create risky circumstances for children, can make it difficult to secure safe child care and housing, and can create circumstances in which needed substance abuse and mental health treatment for adults or children cannot be sought nor treatment plans maintained. Challenges with social infrastructure include availability and accessibility of childcare and transportation, to name a few. Finally, constituents do not always have access to the service that meets their family's specific need and have expressed a need for a degree of service coordination.

As DCF builds a child and family serving system for the 21st Century, advancing Governor Murphy's vision for a stronger, fairer New Jersey, the Department will take steps to ensure that its approaches to the work are mindful of these and other lived experiences of the constituents we serve.



2018 IMPACT

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Through a combination of directly operated programs and a sizeable array of purchased programming, DCF provides a comprehensive network of services to support New Jersey's families, prevent violence across the lifespan, and to prevent and interrupt child maltreatment in all forms. These include community services that are universally accessible to anyone in New Jersey, as well as specialized services including those managed within the Children's System of care; those designed solely for families involved with the child protection system; specialized educational programming; licensing; and investigations of institutional abuse.

PREVENTION AND COMMUNITY SERVICES

DCF designs and manages a vast network of [community based, universally-accessible services](#) throughout New Jersey that are aimed at: strengthening and building capacity of individuals, families and communities; preventing violence and maltreatment throughout the lifespan and supporting survivors. These services are delivered in partnership with communities through a network of providers that includes Family Success Centers, Kinship Navigator Programs, home visiting and other early childhood services, school-linked after-school and in-school programming for children and youth, adult employment and training programming, sexual assault prevention and direct service, domestic violence services, and provision of Plans of Safe Care for substance-exposed infants. DCF's community services reach thousands of New Jersey residents each month, and in 2018 supported children, youth, families and individuals to thrive:

- **5,700** children and their families received evidence-based home visiting services through DCF's home visiting network. An average of **85%** of these children were appropriately immunized, and an average of **89%** of children were screened for developmental delays.
- During FY18, **602** families were involved with DCP&P while receiving home visiting services. In the 12 months after enrollment with Home Visiting services, **98%** of families had no subsequently substantiated child protective findings.
- DCF's network of **57** Family Success Centers continued to support the capacity of families and communities: during FY18, Family Success Centers supported over **31,000** families, providing over **43,000** referrals for families, approximately **20,000** sessions on life skills, and nearly **16,000** sessions on advocacy.
- In FY18, New Jersey's Kinship Navigator Program served **3,760** caregivers in maintaining a safe, stable permanent home for the children they took into their care.
- In FY18, DCF's displaced homemaker program served nearly **6,000** individuals. **435** DCF-funded displaced homemaker grants were provided for short-term education/training certificates and related expenses such as books and transportation. **Forty-two percent of 312** individuals who completed the Displaced Homemakers program in FY 18 or no longer needed services were employed full or part-time.
- During federal fiscal year 2018, NJ began piloting Plans of Safe Care in two counties (Atlantic and Essex). During this time, DCF referred **52 (81%)** families of substance-exposed infants to support services such as early childhood intervention, domestic violence services, family preservation services and health-care related services.
- In FY18, there were **15,201** hotline calls to the DCF-funded sexual assault crisis line, and **31,114** people received accompaniment, outreach, and support services.
- Over **17,000** survivors of domestic violence were supported to remain safe in FY18: **92%** of survivors receiving services through DCF programs reported that they have gained strategies to enhance their safety and **91%** report increased knowledge of available community resources.
- DCF's school-linked services helped over **34,000** youth to navigate social and emotional development, providing over **10,000** individual and **25,000** group sessions with students statewide in CY18. **85%** of middle and high schoolers seeking specific help from these programs felt that the services helped them prepare for life after school, **85%** felt that the program helped them have greater success in school, and **74%** expressed that the same services helped them have more meaningful peer relationships.

CHILDREN'S SYSTEM OF CARE

DCF's Children's System of Care (CSOC) is New Jersey's [public children's behavioral health and intellectual/developmental disabilities services system](#), serving children, youth and young adults under the age of 21, and their families. The Children's System of Care was created in 2000, in response to family-led advocacy. CSOC's goals are to: provide a spectrum of effective, community-based services and supports that are organized into a coordinated network; build meaningful partnerships with families and youth, and; to address cultural and linguistic needs so that children and youth function better at home, in school, in the community, and throughout life.

CSOC services and supports are accessed and coordinated through the CSOC Contracted Systems Administrator (CSA), the single point of entry for services and is accessible 24-hours a day, 7-days a week. The CSOC service continuum includes Care Management Organizations (CMO), Mobile Response and Stabilization Services (MRSS), Family Support Organizations (FSOs), and a range of treatment and therapeutic support services. CSOC is the state entity responsible for determining eligibility for an array of services for children under age 18 with developmental disabilities.

Over the years, CSOC has had a significant impact on the lives of New Jersey's families, supporting de-institutionalization of children experiencing challenges at home and school, and ensuring that New Jersey has robust services available in state to meet needs. For example: in 2004, there were 200 youth in detention awaiting residential treatment post disposition; currently there is rarely any child awaiting treatment statewide. In 2007, there were over 300 youth being served in behavioral health residential centers out of state, today there is one youth out of state. CSOC has managed a 37% reduction in residential treatment since 2003, as well as a vast expansion of needed services to New Jersey's children and families. In 2000, NJ served ~7,000 children, youth and young adults in home and community programming; today CSOC serves 59,000 children, youth and young adults in home and community settings. Additional data regarding the utilization and impact of CSOC services are available on the DCF website.

In 2018:

- Over **59,000** youth and their families were provided services through CSOC, and approximately **26,000** children and youth were actively enrolled in a CSOC service at any point in time during the year
- In FY2018, **23,768** youth had an episode of care with the CMO, **17,751** youth with an FSO, and **31,100** with MRSS; and **13,605** youth under 21 were DD eligible. **57%** of the youth served were aged 13 or under.
- **87%** of children receiving CSOC care management were able to receive treatment and supportive interventions while remaining at home with their families
- **90%** of youth who transitioned from CMO services in 2017 were able to maintain their health with family and other supports and did not need to re-enroll in services within 12 months of transition.
- DCF's Mobile Response and Stabilization Services were dispatched to support **26,523** youth and their families across New Jersey in 2018; **97%** of youth who received an MRSS dispatch remained safely in their current living situation, so that youth and families avoided costly and disruptive events such as hospitalization or arrest.

CHILD PROTECTION & PERMANENCY

DCF's Division of Child Protection and Permanency (CP&P) is [New Jersey's public child welfare agency](#), responsible for receiving and responding to reports of alleged child maltreatment, and ensuring the safety, permanency and well-being of children. To carry out these responsibilities, CP&P directly operates the State Central Registry, carries out child protective investigations and child welfare assessments, provides case management for children and their families, recruits, trains and supports kinship and unrelated foster and adoptive parents, facilitates family preservation, reunification, adoption and guardianship processes, and accesses a statewide network of community-based services built to assist families that struggle to parent safely in their process of healing, learning, changing and thriving.

Over 5,000 CP&P staff work in 46 local offices across New Jersey, serving over 48,000 children and their families each day. These DCF staff are assisted by a range of embedded clinical and legal support staff and operate according to a well-developed case practice model. CP&P staff receive extensive pre-service training and case-carrying staff receive a minimum of 40 hours of ongoing professional training annually. As with all DCF policies, CP&P's policies are publicly available on the DCF website.³⁹ The quality of case-practice is managed within the Division through dedicated Area Quality Coordinators, Case Practice Specialists, and Case Practice Liaisons, and CQI efforts are managed and supported within the Department by the DCF Office of Quality. CP&P monthly performance data is available in the Commissioner's Monthly Report⁴⁰ and additional data regarding CP&P's work is available through the New Jersey Child Welfare Data Hub.⁴¹

Most often, when CP&P becomes involved with a family, the Division is able to help the family develop and carry plans that allow for the family to remain together, safely: on any given day, over 85% of the children with active CP&P involvement are at home with their family. In the event that CP&P needs to make use of legal procedures such as seeking Court supervision or custody of children in order to them safe, CP&P is capably represented by the NJ Office of the Attorney General. New Jersey provides free legal representation to children and caregivers through the NJ Office of the Public Defender.

In 2018, DCF:

- Responded to over **165,000** calls to the state's child abuse hotline, and conducted approximately **60,000** Child Protective Services (CPS) investigations involving **94,000** alleged child victims
- Provided child welfare case management to over **24,000** families at any given time, including almost **43,000** children being served in their own home
- Safely reduced the number of New Jersey children living in foster care by **10.8%** from 2017 to 2018
- Reunified over **2,200** children who had been placed into foster care, with their families.
- Facilitated the adoption of nearly **1,100** children for whom reunification was not possible.

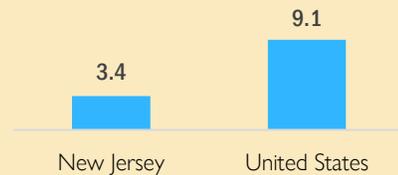
New Jersey's child protection and permanency system outperforms the nation in several important respects:

NJ children are far less likely to die as a result of maltreatment than children in the US, on average.

In 2017, the most recent year for which national data are available, the rate of child maltreatment-related fatalities in New Jersey (0.66 per 100,000) was **less than a third** of the national average (2.32).⁴²

NJ children are victims of maltreatment substantially less often than children in the US, on average.

For each of the five years between 2013-17 (last year for which national data is available), NJ's children were victims of child abuse/neglect at a rate of **3.4 per 1,000**, about **one-third** as often as children in the US on average. The national average for the same year was 9.1 per 1,000.⁴³



Infants, in particular, are safer in NJ than in the US, on average.

Babies in NJ under the age of 1 are victims of abuse or neglect **one-third** as often as babies in the US on average (NJ <1 victimization rate in 2017 was **8.2 per 1,000** compared to the national average at 25.3/1,000).⁴⁴

NJ families are safer and kept together much more often than in other parts of the country.

NJ uses family separation (foster care placement) as a safety intervention for children with active child welfare cases **42% less often** than the national average. In 2016, in the US as a whole 272,952 out of the 73,658,812 US children entered care (a rate of **3.71 per 1,000**). That same year, 4,271 out of 1,987,515 NJ children entered foster care (a rate of **2.15 per 1,000**).⁴⁵

Children in foster care experience fewer replacements in NJ than the national average.

In New Jersey in 2017, **87.3%** of children experience two or fewer placements during their time in foster care, compared to a national average of **83.8%**.⁴⁶

DCF continually strives to improve its child protection and permanency services, and our 2018 self-assessments demonstrated both areas of high quality and areas in need of improvement:

- A case record review of 331 investigations conducted in March 2018 found that **91% of the investigations were either “completely” or “substantially” of Good Quality**, an **8% increase** from the 2016 performance.
- **Children remained safe in New Jersey's resource family homes.** Most recent outcomes data from 2018 shows that only 25 children (**0.27%**) out of over 9,000 were victims of maltreatment by a resource family parent or facility staff.
- DCF staff work effectively to engage and assess Resource Parents. In a comprehensive statewide case review of 231 cases (CY16 and CY17), **engagement was rated as a strength in 88% of the cases** and assessment was rated as a strength in **90%** of cases.
- Finally, **DCF continues to work to achieve benchmarks set forth in the Sustainability and Exit Plan (SEP)** related to the quality of teaming, case planning and provisions of services to support transitions. Detailed information regarding DCF's performance with respect to the SEP are available in the appendix to this report.

DCF routinely shares performance and management data with the public. Monthly child welfare data snapshots are available on DCF's website,⁴⁷ including continually updated SEP performance data. Customizable reports on over 20 child welfare outcomes measures are also available to the public on the New Jersey Child Welfare Data Portal.⁴⁸

SCHOOLS

The DCF Office of Education (OOE) was created in 1979 with the passage of NJSA 18A:7B-1 et seq, the State Facilities Education Act (SFEA) and provides intensive 12-month educational services and supports to children and young adults ages 3 through 21 who have severe or unique needs that require alternative school placement for a period of time. OOE also provides child study team services to State Responsible students. The goal for most OOE students is a successful return to school and participation in community life. OOE regional schools and child study team services are individually designed and tailored to the meet students' needs in the least restrictive school setting. Students are educated in 22 program sites across the State, including: DCF contracted residential facilities, psychiatric facilities operated by the Department of Health, 16 DCF Regional Schools, and two hospital-based satellite programs. The OOE graduated **136** high school students during the 2018-19 academic year.

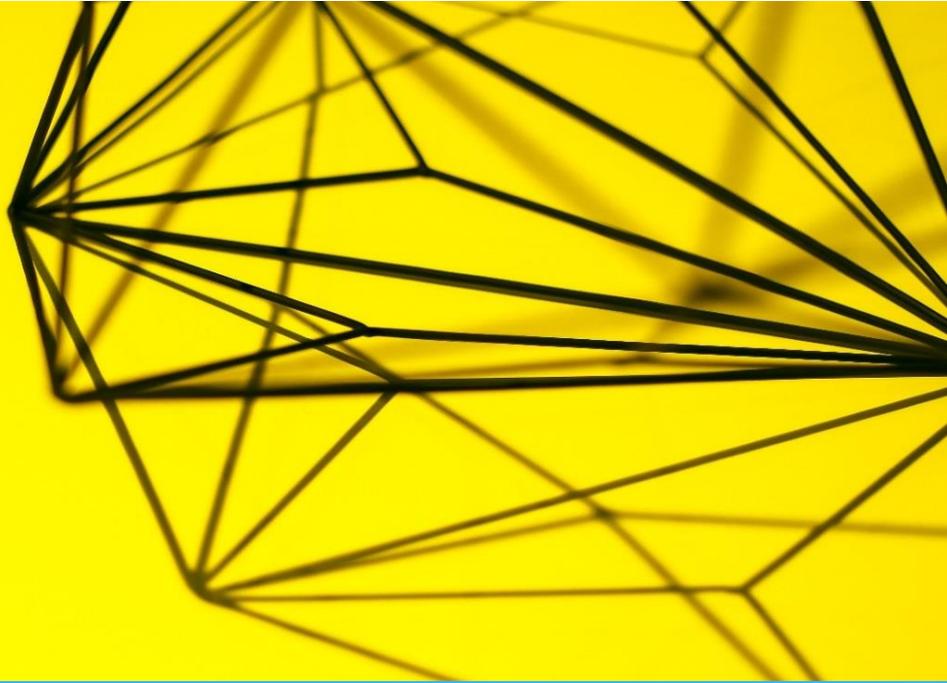
LICENSING

The DCF Office of Licensing (OOL) is the licensing and regulatory authority of the Department of Children and Families. OOL is responsible for licensing, inspecting, monitoring and regulating New Jersey's child care centers, family child care homes, adoption agencies, group homes, youth residential facilities, partial care programs, youth substance abuse treatment programs, and residences for youth with intellectual and developmental disabilities. In addition, every out of home placement program utilized by CP&P or CSOC is first inspected and licensed by OOL to ensure that it meets rigorous standards for safety and quality. Each year OOL licenses **more than 1,300** child care, and **more than 200** youth residential programs, and **more than 600** family child care certificates of registrations are issued each year through OOL.

INVESTIGATION OF INSTITUTIONAL ABUSE

DCF's Institutional Abuse Investigation Unit (IAIU) is a child protective service unit that investigates allegations of child abuse and neglect in out-of-home settings, such as foster homes, residential centers, schools, and detention centers. IAIU's structure is comprised of a Central Administrative Office and four Regional Offices. Additionally, IAIU's internal Continuous Quality Improvement Unit focuses on ensuring investigation quality by following up on concerns found on IAIU investigations in DCF regulated programs and leads quality improvement collaborations with system partners.

In 2018, IAIU received **over 3,100** reports alleging child maltreatment in an out-of-home setting. IAIU continued to complete the majority (**83%**) of investigations within 60 days and continued to exceed DCF's performance target (**95%**) for caseload standards with **100 percent** of IAIU investigators having no more than 12 open cases at one time and no more than eight new referrals assigned in a month. In addition, through on-going collaboration with our internal and external partners, IAIU works to ensure policies and procedures within a facility/institution have measures in place to assist in preventing future abuse/neglect with regards to the other children and youth who reside in these programs.



SERVICE DESIGN & DELIVERY FRAMEWORK

4

NJ DCF has been working to establish a systematic process to identify effective, well-defined services to meet the needs of residents and to guarantee those services are available, accessible, acceptable and high quality.⁴⁹ As DCF continually evaluates its existing services, and whenever new or revised services are contemplated, it manages the work of service design and delivery using the following framework:



PRACTICE MODELS

DCF is working to incorporate evidence-based practices into the service network where appropriate, and for all services, is working to create clear logic models and practice profiles. These promote a common understanding of program goals such as: implementation, outcomes, and core components.



FAMILY VOICE

DCF seeks to elevate the voices of families to ensure the community's concerns are acknowledged, understood, and incorporated into systems designs, policy development and quality improvement processes. In 2018, Commissioner Beyer created the Office of Family Voice (OFV) to ensure that parents, youth, and kinship care providers all have a seat at the table, and DCF has pledged to work to amplify family voice into program and policy design, implementation and management across the department.



TEAMING AND COLLABORATION

DCF's practice models prioritize team approaches, and DCF intentionally partners internally across its divisions and externally with government agencies, advocacy groups, research institutions, community-based providers and families to ensure our services are well-coordinated, comprehensive, and responsive to families' needs. DCF's collaboration with stakeholders helps to guide efforts, inform goals and strategies, improve practice, enhance services, and monitor progress towards goals.



IMPLEMENTATION

DCF uses an implementation science framework to ensure services are delivered with high quality and are available and accessible to the New Jersey residents that need them. It hires, trains, and coaches qualified, competent staff to provide services and supports, and carefully contract for clinical and specialized services in the community. DCF works to ensure that needed organizational supports are in place to facilitate implementation including clear administrative processes, information technology, data systems to support programmatic decision-making, and leadership support.



MEASURING OUR IMPACT

DCF monitors program implementation, fidelity to practice models, and overall achievement of intended outcomes on an ongoing basis, using a combination of quantitative and qualitative measures.

DCF's services are at varying stages of maturity within this framework, as described in Section 5. A significant part of DCF's work in the coming years will be to continue to evolve the service network, as part of its strategy to ensure service excellence in all areas.



PROGRAM & SERVICE DESCRIPTIONS

5

A group of people are shown from the chest up, with their hands stacked together in a circle. The people are wearing various casual clothing like t-shirts and hoodies. The background is slightly blurred, suggesting an outdoor setting. A yellow semi-transparent banner is overlaid on the top left, containing the text.

PART I: PREVENTION AND COMMUNITY SERVICES

Family Success Centers

DCF has designed and manages a network of Family Success Centers (FSCs), community-based, family-centered, neighborhood centers where parents can connect with other parents, access free wrap-around resources and supports, and be part of building their community. Each Family Success Center is uniquely designed by local parents to support the particular community in which it is located. Programming at FSCs may range from GED classes, support groups, community outings, ESL and citizenship classes, exercise, and more.

WHO FSCs SERVE

The 57 warm and welcoming FSCs located throughout New Jersey serve children, youth, families, individuals, and communities. In 2018, 31,557 families, including 56,834 individuals, were engaged with a Family Success Center.

FAMILY VOICE

A key element of each FSC is the development of parent leadership through its Parent Advisory Boards. These boards serve as a way for parents to become stewards of their respective communities and for the FSCs to customize services based on the identified needs within a geographic area. Parents are also organically encouraged to provide feedback on services and volunteer in FSCs.

TEAMING AND COLLABORATION

FSCs collaborate with families, local governments, and community entities to serve their communities. Through these partnerships, FSCs develop networks of family strengthening services in consultation with their Parent Advisory Boards and community voice, and then determine together what types of workshops, activities and groups can be held through the FSC, led by local experts and parents. The core focus on teaming and collaboration in the Family Success Network strengthens connections with families, between families, and to the community as a whole.

PRACTICE MODELS

In 2018 DCF, in consultation with the National Implementation Research Network (NIRN), completed the development of a practice profile for Family Success Centers, and conducted an assessment of needed infrastructure for effective implementation of the profile.

IMPLEMENTATION

The DCF Office of Family Support Services leads the network of Family Success Centers, providing ongoing coordination and technical assistance. FSCs report monthly to DCF on the number of individuals and families they serve, and which services are provided to families. In 2018, DCF launched needed training, data support and administrative infrastructure that will ensure the practice profile is implemented with fidelity. DCF also continued to support the community of practice through provision of conferences and professional development opportunities such as the Annual FSC Conference and Child Abuse Prevention Conferences. The 2018 FSC Conference provided technical workshops that focused on the 2Generation Approach to align and coordinate services for children and families, while the Child Abuse Prevention Conference focused on identifying trauma-informed strategies for working with children and families facing Adverse Childhood Experiences (ACEs).

Kinship Navigator

DCF's Kinship Navigator Program (KNP) supports family members that find themselves caring for their relatives' children, so that caregivers have access to economic and social supports that they will need as they welcome a new child into their family. DCF's network of four contracted regional kinship navigator service providers (North, Metro, Central and South) help caregivers to navigate various forms of government assistance such as housing and economic assistance, determine their eligibility for Kinship Navigator Program benefits, and provide technical support with legal commitments to the child. Any New Jersey kinship caregiver can access Kinship Navigator services by calling 211, contacting DCF, or directly contacting a service provider.

WHO KNP SERVES

During SFY2018, KNP received almost 23,000 contacts by phone, walk-in, or email, and KNP supported 4,755 kin-caregivers in accessing needed resources. 74% of caregivers were grandparents, 22% were other relatives, 3% were neighbor/family friends and 2% were siblings.

FAMILY VOICE

KNP caregivers are engaged to participate in their local FSCs and encouraged to offer feedback as to the programming that would support their needs.

TEAMING AND COLLABORATION

Kinship Navigator providers partner with FSCs, local schools, CP&P, County Councils for Young Children, Social Security, court systems, Boards of Social Services, civic organizations, and other local community providers to create a network of support for kin-caregivers.

PRACTICE MODELS

While Kinship Navigator services have been standardized and in place for over 20 years in New Jersey and throughout the United States, there are few evidence-based models in place for this work. In 2018, as part of DCF's implementation of the Family First Prevention Services Act, the Kinship Navigator Program began the process of developing a practice profile, which will provide a basis from which to establish a New Jersey practice model.

IMPLEMENTATION

DCF manages the Kinship Navigator network, annually reviews the Kinship Navigator Programs, and monitors quality through quarterly site visits to each agency. DCF staff provide or coordinate training and technical assistance when needed and maintain a community of practice amongst the programs DCF collects monthly reports from providers with service and demographic information.

Early Childhood Services

Early Childhood Services (ECS) are integral to New Jersey's development of a comprehensive and seamless system of care. ECS links pregnant women and parents of young children with necessary healthcare and social supports. Core services include management of a statewide Central Intake Network in collaboration with the NJ Department of Health, development and management of a statewide network of home visiting services, and support of the County Councils for Young Children. The County Councils for Young Children have a vital role to support, engage, listen to parent's input and voice, and apply information gained to enhance New Jersey's mixed delivery approach to help families access support services. The ECS portfolio is informed by the Strengthening Families™ framework, a research-informed approach that is applied to practice to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect.

WHO ECS SERVES

ECS serves families with pregnant women, new mothers or fathers, or any other caregivers with children up to the age of 8, based on family needs. During 2018, more than 73,000 home visits were provided, serving 5,700 children. In FY18, 33,684 referrals were made to Central Intake, and County Councils for Young Children served 2,096 unduplicated constituents and 1,167 professionals/ community stakeholders. Additionally, an estimated 6,513 children and 5,393 families received information and support from Strengthening Families.

FAMILY VOICE

DCF has a strong network of local infrastructure to incorporate family voice in Early Childhood Services. Community Advisory Boards provide a vehicle for Central Intake to include the voices of families in their decision-making regarding the direction of the program, and the County Councils for Young Children serve as a platform for family and community engagement, allowing parents and community agencies to come together as active partners.

TEAMING AND COLLABORATION

In partnership with other state and local entities, home visiting is supported by DCF, the NJ Department of Human Services, and the NJ Department of Health. County Councils for Young Children operate through a partnership between DCF and the NJ Departments of Education, Health, and Human Services.

PRACTICE MODELS

Early childhood services use multiple evidence-based and evidence informed models. Central Intake coordinates services using the national Help Me Grow System Model. The Home Visiting network provides three different evidence-based models of service in each of NJ's 21 counties: Healthy Families, Nurse-Family Partnership, and Parents as Teachers. County Councils for Young Children make use of the Shared Leadership Model and Parent Leadership Development.

IMPLEMENTATION

Training and technical assistance for this suite of services is provided through multiple partnerships. The Nurse-Family Partnership National Service Office (NSO) and Prevent Child Abuse New Jersey (PCANJ) provide model-specific training, technical assistance, data monitoring and reporting, and administrative support services for the three evidence-based home visiting models. Home Visiting and Central Intake programs partner with Johns Hopkins Bloomberg School of Public Health to conduct program evaluation and quarterly continuous quality improvement (CQI) cycles. Strengthening Families childcare members receive ongoing training on how to integrate the Protective Factors Framework into their program services. The County Councils for Young Children members are offered training and technical assistance on leading parent and community collaborations. Free training and technical assistance for members of the local councils is provided by The Statewide Parent Advocacy Network (SPAN).

School-Based Services for Youth

DCF manages a network of out-of-school and in-school prevention and support services that build on youth's strengths to assist them with achieving their educational and life goals, as well as a network of Family Friendly Centers that provide academic, recreational, and social enrichment activities to students and their families. DCF contracts throughout the State with non-profit organizations, universities, hospitals, and school districts to implement programs. Through these school-linked services, youth can access mental health support, employment assistance, substance use counseling, preventive health care, violence prevention programs, learning support, mentorship, teen parent skill development, and recreation.

WHO SBYS SERVES

DCF's school-linked services support students ages 5 through 21 and their parents and educators. During SFY18, over 34,000 students were supported by School Based Youth Services Programs (SBYSP), before-and after-school programming that includes recreation, educational supports, mental health counseling, substance abuse prevention, and pregnancy prevention. In addition, in 2018 out of school time programming for elementary-aged students reached 1,349 students in 46 afterschool enhancement programs, and the Parent Linking Program worked with 372 expecting and parenting teens to prevent child abuse and neglect and reduce the barriers that can impede their ability to complete their education. The New Jersey Child Assault Prevention Program (NJCAP) reached more than 92,000 youth and young adults in 494 schools; the 2NDFLOOR youth helpline (available to youth 24/7) received calls or texts from 10,431 youth in need of counseling, and the Traumatic Loss Coalition responded to 133 trauma-related events.

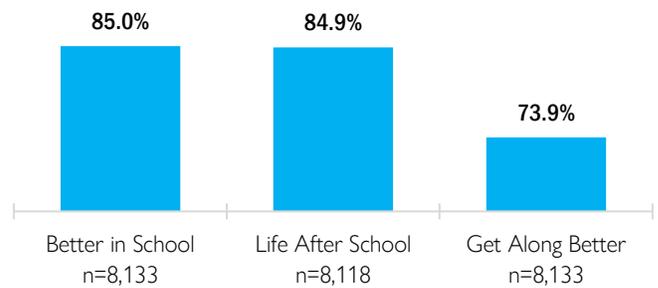
FAMILY VOICE

SBYSP integrates the voices of parents and caregivers into services through Community Liaison Boards and by hosting at least one fatherhood program annually. Parent Linking Program design and operations are informed by Parent Advisory Groups that include the participation by parenting teens and their parents. Family Friendly Centers host family engagement activities to encourage parental participation.

TEAMING AND COLLABORATION

New Jersey school districts and various non-profit organizations provide a wide array of prevention and support services to youth in public elementary, middle, and high schools. Capitalizing on these established programs, DCF partners with these non-profit organizations, hospitals, universities, and school districts to serve students locally.

2018 Activity Specific Impact



PRACTICE MODELS

All SLS providers are expected to integrate elements of the New Jersey Standards for Prevention Programs and the national Strengthening Families Programs into their service delivery. In CY18, School Based Youth Services Programs started the process of aligning their program practice with the Center for the Study of Social Policy's Youth Thrive Framework.⁵⁰ The Adolescent Pregnancy Prevention Program uses an evidence-based curriculum, Reducing the Risk: Building Skills to Prevent Pregnancy, STDs & HIV.

IMPLEMENTATION

SLS's programs include infrastructure for training, coaching, and data collection. All SLS staff attend required trainings related to program implementation, including data system training. Providers with access to the cloud-based data collection system report on students served including their needs, services received, and outcomes. An impact survey is implemented on a bi-annual basis to evaluate student satisfaction with SBYSP to assist and guide decision making related to future services. Several programs also collect pre/post data on outcomes such as resilience, refusal skills and self-regulation.

Fatherhood Services

Fatherhood services seek to strengthen parenting and leadership capacities of New Jersey fathers by connecting them to concrete services and increasing parenting knowledge and skills. Through these services, fathers become more engaged with their children and stronger leaders at home and in the community. Fatherhood providers also build and strengthen community father engagement supports to link fathers to necessary resources. Group parenting education and empowerment groups are offered to participants varying from teen fathers to stepfathers to grandparents. Services are currently available in Middlesex, Monmouth, Mercer, Salem, and Cumberland counties.

WHO IS SERVED

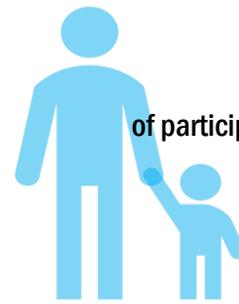
Fatherhood services reach fathers and father-figures (e.g., grandparents, uncles, community leaders, etc.) who may or may not have custody of their child/ren and wish to improve their parenting skills. During SFY 2018, 151 fathers received multi-session parenting training. Most fathers receiving services had young children (ages 0-5 years) or adolescent youth.

FAMILY VOICE

Fatherhood services integrate the voices of parents and caregivers into their services through engaging fathers to provide direction related to the activities and programming offered.

TEAMING AND COLLABORATION

Fatherhood services collaborate with local community entities and schools to market parenting education to fathers. Collaborations are also created to host community activities led by participating fathers. Lastly, providers connect with employment services, clothing and food services, and probation offices to assist fathers with overcoming barriers to accessing needed supports.



88%

of participants improved their protective factors.

PRACTICE MODELS

Fatherhood service providers are expected to integrate the Protective Factors into their service delivery. Some programs are based on the Parents Anonymous Evidence-Based Model. Parenting education is based on a multi-dose curriculum such as Active Parenting or Nurturing Fathers or 24/7 Dads. Providers are also expected to connect fathers to concrete supports as they are identified.

IMPLEMENTATION

Some programs include leadership opportunities for participating fathers to plan community activities, allowing fathers to practice leadership skills while strengthening their social connections. Leadership trainings are available within several sites to increase leadership skills within the groups. Providers may also provide technical assistance to other agencies regarding fathers.

Employment & Training Services

A displaced homemaker is someone who, after serving as an unpaid homemaker for many years, must integrate into the paid workforce due to the separation, divorce, disability, or death of a spouse or significant other, and:

- Is receiving public assistance because of dependent children in the home but is within one year of no longer being eligible for assistance, or
- Is unemployed or underemployed and is experiencing difficulty in obtaining or upgrading employment, or
- Is at least 40 years of age, an age at which discrimination based on age is likely, and at which entry or reentry to or advancement in the labor market is difficult

The mission of Displaced Homemaker (DH) Programs is to help participants gain marketable skills and economic self-sufficiency. Services include job counseling, training, and placement assistance, educational information and services, short term certificate education/training grants, computer literacy training, financial management services, legal information and services, life skills development, referrals and community outreach.

WHO DH SERVES

There are currently 17 displaced homemaker programs located in 16 counties across New Jersey. Approximately 5,945 individuals were served in fiscal year 2018. DCF is expanding the program to 22 sites in 21 counties during FY19.

FAMILY VOICE

The voices of participants are critical to ensuring Displaced Homemakers programs are meeting their needs. Each participant comes into the program with a unique set of circumstances as he or she is navigating entrance or re-entrance into the paid labor market. DCF meets quarterly with the Displaced Homemakers Network and conducts site visits to individual programs to ensure that we understand the evolving needs of participants.

TEAMING AND COLLABORATION

DCF collaborates with state and local resource partners, Domestic Violence programs, the Department of Labor and Workforce Development, Family Success Centers and County Colleges to provide an effective network of services for Displaced Homemakers.



PRACTICE MODELS

The Displaced Homemakers program is developed as described in New Jersey statutes P.L. 1979, c. 125 (N.J.S.A. 52:27D-43.18 et seq). This legislation sets the definition of a displaced homemaker and requires the following core components to be provided: job counseling, job training, job placement, health education and counseling, financial management, educational services, legal counseling, and outreach/information services.

IMPLEMENTATION

The Displaced Homemaker program logic model specifies key activities, process and outcome indicators. The NJ Division on Women provides quarterly technical training days to the Displaced Homemaker providers with speakers from DCF and external sources. There is a web-based data system in place to collect data on service delivery and effectiveness to support continuous quality improvement processes. The data is reviewed monthly by DCF and regularly discussed with providers. Additionally, DCF's Office of Research, Reporting and Evaluation (RER) provided training to Displaced Homemaker providers related to demographics, service and outcome data. In CY 2018, DCF held webinars to provide technical assistance and discuss best practices for data entry/management.

Primary Prevention of Sexual Violence

DCF's efforts to prevent sexual violence include educational seminars, education and awareness to communities, community mobilization and training for professionals. A primary prevention coalition in each county in which a program operates identifies the population most in need and the strategy used to serve that population. The programming promotes collaboration among a variety of sectors and works to increase protective factors and decrease risk factors associated with the perpetration of sexual violence.

WHO PPSV SERVES

In FY18, 65,944 people participated in evidence informed or evidence-based curriculums, coalition/community building and outreach/education activities across New Jersey. Outreach/education activities occurred mainly at schools (36%), non-profit/community-based organizations (29%), and colleges/universities (21%), with the remaining amount occurring in other locations (15%).

FAMILY VOICE

Primary prevention programs provide various opportunities for survivors and families to share their input and insight. Feedback and input is gathered through surveys, listening sessions, and stakeholder meetings, and has been incorporated into strategic plans for future programming. Ensuring the voices of all survivors are heard, particularly from underserved and marginalized communities, remains a priority for DOW.

TEAMING AND COLLABORATION

The 20 county-based providers and the Rutgers University Office for Violence Prevention and Victim Assistance team with DOW, the New Jersey Coalition Against Sexual Assault, the Governor's Advisory Council Against Sexual Violence, other state and federal departments and local communities to deliver sexual violence prevention programming.

PRACTICE MODELS

This program utilizes the Centers for Disease Control and Prevention's Public Health Framework as well as three evidence based/informed models: The New Jersey Coalition Against Sexual Assault's Media Literacy curriculum, Safe Dates, an Adolescent Dating Abuse Prevention Curriculum and Rutgers' Office for Violence Prevention and Victim Assistance SCREAM Theater peer education.

IMPLEMENTATION

The New Jersey Coalition Against Sexual Assault provides training and coaching to the county-based providers. DCF has a web-based data system to collect comprehensive process and outcome evaluation data for data informed decision making and program improvement.

Sexual Assault Direct Services

DCF provides an array of services for survivors of sexual assault that are designed to reduce trauma, increase self-efficacy and empowerment, and provide a path for survivors' long-term healing:

- 24-hour hotline services for crisis intervention and referral;
- Accompaniment and advocacy through medical, criminal justice and social support systems including medical, police and court proceedings;
- Crisis intervention, individual and group support services, and comprehensive service coordination to assist sexual assault victims and family and household members;
- Information and referral to assist sexual assault victims and family or household members;
- Community-based culturally specific services and support mechanisms, including outreach materials for underserved populations and;
- Development and distribution of materials to educate on issues related to the aforementioned services.

“A recent client was able to successfully complete her trauma treatment after an extensive history of sexual assault... [they] reported a significant decrease in depression symptoms as well as an increase in functioning, gaining full-time employment.”

**Program Director,
Sexual Assault Service Provider**

WHO SADS SERVES

DCF contracted agencies provide free and confidential, sexual violence care services to survivors regardless of when the violence took place or whether a police report was created. In FY18, there were 15,201 hotline calls, and 31,114 people received accompaniment, outreach, and support services across New Jersey.

FAMILY VOICE

Through community outreach and direct services, sexual violence programming has highlighted the needs, experiences and resiliency of survivors. These voices have and continue to inform sexual violence responses throughout the state. DCF has taken care to ensure its programming meets the needs of all survivors, particularly those from underserved and marginalized communities.

TEAMING AND COLLABORATION

The 21 county-based providers and Rutgers' Office for Violence Prevention and Victim Assistance team with DCF, the New Jersey Coalition Against Sexual Assault, the SART/FNE Coordinating Council, the Governor's Advisory Council Against Sexual Violence and local communities to ensure a strong network of community-based culturally specific services.

PRACTICE MODELS

DCF funded the New Jersey Coalition Against Sexual Assault to develop a manual with standards for sexual assault services. Once this work is completed, training will be provided, and it will be incorporated into the providers' contracts.

IMPLEMENTATION

The New Jersey Coalition to End Sexual Assault provides training and coaching to the county-based providers. DCF receives monthly reports on the number of people served and types of services provided. DCF program administrators regularly review process data from the county providers and use this information to identify needs and for continuous quality improvement efforts.

Domestic Violence Services

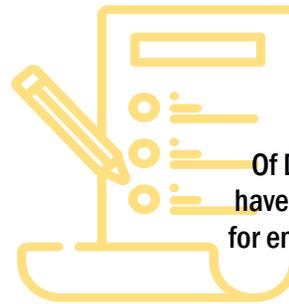
DCF funds an array of domestic violence services that assist survivors statewide. Services for survivors and their families include emergency shelters, 24-hour hotlines, counseling, children's services, legal services, and advocacy. Children's services include evidence-informed creative arts therapies and evidence-based Trauma Focused Cognitive Behavioral Therapy™. Additionally, a Batterers Intervention Program provides services to individuals with children who perpetrate domestic violence to increase household safety and prevent further violence. DOW also operates the New Jersey Address Confidentiality Program, which provides domestic violence victims and survivors with a legal substitute address to safeguard their location and safety. Lastly, DOW funds education/awareness, training, and networking opportunities to communities throughout New Jersey.

WHO DVS SERVES

In FY 2018, there were over 100,000 calls to DCF-funded domestic violence hotlines. Approximately 17,416 individuals received DCF-funded domestic violence services across the state of New Jersey: 80% of the individuals accessing these services were women, 14% were children and 6% were men.

FAMILY VOICE

Utilizing the safety and accountability assessment framework, the DCF has been conducting data collection activities with diverse stakeholders and listening sessions with survivors of domestic violence. Central themes that have emerged include the difficulty in reaching harder-to-serve communities and the importance of being culturally inclusive and accessible. The statewide domestic violence plan has also facilitated pathways for robust conversations with stakeholders who provide information regarding the complex needs of our constituents throughout the diverse communities that make up our state. This approach informs our collective work to ensure our services are inclusive and accessible while also identifying what has worked well, barriers, and the unmet needs experienced by survivors.



92%

Of DV clients report they have increased strategies for enhancing their safety.

TEAMING AND COLLABORATION

DCF teams with county-based providers, the New Jersey Coalition to End Domestic Violence, other departments in New Jersey such as the Departments of Community Affairs and Health, the judicial system, CP&P, universities, and local communities to provide domestic violence services.

PRACTICE MODELS

Emergency shelters in New Jersey follow the Standards for Shelters for Victims of Domestic Violence ([N.J.A.C. 3A:57](#)). Specific service types also use various models such as Trauma-Focused Cognitive Behavioral Therapy®, and the Batterer's Intervention program uses the Duluth Model for group counseling and the Safe and Together™ model for training.

IMPLEMENTATION

All domestic violence service providers submit monthly or quarterly reports on the number of people served and types of services provided. DCF uses this information for contract monitoring and program improvement. In addition, DCF is working with statewide stakeholders to conduct ongoing safety and accountability assessments. The data collected through this process will increase knowledge of system gaps and promising practices to increase collaboration and implement solutions.

Plans of Safe Care

In 2016, Congress amended the Child Abuse Prevention and Treatment Act (CAPTA) regarding infants and their families, adding requirements that States establish Plans of Safe Care to address the needs of infants who are identified as affected by substance abuse, experience withdrawal symptoms, or have fetal alcohol spectrum disorders (FASD). In May 2017, DCF adopted regulations ([N.J.A.C. 3A:26](#), Substance Affected Infants) to guide New Jersey's compliance with this law.

Consistent with the new regulations, hospitals and other birthing centers are required to report every birth of a substance-exposed infant to DCF. Upon receipt of the report, a DCF caseworker assesses the family situation and supports the family in planning for the safe care of the infant prior to the mother's discharge from the hospital. The practice model includes the use of multi-disciplinary clinical conferencing to support appropriate planning on behalf of the infant and the family and the use of Family Team Meetings through which the family and DCF can further develop and finalize the Plan of Safe Care to mitigate current and future risk to the child.

WHO IS SERVED

Plans of Safe Care are available for every NJ family in which a child is born with exposure to substances.

FAMILY VOICE

For each case, Plans of Safe Care are fully developed and finalized with each family through a Family Team Meeting that includes families and their natural supports.

TEAMING AND COLLABORATION

Plans of Safe Care are uniquely created with each family in consultation with a multi-disciplinary team that includes DCF casework staff; a Domestic Violence Liaison, a Certified Alcohol Drug Counselor (CADC) and/or Peer Recovery Coach, a Mental Health Clinician, a Child Health Unit Nurse, and an Early Childhood Liaison.

At a system level, a cross-divisional Plans of Safe Care leadership team drafted regulation and policy, developed protocols, assessed the scope and impact of the work, engaged partners, and developed and implemented a training model for CP&P Local Offices. DCF collaborates with the Department of Health, Division of Family Health Services, Maternal Child Health, as well as the three NJ regional maternal child health consortia.

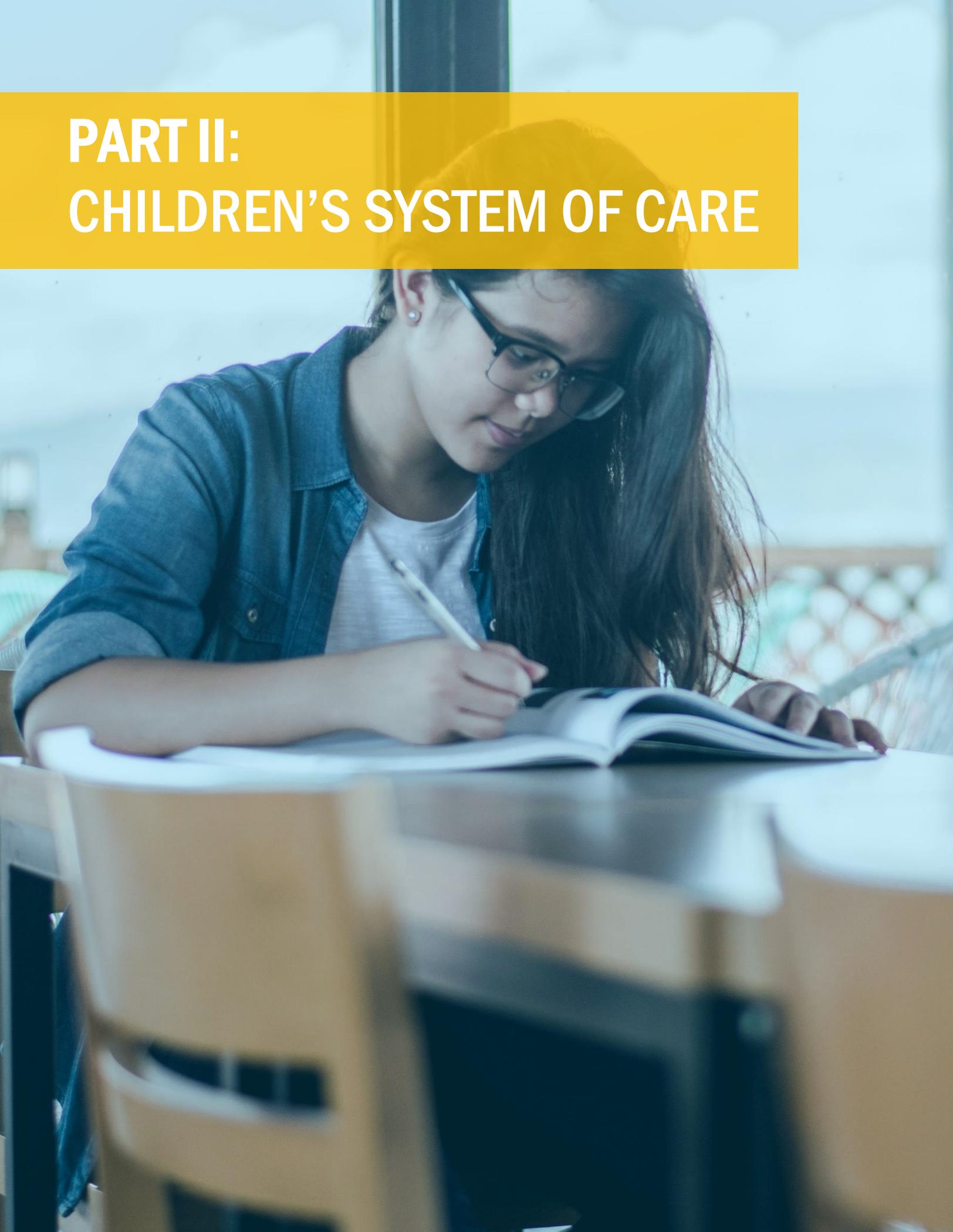
PRACTICE MODELS

Plans of Safe Care are implemented in accordance with the provisions in the Child Abuse Prevention and Treatment Act (CAPTA) legislation. DCF worked with the National Alliance of Children's Trust and Prevention Funds to adapt their "Bringing the Protective Factors Framework to Life in Your Work" training for our child welfare workforce in support of implementing the Plans of Safe Care protocol.

IMPLEMENTATION

In 2017, the DCF developed the Plans of Safe Care protocol, and began implementation in 2018 with a demonstration project in Atlantic City. Since then, DCF has been able to revise the protocol, develop data tracking systems, and expand implementation. DCF tracks all Plans of Safe Care with NJ families including information on families' alcohol and drug risk factors, services offered, and families' child welfare outcomes.

PART II: CHILDREN'S SYSTEM OF CARE



Network of Treatment & Support Services

The Children's System of Care (CSOC) oversees the development and management of a network of contracted treatment and support services children, youth, young adults and their families with behavioral health (BH), intellectual/developmental (I/DD) or substance use (SU) challenges. All treatment services and supports are trauma-informed and healing-centered, and many serve youth with co-occurring BH-I/DD or BH-SUD treatment needs. Services are delivered in the community or in out of home (OOH) settings.

WHO IS SERVED

CSOC's complement of needs-driven supports and services are available to any NJ child meeting clinical criteria and their family, regardless of income level or insurance status. Treatments for youth ranged from those with behavioral health needs, substance use, intellectual and developmental disabilities as well as youth with co-occurring disorders.

TEAMING AND COLLABORATION

The Child Family Team (CFT) Wraparound Approach supports collaboration among a team of family members, professionals, and significant community residents identified by the family and organized by the care manager to design and oversee implementation of the youth's Individual Service Plan (ISP). The ISP aligns the assessed strengths and needs of the youth with plan elements including family vision, goals, strategies, and supports and services. As an ongoing process, the CFT continuously includes participation from the youth, the youth's family, the care manager, and any other individual identified by the youth and family to help support the family towards a sustainable plan of care.

PRACTICE MODELS

Intensive in-community (IIC) behavioral services include biopsychosocial strengths and needs assessments to support diagnosis and treatment planning, and (IIC) behavioral health and behavioral assistance services using best practice and evidence-based, family-centered treatment models, including MST, FFT, and ARC-GROW.

For youth with I/DD who are determined DD eligible, CSOC provides Intensive in-home (IIH) habilitation services including behavioral and clinical/ therapeutic supports such as Applied Behavioral Analysis (ABA) to support improved behavioral, social, educational and vocational functioning and to prevent, decrease or eliminate behaviors or conditions that may impact the ability of the youth to function in their home, school or community. Individual support services (IIS) assist youth with acquiring, retaining, improving and generalizing behavioral, self-help socialization and adaptive skills. DD eligible youth may also access services including respite for caregivers, summer camp, assistive technology, and educational advocacy.

Youth with SU challenges are able to access outpatient and intensive outpatient services through a network of qualified agency providers.

CSOC maintains a comprehensive array of OOH services provided through a network of provider agencies. OOH services deliver varying intensities of service designed to address the unique needs of youth with BH, SU, I/DD, or co-occurring challenges. Clinical criteria for the OOH continuum of services is available at <http://www.performcarenj.org/provider/clinical-criteria.aspx>. In addition to existing contractual standards, over the last several years CSOC has infused the Nurtured Heart Approach and Six Core Strategies to Reduce Seclusion and Restraint within the OOH provider network.

IMPLEMENTATION

CSOC contracts and Medicaid provider agreements ensure that there are clear descriptions of program deliverables and defined standards for each service. All CSOC system partners and treatment providers document their work in the CYBER electronic behavioral health information system. CSOC and system partners routinely assesses access, utilization and outcomes using data from CYBER. In addition to these quantitative reviews and assessments, CSOC conducts program monitoring visits and system reviews facilitated by standardized data collection and evaluation tools. CSOC evaluates trends across providers and monitors adherence to provider contract and program standards.

Since its inception, CSOC has placed importance on ensuring workforce development. All in-community and in-home services are delivered by appropriately licensed, credentialed, and trained clinicians and behavioral assistants. As described in the previous section, CSOC funds a spectrum of training through a contract with Rutgers University Behavioral Health Center (UBHC), and these trainings are available to all system partners, treatment providers as well as families. In 2018 Rutgers supported 12,891 training and technical assistance (TA) participants through 281 trainings and 493 TA hours. Additionally, they introduced 11 new trainings including: Setting the Stage for Change: Engagement and Motivational Skills, Working with a Trauma Lens in Crisis Intervention, Resilience: Moving from at Risk to at Promise, ACE and the Neurobiology of Trauma, Complex Trauma and Attachment, and NHA in the Therapeutic Context and CBT with Latino Populations for which a Spanish version is currently in development.

Care Management

Care Management Organizations (CMOs) are county-based, nonprofit organizations responsible for care management, assessment, and comprehensive service planning for youth and their families with intense and/or complex needs related to behavioral health, substance use, and/or intellectual or developmental disability. CMOs engage families and youth, coordinate Child Family Team (CFT) meetings, implement Individual Service Plans (ISP) for each youth and their family, and coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth. In 5 counties, CMOs serve as the designated Behavioral Health Home (BHH) entities for youth in New Jersey, serving as a "bridge" to connect prevention, primary health care, and specialty behavioral health care. The CMO's goal is to help youth and families develop a long-term, sustainable plan that will support improved functioning long after CMO involvement.

WHO CMOs SERVE

CMO services are available to New Jersey youth aged 5-21, with consideration for youth under 5, who present with moderate or complex emotional or mental health, substance use, intellectual or developmental challenges that are impairing individual or family functioning, and/or who are determined DD eligible and have moderate or complex challenges and skill building needs.

FAMILY VOICE

The perspectives of all family members, particularly youth, are given primary importance throughout the CMO's work. In addition to utilizing a Child and Family Team process to guide treatment planning, CMOs also assist families in accessing a Family Service Organization (FSO) peer support partner at the time youth are enrolled with the CMO to provide support, education and advocacy from peers with lived experience.

TEAMING AND COLLABORATION

CMOs coordinate services through the Child and Family Team (CFT) process which includes families' formal and informal supports to help identify family needs, develop goals, and plans for change and sustainable support. CMOs collaborate within their community through the Children's Interagency Coordinating Council (CIACC) and other local stakeholder groups to coordinate and problem-solve local systems concerns. CMOs also coordinate closely with FSOs, staff local DCP&P offices with clinical consultants, and make use of a joint protocol for facilitating family planning processes when families are dually involved with DCP&P and CSOC. CSCOC state and local partners participate in the JDAI to increase collaboration for and respond to needs of court-involved youth. JDAI is active in all 15 vicinages.

PRACTICE MODELS

The Care Management Organization model is grounded in CSOC's guiding values and principles, which are adapted from the System of Care (SOC) approach. The practice model is rooted in the work of the National Wraparound Initiative, and recently incorporated the Nurtured Heart Approach®, a promising practice approach to supporting youth with intense behaviors. The New Jersey CMO model is manualized in the *Care Management Organization Policy Manual*. CSOC holds monthly meetings with CMO executive directors to share information about CSOC/DCF initiatives, exchange practice ideas, and share data to improve practice.⁵¹

IMPLEMENTATION

CMOs are active in all 21 counties in New Jersey and utilize a statewide electronic behavioral health information system (CYBER), to manage workflow, track utilization, and support performance management. CMO staff receive training through CSOC's partnership with Rutgers UBHC. The CMO annual certification process includes achievement of standard training requirements and an on-line review and core competency certification by supervisory staff. The CMOs are routinely monitored by DCF through data review and available qualitative information. CSOC holds monthly meetings with CMO executive directors to share information about CSOC/DCF initiatives, exchange practice ideas, and share data to improve practice.

Family Support Organizations

FSOs are nonprofit, county-based organizations run by family members of youth with emotional, behavioral, developmental, and/or substance use challenges that have received services from any youth serving system. FSOs provide direct family-to-family peer support, education, advocacy, and other supports, to help them navigate the System of Care, school system, DCP&P, and the legal system, and most importantly are there to listen and provide moral support. In addition to caregiver supports, FSO Youth Partnerships (YPs), led by a young-adult Youth Coach, help youth to engage with other youth with mental, emotional and behavioral health needs. Through support groups, social activities, and leadership development, youth and young adults ages 13-21 find their voice to affect change in their own lives and the lives of others. YPs have their own boards, websites, logos and funding. Each YP participates in monthly community activities to challenge stigma and strengthen other youth in their communities, and each year, youth leaders across the state develop and facilitate an annual youth conference.

WHO FSOs SERVE

FSOs support parents/caregivers of youth who have behavioral health needs, intellectual or developmental disabilities, and/or justice system involvement, and who need support, education and advocacy in helping respond to their youth and family needs. FSO is open to youth involved with the CMO and continue to offer support to families after youth no longer demonstrate a clinical need for other CSOC services.

FAMILY VOICE

FSOs are the embodiment of family voice within the Children's System of Care. CSOC places great emphasis on the presence of the family voice within the CFT as a necessary component of a youth and family's treatment and success, and it is a priority that FSOs participate with the CMO, families, and youth when coordinating initial and CFT visits to ensure that family voice is integrated into treatment. This collaboration allows families to incorporate formal and informal supports to identify family needs, and to develop plans for change.

TEAMING AND COLLABORATION

On an individual level, CMO and FSO team during a family's involvement with CSOC; youth and families referred to the CMO are at the same time referred to the FSO, and the CMO and FSO coordinate around the introduction of FSO services to the families, initial face-to-face meetings and Child Family Team (CFT) meetings. At a system level, the FSO participates in the local CIACC to ensure that family voice is actively involved in the county's work with the youth.

PRACTICE MODELS

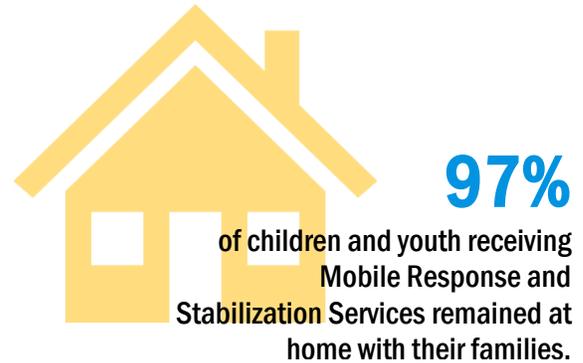
The FSOs use the Family Assessment of Needs and Strengths (FANS) to maximize communication about the strengths and needs of families as they navigate the Children's System of Care. In addition to the use of this standard assessment tool, the following program models are in use within the FSO network: EPIC (Every Person Influences Children), Explosive Child, Strengthening Families, STEP (Systematic Training for Effective Parenting), I Can Problem Solve, and Raising a Thinking Child/Adolescent. FSO Family Support Partners are certified through the State of New Jersey's Children System of Care approved curriculum.

IMPLEMENTATION

DCF supports training for the FSO Family Support Partner staff through provision of a standardized training and certification process. Training is provided by Rutgers University UBHC, and the Alliance of FSOs. New Family Support Partners are required to be certified within 12 months of their date of hire and must complete certification on the FANS tool annually.

Mobile Response & Stabilization Services

MRSS is the CSOC's urgent response service designed to help families stabilize youth in home and community settings. MRSS provides immediate (within one hour) intervention designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains such as school and home routines. The initial phase of MRSS can extend for up to 72 hours after the dispatch request and includes de-escalation, assessment, crisis planning services and linkage. Based on the youth and family's needs, MRSS may remain involved with the youth and family for up to eight weeks, during which time MRSS staff will coordinate formal and informal services and supports for the youth and family.



WHO MRSS SERVES

In 2018, MRSS were dispatched to support 26,523 youth and their families across New Jersey. MRSS is available to all New Jersey youth under 21 and their families, regardless of income, insurance eligibility, residency or additional system involvement. MRSS clinical criteria are broad and allows response based on family indication that their youth is experiencing needs and changes in their functioning and the caregiver needs help in supporting their youth. Families of youth discharged from a psychiatric screening center are eligible to receive MRSS given the youth's vulnerability after these experiences, and DCP&P requests MRSS for every youth placed or re-placed in a resource or kin home in order to support youth and the resource family, and to facilitate the stability of the placement.

FAMILY VOICE

DCF relies on a family's definition of a crisis as the standard for what constitutes a crisis that would indicate a need for MRSS dispatch. Allowing families to define their crisis honors their expertise in their family and respects their judgment on whether immediate intervention is required. MRSS service delivery adheres to system of care principles including the need for family driven and youth guided care to support the family vision. MRSS can also provide a valuable link to the Family Support Organizations if a family is agreeable.

TEAMING AND COLLABORATION

At a family level, the MRSS response includes collaborative development of a crisis plan, which involves teaming with the family and its natural and formal network of support. At a systems level MRSS providers have formal collaborative relationships with multiple public systems such as schools, juvenile justice and child protection, and often function as a point of entry into CSOC and other services such as Care Management, partial care or community programs. MRSS is a key participant in local CIACCs and partner with other members to provide education and support throughout the community.

PRACTICE MODELS

The MRSS service model is guided by N.J.A.C. 10:77-6 et al. MRSS is the direct service provider within the initial phase and delivers all services necessary within 72 hours with few exceptions. MRSS uses a standardized assessment tool, the Crisis Assessment Tool, to help families communicate about needs and strengths.

IMPLEMENTATION

DCF contracts with 15 MRSS providers to serve all 21 counties in New Jersey. Training for MRSS staff is provided through CSOC's partnership with Rutgers UBHC, and MRSS performance is monitored by DCF. The annual MRSS certification process includes standard training requirements, an on-line review and core competency certification by supervisory staff. CSOC holds monthly meetings with MRSS executive directors to share information about CSOC/DCF initiatives, exchange practice ideas, and share data to improve practice.

**PART III:
CHILD PROTECTION &
PERMANENCY SERVICES**



State Central Registry

Promptly and appropriately responds to reports of suspected child abuse or neglect is one of the most critical child protective service functions. New Jersey's SCR is a hotline system that operates 24 hours a day, seven days a week. The SCR receives, prioritizes and dispatches responses to suspected child abuse and neglect situations and provides information and referrals for families in need of support.

WHO SCR SERVES

The SCR is available to anyone who suspects that a child in New Jersey is being or has been maltreated. The SCR receives, on average, nearly 15,000 calls a month. In 2018, SCR received a total of 178,688 calls of which 64,680 (36%) were calls concerning abuse and neglect, 21,299 (12%) were requesting supportive services on behalf of families, and 50,027 (28%) were calls with related information for families that have active cases. It was determined that CP&P intervention was not warranted for 21,437 (12%) of the calls received. In these instances, callers were referred to other state agencies, community partners or other entities to assist with family stabilization or access to other supportive services. The remaining 21,245 (12%) of the calls were not related to child abuse or neglect or child welfare (e.g., requests for CP&P Local Office phone number, verifying state closure).

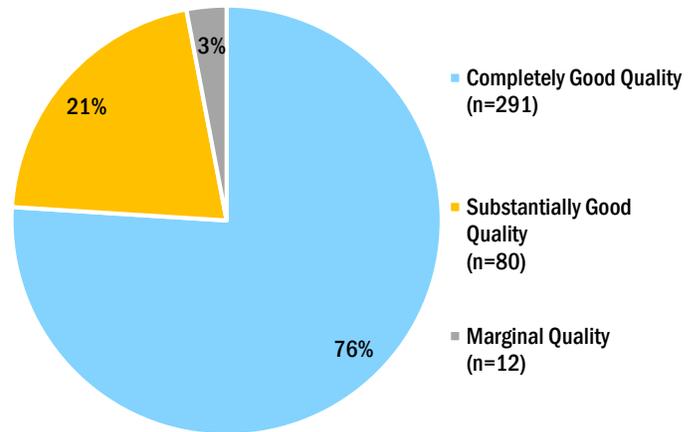
TEAMING AND COLLABORATION

SCR collaborates with the New Jersey Chapter of the American Academy of Pediatrics (NJAAP) and provides Suspected Child Abuse and Neglect (SCAN) trainings to health care and early childhood professionals. The SCR partners regularly with DCF's Children's System of Care, law enforcement and other government programs to ensure appropriate responses to family crisis.

PRACTICE MODELS

The SCR practice specifications are outlined in DCF policy. Calls are coded into different categories for review and action. Reports requiring a field response are forwarded to the appropriate CP&P Local Office, which investigates or assesses the family's needs. Reports regarding child abuse/neglect that occur in resource home or institutional settings are forwarded to the appropriate Regional Institutional Abuse Investigation Unit (IAIU).

Quality of SCR Calls



IMPLEMENTATION

SCR is staffed by over 100 full and part-time employees. DCF's Office of Training and Professional Development provides formal training to staff. Supervisory staff are required to review a set number of recorded calls and the corresponding documentation which are then graded for quality and accuracy. The Quality Assurance Peer Review Team within SCR is responsible for reviewing reports that were not sent out for a CP&P field response to ensure the call was processed appropriately and no further assessment/investigation is needed. SCR is committed to enhancing the professional development of supervisory staff by focusing on leadership trainings that will increase supervisors' capacity to address complex situations, measure results and assist in the implementation of sustained system change to better support staff.

Child Protective Investigations

When the SCR receives a report alleging that a child is being abused or neglected, the Intake referral is sent from SCR to a designated Local Office. Highly trained CP&P staff then conduct a child protective investigation, to determine if a child has been maltreated or is at risk of maltreatment, plan with the family for reduction of risk and increase of safety for the child, and help families determine what support they may need in order to parent safely. In New Jersey, each allegation is determined to be *Substantiated*,⁵² *Established*,⁵³ *Not Established*,⁵⁴ or *Unfounded*.⁵⁵ A finding of either *Substantiated* or *Established* indicates that child abuse or neglect has occurred. Decisions are made to open/maintain or close a family's CP&P case following an investigation based upon levels of risk to the child(ren) in the home and/or the service needs of the family.

WHO CPS SERVES

In CY2018, DCF conducted approximately 60,000 Child Protective Services (CPS) investigations involving 94,000 alleged child victims, of which 6.3% were victims of maltreatment (3.1% Substantiated, 3.2% Established, 64% Not Established, 29.5% Unfounded). The number of CPS investigations increased 8% from CY17.

FAMILY VOICE

CP&P intake staff make diligent efforts to engage families and their formal and informal supports throughout the investigation, in order to support accurate identification of the family's underlying needs, understand the family's history, respond to concerns around safety and risk, and identify family supports. Caseworkers use the Intake Family Agreement to capture discussion around case planning and the family's agreement to services provided by CP&P. The family's voice is used to gain a broad understanding of family dynamics beyond the incident that led to CP&P involvement and to inform decision making.

TEAMING AND COLLABORATION

Throughout the investigation process, CP&P staff make diligent efforts to engage families, extended family members, and formal and informal supports to the family. Investigators also collaborate with law enforcement, health care professionals, school staff and others to gather information that is pertinent to the case and to support a holistic identification of the underlying needs of the family. At a system level, CP&P participates in local Multi-Disciplinary Teams to ensure that investigations and service provision for child victims is well coordinated.



PRACTICE MODELS

CP&P caseworkers make several decisions using Structured Decision Making® (SDM) tools and processes when investigating reports of child abuse/neglect. SDM is an evidence- and research-based system that identifies the key points in the life of a child welfare case and uses structured assessments to improve the consistency and validity of each decision, promoting objective decision making informed by actuarial models. Decisions made by caseworkers during an investigation are related to child safety, including whether there is imminent risk of abuse or neglect, whether there is credible evidence that maltreatment has occurred, whether safety interventions are needed to protect children from harm, whether a child may remain safely in the care of the current caregivers, and whether the family's needs indicate that they would benefit from ongoing services.

IMPLEMENTATION

As of December 31, 2018, there were 1,072 active CP&P investigative caseworkers. New Jersey practice standards are to ensure investigative caseworkers are assigned no more than eight new investigations per month and serve no more than 12 active families at one time.

DCF intake staff receive extensive training from DCF's Office of Training and Professional Development and DCF conducts numerous reviews to assess the efficacy of our practice and policies. Reviews are carried out by trained reviewers representing DCF and a range of internal and external stakeholders. DCF uses the biennial Quality of Investigations Review process to assess the investigative practice for child abuse and neglect referrals.

Case Management

DCF's Division of Child Protection and Permanency (CP&P) directly provides case management services and linkages to needed services and supports for families involved in the child welfare system. The first goal of case management and family-centered supports is to, whenever possible, keep children safe in their own homes. When this is not possible, and children experience out-of-home placement, the primary goal is to reunify children with the caregiver(s) from whom they were removed. If ample efforts toward reunification are unsuccessful, adoption or guardianship by kin or an unrelated licensed resource provider is an alternative option for children to achieve safe and timely permanency.

WHO IS SERVED

As of December 31, 2018, DCF was providing child welfare case management to over 24,000 families, including almost 43,000 children being served in their own home, and 5,586 children in out-of-home placement. Of the children being served out of home, 2,965 (53%) children were in non-kin resource family placements, 2,088 (37%) children were in kinship placements, 441 (8%) youth were in group and residential placements, and 92 (2%) youth were in independent living placements. Additional information regarding race, age and gender of children receiving case management services can be found at the NJ Child Welfare Data Hub.⁵⁶

FAMILY VOICE

At an individual level, CP&P caseworkers encourage families to play active roles in the development of the case goals and planning. CP&P strives to continuously engage and assess families through teaming and by discussing what is working or not working from the perspective of the family. These steps support planning and assist CP&P caseworkers and families to identify appropriate services and sustainable formal and informal supports. At a system level, DCF uses in-person interviews with families within the Qualitative Review (QR) process to assess the overall system performance, including the extent to which family voice is accounted for in our work.

TEAMING AND COLLABORATION

For each case, CP&P seeks to help families form their own team to identify and work toward achieving family goals that reduce risk and increase safety for children. Teams may consist of everyone important in the life of the child/parents, including interested family members, foster/adoptive parents, neighbors, and friends as well as representatives from the child's formal support system, such as schools, therapists, and substance use treatment providers. At a system level, Local Offices are engaged with local Human Services Advisory Councils, Child Inter-Agency Coordinating Councils, and other local planning and service coordination bodies.

PRACTICE MODELS

Services provided by CP&P to children and families are highly individualized, but the basic case management approach is standardized. DCF's New Jersey Case Practice Model⁵⁷ consists of the following six key functions: engagement, teaming, ongoing assessment, planning, intervening, and tracking and adjusting.

IMPLEMENTATION

The Case Practice Model was implemented in 2007, revised in October 2015, and is carried out statewide. DCP staff use NJ SPIRIT, New Jersey's Comprehensive Child Welfare Information System, to collect data and maintain electronic case records. Data from NJ SPIRIT is compiled into management reports through Safe Measures and reported to the Commissioner and the public in monthly reports. Outcomes and longitudinal data gathered from this system are used to inform practice and policy decisions and are made available to the public via the New Jersey Child Welfare Data Hub. DCF's Office of Quality and Office of Research, Evaluation and Reporting support DCP's use of administrative data, systematic case review processes and feedback from systems partners to inform quality management, and the Office of Training and Professional Development provides formal training to DCP staff on topics that range from safety, stability, and teaming, to human trafficking and the case practice of family engagement. As discussed in Appendix 3, DCF continues to focus on maintaining its more recent progress and strengthening performance related to caseloads, case management processes, quality of case practice, and outcomes.

Resource Family Care

The Office of Resource Families (ORF) oversees the work in CP&P's 46 Local Offices related to services for resource families. DCF provides support to individuals who are considering becoming resource parents, helps families navigate the rigorous screening and application process to become licensed foster/adoptive parent(s) and provides support services while children are in out-of-home placement.

WHO ORF SERVE

Resource family parents are individuals who open their homes and become temporary parental figures to children supervised by CP&P that are in need of a home due to protective or other social service issues. As of December 31, 2018, DCF had 4,086 licensed resource homes with a total bed capacity of 8,946 children. Of the total number of resource family homes, 1,289 were kin homes and 2,797 were non-kin homes.

FAMILY VOICE

Resource Family Care staff conduct annual surveys around key areas (e.g., placement information, staff communication, medical and daycare coverage) to ensure that resource families are receiving the tools and supports they need to be successful. The information provided by the families is used to drive local practice. Local and/or Area Office staff also conduct random quality assurance calls. These are courtesy check-in calls to strengthen our teaming practices, verify how the families are doing and identify needs. Exit interviews are also conducted with resource families who decide to resign as a result of being dissatisfied. This provides ORF an opportunity to learn from the families' experiences and address any areas of concern.

TEAMING AND COLLABORATION

Teaming is a critical aspect of DCF's work in providing services for resource families and is expected of both staff and resource parents. DCF views resource parents as members of the service delivery team. Trainers, resource staff, and prospective resource parents work together to determine if becoming a resource family home is the right decision for the family, an assessment that is ongoing and continues after a home is licensed. Resource unit staff also participate in monthly meetings comprised of staff from DCF central office, CP&P Area and Local Offices and the Office of Licensing.



90%

of cases had assessment rated as a strength during a comprehensive case review of DCF staff work.

PRACTICE MODELS

DCF's approach to working with and retaining resource families incorporates all of the elements of the CP&P Case Practice Model. Resource staff work to engage resource family parents and build relationships and partnerships that are grounded in respect, concern for family needs, and open dialogue. They provide support during placement and, before that, during the recruitment and licensing processes. This includes nine training sessions using the PRIDE and Traditions of Caring curricula, a home evaluation, reference checks, criminal history checks, and a life safety home inspection. Once a child is placed in a resource home by CP&P, the Office of Licensing (OOL) is responsible for inspecting and monitoring that resource home and all persons residing in that home.

IMPLEMENTATION

The dedicated staff that support resource families includes staff from the ORF, Local Office Resource Units and OOL staff. CP&P partners with Office of Training and Professional Development to provide training to Local Office Resource Unit staff and OOL inspectors, and the ORF develops the state's PRIDE trainers who are responsible for training resource families. DCF evaluates the quality of our performance with resource families through ongoing in-home support, monitoring of data, assessing case practice delivery for resource families in case reviews and the collection and analysis of resource family survey data.

Permanency: Reunification, Adoption, and Kinship Legal Guardianship

When children enter foster care, state and federal law require that there is immediate movement to plan toward that child's timely, safe and permanent exit from substitute care. The first goal for each child in out-of-home placement is to work toward safe and timely reunification with the family of origin. However, in some instances, children are not able to return home and an alternate permanency goal must be identified. Alternate permanency goals can include: adoption, through which the original caregiver's parental rights and responsibilities are terminated and legally transferred to another person who desires to assume those rights and responsibilities; or kinship legal guardianship, through which a relative or family friend is awarded Guardianship of a child.

WHO PERMANENCY SERVES

DCF serves children in out-of-home placement, their biological parents, resource family parents and prospective adoptive families or legal guardians. In CY 2018, over 4,100 children exited placement with 55% of children reunified home, 26% of children adopted, and 3% exited to kinship legal guardianship. Additional information regarding permanency timeframes and outcomes can be found at the NJ Child Welfare Data Hub.

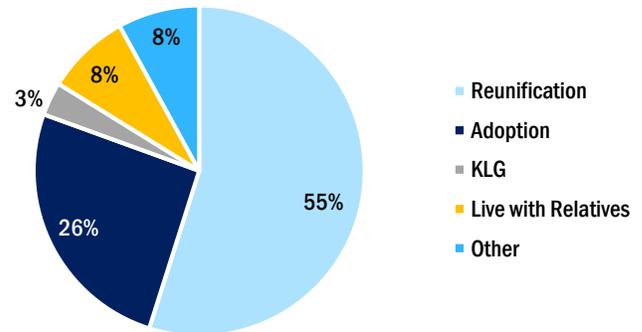
FAMILY VOICE

As described previously in the section on Case Management, CP&P uses family teaming as a means to identify and manage case plans, including permanency plans, and family voice is included in ongoing quality assurance practice through participatory, system-wide Quality Reviews.

TEAMING AND COLLABORATION

Local office permanency units engage biological parents and support them in participating and completing required services and making the necessary lifestyle changes to ensure that they can sustain overall safety and well-being of their children when they return home. Parents and their team plan the activities that will support them in meeting their identified case goal. Local office adoption units team with and provide services to birth parents and children, attend court hearings, support resource and pre-adoptive parents, and assist with preparing children for adoption. They also work alongside staff from Adoption Operations to identify potential adoptive families for children not already living with a committed family, and to facilitate the adoption process for families seeking to adopt.

Children Discharged from Out of Home Placement in 2018 (n=4,123)



PRACTICE MODELS

CP&P first teams with children and their families to make ample efforts toward reunification. Reunification is almost always the primary case goal, and most children who enter a CP&P out-of-home placement are reunified with their families. Since there are some instances in which children are not able to return home, CP&P concurrently plans alternate permanency options so that if reunification efforts are unsuccessful, an alternate permanency plan is immediately actionable. Whenever a child is in out-of-home placement, the ultimate decision regarding the timing and type of exit from care (e.g., reunification, adoption or guardianship) is made by the Superior Court. The Superior Court reviews all permanency plans proposed by CP&P. During those proceedings, DCF is represented by the Office of the Attorney General. As of December 2018, there were 137 Deputy Attorneys General available statewide for the DCF Practice Group. Children and biological parents are assigned counsel through the Office of the Public Defender or, when able, they attain private counsel.

IMPLEMENTATION

As of December 31, 2018, there were 1,118 active CP&P permanency unit caseworkers. Permanency unit caseworkers' caseload standards are no more than fifteen families and no more than ten children in out-of-home placement. In addition, DCF's Office of Adoption Operations provides statewide oversight of CP&P's adoption case practice, to ensure the timely movement of children and young adults towards permanency. In addition to Adoption Operations staff, CP&P employed 219 active adoption caseworkers as of December 31, 2018. Each adoption caseworker manages up to 15 children.

Coordination of Specialized Services

Families involved with CP&P often face multiple stressors, which may include medical and mental health challenges, substance use and domestic violence. Responding to these challenges oftentimes requires specialized clinical skills and knowledge. CP&P staff help to ensure families have access to appropriate supports and services by partnering with specialized consultants in assessment, planning and coordination of services. Each CP&P Local Office has access to Child Health Unit (CHU) Nurses, Care Management Organization (CMO) Clinical Consultants, Child Protection Substance Abuse Initiative (CPSAI) counselors and aides, and Domestic Violence Liaisons (DVL).



WHO SERVICES BENEFIT

Specialized services are available to children and families with needs that require clinical medical and behavioral health intervention, substance use treatment, and/or domestic violence support. These services are coordinated by designated staff in all 46 Local Offices and provided to children and families served by CP&P. In CY 2018 DVLs served 6,127 non-offending female parents and 184 non-offending male parents, and their 12,344 children. Similarly, the three contracted CPSAI provider agencies received a combined total of 18,621 referrals. The agencies also completed 12,320 assessments and referred 10,168 clients for treatment.

FAMILY VOICE

The CHU nurses, CMO clinical consultants, CPSAI counselors and DVLs participate in the family teaming process described in the section on Case Management. The CHU nurses engage with parents and resource parents to provide support around health care for children and youth. The CPSAI assessment process ensures that the parent's readiness to engage in services and service preferences are considered in the treatment recommendations.

TEAMING AND COLLABORATION

Each of the identified specialized consultants team and collaborate with CP&P leadership and staff, children and their families, and system partners to assist to develop an overall understanding of needs of families and identify factors that may impact safety and stability. They also assist with case planning and identifying appropriate supports and services.

PRACTICE MODELS

CP&P coordinates with specialized consultants when families' unique needs require an integrated service approach that includes both clinical and case management services.

- **CHU Nurses:** Nurses help to ensure each child's medical and behavioral health care needs are met and provide overall health care case management to address daily needs for each child in out-of-home placement. In addition, CHU Nurses visit children in the resource home and attend Family Team Meetings.
- **CPSAI:** CPSAI provides Certified Alcohol and Drug Counselors (CADCs) and Counselor Aides that support

caseworkers in planning for cases where substance use has been identified as a concern. They assess, refer, and engage clients in appropriate treatment to address their individual needs. Once assessed, cases remain open in CPSAI for a minimum of 30 days and a maximum of 90 days to allow the CADC and counselor aide to monitor/follow up with provider agencies.

- **CMO Clinical Consultants:** The CMO Clinical Consultants are funded by DCF-Children's System of Care (CSOC) and employed by contracted CMO agencies. This position was created as a collaboration between CP&P and CSOC. They are licensed behavioral health professionals, who provide on-site consultation services to CP&P staff regarding children and youth with mental and behavioral health concerns. Clinical Consultants also review records and make recommendations regarding appropriate behavioral health interventions to improve and support each child in achieving positive outcomes.
- **DVL:** DVLs are specially trained professionals with extensive knowledge of domestic violence and domestic violence support services. They assess, develop case plans (for non-offending parents and batterers), and refer for services. They also team with and educate CP&P staff on the dynamics of domestic violence and align their practices with DCF policy.

IMPLEMENTATION

CHUs and CPSAI are supported from DCF's central office by the Children's System of Care. CHUs are staffed by nurses and staff assistants. Each nurse is credentialed to enter data within DCF's child welfare data information system, and partner with CP&P, biological and resource parents, and medical providers. As of December 2018, there were 163 health care case managers and 84 staff assistants statewide. CADCs are staffed from the three contracted CPSAI providers that serve designated catchment areas statewide. CPSAI also provides training to CP&P staff on topics related to substance use disorders. Clinical Consultants are supervised by their local CMO and receive support and guidance from CP&P Area Office Leadership regarding CP&P policies and procedures. There are 15 Clinical Consultants statewide. All counties have at least one DVL who are trained by the New Jersey Coalition to End Domestic Violence and the New Jersey Child Welfare Training Academy Partnership.

Family Preservation Services

Family Preservation Services (FPS) is an intensive, time limited in-home crisis intervention and family education program serves families with children at imminent risk of out-of-home placement or preparing to be reunified. Through the use of skill-based interventions, linkages to resources, and limited financial assistance, the program strives to ensure the safety of children, stabilize families, improve family functioning, prevent unnecessary out-of-home placements and link families with community supports. DCF's statewide FPS service network is delivered through contracts with eight providers.



96%

of FPS families remained safely in their own homes at discharge.

WHO FPS SERVES

In FY 2018, FPS served nearly 950 families and more than 2,180 children involved with CP&P. Families had a presenting crisis that placed at least one child at imminent risk of child abuse/neglect and removal from the home as determined by CP&P or; had a child returning from out-of-home care within 30 days and had a need for intensive reunification services.

FAMILY VOICE

Each FPS provider partners with the family and CP&P to collaboratively identify families' goals and steps that can be taken to meet those goals. Additionally, there is a mid-case conference that includes the CP&P Case Worker, the FPS provider, any relevant stakeholders, and the family to ensure their voice is included in discussing their progress and next steps.

TEAMING AND COLLABORATION

In 2018, DCF created a multi-level teaming structure for the NJ FPS initiative, including teams to manage state operations, provider operations, model development, and evaluation. The function of the state operations team is to address, review, and prioritize utilization and implementation issues raised by the provider operations team. The provider operations team, in turn, is a vehicle to gather information from CP&P Local Offices and FPS Providers regarding the implementation of NJ FPS. The model development team is responsible for the development of the NJ FPS logic model and practice profile and the evaluation team is tasked with evaluating the effectiveness of the FPS intervention. These teams meet regularly and include representation from FPS providers, stakeholders, and multiple divisions within DCF.

PRACTICE MODELS

In 2018, DCF partnered with FPS providers to create an NJ FPS logic model and a practice profile. The logic model and the practice profile outline the key activities and the essential functions expected of FPS staff, helping to ensure consistency of practice across sites. Both will be included in the NJ FPS program manual expected to be finalized in FY20.

IMPLEMENTATION

The FPS program has built a statewide training and data collection infrastructure. All FPS staff attend required trainings related to program implementation and providers report monthly to DCF on families served including their needs, services received, and whether families remain safely together.

Supportive Housing Services

Keeping Families Together (KFT) is New Jersey's supportive housing program, built to support a subset of high-needs child welfare-involved families faced with co-occurring challenges (e.g. homelessness, substance use, medical or mental health disorders, and domestic violence). KFT programs are operated through a statewide network of eight providers contracted to provide the service. The goal of the program is to safely prevent child protection removals of children, and to reduce recidivism within the child welfare system by improving housing stability and family well-being. KFT aims to achieve this by providing caregivers and their children with a safe, stable living environment along with robust support services.

WHO KFT SERVES

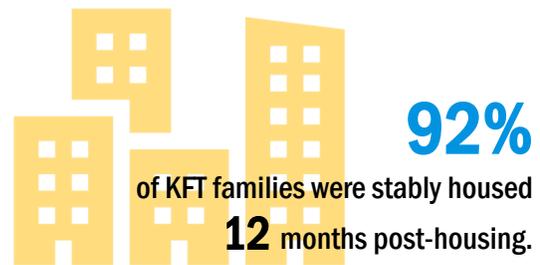
KFT is a state-wide program serving a subset of child welfare-involved families that are homeless or unstably housed and who have multiple, co-occurring challenges (e.g., domestic violence, substance use, child, or parent mental health issue). As of December 2018, there were 613 families enrolled in KFT.

FAMILY VOICE

KFT is a family- driven intervention. All program services are voluntary and flexible, so families dictate the type, frequency and intensity of services. Providers also capture family feedback, formally and informally, via agency-specific consumer satisfaction feedback processes. Additionally, DCF is partnering with an external evaluator to gather qualitative data on families' experiences with the program. Information from this evaluation process will inform the ongoing development of the practice model.

TEAMING AND COLLABORATION

DCF works closely with the state Department of Community Affairs (DCA), the Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), CP&P, housing developers, provider partners and other stakeholders to implement KFT. In 2018 DCF created a multi-level teaming structure as part of its expansion of the service. These teams include internal stakeholders from across the Department, as well as providers and other external stakeholders.



PRACTICE MODELS

DCF partnered with KFT providers to build the program logic model for KFT and is currently collaborating with providers, CP&P, the Corporation for Supportive Housing (CSH) and DCA to develop the practice profile. The profile, a component of the KFT Program manual, will outline the essential functions and further define the key practice elements that support consistent practice across sites. The practice profile will be informed by the *Housing First Approach*.

IMPLEMENTATION

The KFT program is in the early phases of implementation, with teams working to continually define and refine the New Jersey practice model. After the practice profile is complete, the focus will shift to strengthening staff competency (e.g. staff selection, training, supervision, and coaching). DCF, with support from CSH, facilitates ongoing learning opportunities and technical support to providers. DCF collects data from providers about families' needs and services on a quarterly basis. This data is used to inform overall decision making and the CQI process. In 2016, DCF launched a mixed-methods evaluation of KFT which examines changes in well-being and long-term child welfare outcomes among KFT families, practice across sites, and facilitators and barriers to families' success in the program.

Caregiver Substance Use Services

DCF has established and oversees a full continuum of assessment, treatment and recovery support services provided via contracts with various agencies throughout the state, to meet the needs of caregivers struggling with substance use and co-occurring mental health disorder. These services include:

- Peer Recovery Support Specialists (PRSS) support parents with substance use disorders by helping them to build and sustain recovery supports. They use their shared life experiences and knowledge of the recovery process to engage with caregivers before, during, and after formal treatment;
- Maternal Wrap Around (M-WRAP) is a service provided in collaboration with DCF and the Division of Mental Health and Addiction Services at the Department of Human Services that provides intensive case management and linkages to needed services and supports including substance use disorder treatment, and mental health treatment and community-based resources for pregnant and parenting mothers with an Opioid Use Disorder; and
- A state-wide network of organizations operating under contract with DCF to provide substance use disorder treatment services to meet the specific needs of CP&P-involved caregivers. The available levels of care include outpatient, intensive outpatient, withdrawal management, halfway house, and short and long-term residential treatment programs such as “Mommy and Me”.

Together, these services aim: to reduce the risk of harm associated with substance use disorders; to increase rates of treatment engagement, completion, and recovery; to improve families’ stability, and; to reduce families’ involvement with the child welfare system.

WHO IS SERVED

The PRSS service was implemented in June 2018, in 22 CP&P Local Offices across nine counties to provide services to families with an identified parent or caregiver with a severe substance use disorder. Priority is given to those families who have a parent or caregiver with an opioid use disorder and a child under the age of five. As of December 2018, the program served 181 caregivers and their families. Maternal Wrap Around Services serve pregnant and parenting mothers with an Opioid Use Disorder in Morris, Sussex, and Warren Counties.

FAMILY VOICE

The evaluation of the Peer Recovery Support Services will include interviews with caregivers aimed at better understanding their perceptions of and experiences with the services. Feedback gained through this process will be used to improve service delivery.

TEAMING AND COLLABORATION

DCF teams across agencies and with community-based organizations to provide substance use-related services to caregivers and their families. Partners include the Department of Health, the Division of Mental Health and Addiction Services at the Department of Human Services, substance use and mental health treatment providers, hospitals and birthing centers.

PRACTICE MODELS

The PRSS model was developed by an interdisciplinary team of child welfare and substance use professionals and is unique among recovery support models in that the peers are dually trained in child welfare and substance abuse peer services. The M-WRAP program model was developed to address service gaps that were identified through in-depth technical assistance provided to NJ by the National Center on Substance Use and Child Welfare.

IMPLEMENTATION

PRSS: DCF established a PRSS implementation team of DCF program and research staff, SUD services provider partners, and a community consultant to introduce the service to the 22 CP&P Local Offices where PRSS occurs. This team meets regularly to track and adjust the service as necessary, and to design and launch a mixed-methods evaluation of the program. The evaluation assesses program performance, program outcomes, and child welfare outcomes for families served.

M-WRAP: On October 1, 2018, DCF entered into a Memorandum of Agreement with New Jersey’s Department of Human Services-Division of Mental Health and Addiction Services to fund M-WRAP services in counties where the overlap of CP&P involved mothers with state-funded services was most likely. This agreement encouraged quality teaming, collaboration and planning between each department to support successful recovery of opioid-dependent mothers.

SUD Network: DCF contracts with various SUD treatment providers statewide who prioritize providing treatment services to CP&P involved parents and caregivers. Parents and caregivers who are identified as having a SUD are referred by CP&P to the Certified Alcohol and Drug Counselors (CADCs) for assessment. The assessment completed by the CADC determines if treatment is needed for a parent/caregiver. If it is determined that treatment is needed the appropriate referral is made.

Services for CP&P-Involved Transition Age Youth & Young Adults

DCF supports adolescents and young adults in their transition to adulthood by (1) ensuring that services provided by DCF are coordinated, effective, adaptive to the needs of families and communities and meet best practice standards, (2) developing linkages with other service providers to create a more equitable and seamless service system, and (3) providing leadership and policy development in the adolescent services field. Services and supports for transition aged youth and young adults include: safe and stable housing, academic and career planning and assistance, tuition assistance, life skills, aftercare, mentoring, youth advocacy and leadership development, financial literacy resources, wraparound funds, and programming to bolster informal support networks. OAS provides DCF staff and community-based providers technical assistance and training to ensure holistic approaches to assist youth to achieve economic self-sufficiency, interdependence, and healthy lifestyles.

WHO OAS SERVES

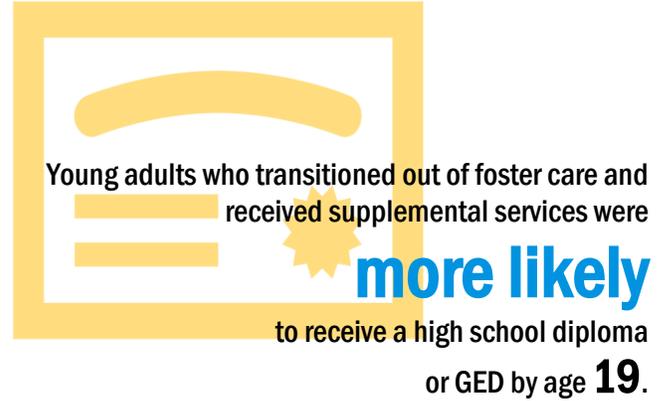
Services and supports available through OAS are primarily for adolescents and young adults between the ages 14-21 in foster care. Some housing and afterschool programs are available to all youth regardless of child welfare involvement. The New Jersey Foster Care Scholars Program provided 216 Education Training Vouchers to youth ages 16 to 23 during FY2018. In addition, DCF provided approximately 660 transition aged youth with supportive housing during FY2018. Of youth who were discharged from these programs in FY2018, 80% discharged to stable housing, and 79% improved both life skills and job readiness.

FAMILY VOICE

OAS emphasizes the importance of youth voice, decision-making, advocacy, and leadership. The Youth Advisory Network (YAN) has been created to ensure that all adolescent and youth serving providers integrate youth advocacy and leadership development into their programs and agency culture. Through the YAN, OAS solicits feedback from youth regarding policy, practice, and resources.

TEAMING AND COLLABORATION

OAS partners with a variety of internal and external stakeholders through trainings, practice forums, provider meetings, partnerships with other State agencies, and technical assistance/consultation across a variety of youth related initiatives.



PRACTICE MODELS

OAS's robust network of programming and support is driven by the YouTHRIVE protective and promotive factors framework. OAS is implementing a youth permanent supportive housing program, academic and career readiness program, and youth advisory network model, which use the implementation science framework approach.

IMPLEMENTATION

OAS leads adolescent training and policy development initiatives for DCF staff and youth serving providers. In addition, technical assistance is offered to DCF and program staff through program design meetings, case practice consultations, and site visits. OAS collects data on these efforts through the National Youth in Transition Database (NYTD) requirements, ongoing record reviews, outcomes required through contracted services, and qualitative reviews.

Part IV: EDUCATIONAL SERVICES



Educational Services

The DCF Office of Education (OOE) was created in 1979 with the passage of NJSA 18A:7B-1 et seq, the State Facilities Education Act (SFEA) and provides intensive 12-month educational services and supports to children and young adults ages 3 through 21 who have severe or unique needs that require alternative school placement for a period of time. OOE also provides child study team services to State Responsible students. The goal for most OOE students is a successful return to school and participation in community life. OOE regional schools and child study team services are individually designed and tailored to the meet students' needs in the least restrictive school setting. Students are educated in 22 program sites across the State, including: DCF contracted residential facilities, psychiatric facilities operated by the Department of Health, 16 DCF Regional Schools, and two hospital-based satellite programs.

WHO OOE SERVES

DCF's state and federally compliant education programs and child study team services are designed for students who exhibit severe cognitive, physical, behavioral and emotional disabilities; exhibit a variety of moderate to severe learning disabilities; are at risk of school failure; and/or are pregnant/parenting teens. OOE serves approximately 1,012 students daily and approximately 1,600 annually. Of the number of children served, 67% of students are special education students and 33 % are general education students.

FAMILY VOICE

OOE has been actively involving families over the last several years. The school communication APP "REMIND" is one tool teachers and administrators utilize to communicate with parents and students instantly that has opened the doors to easier communication about grades, homework, and activities in the school. Families are invited to Individualized Educational Plan (IEP), Individualized Program Plan (IPP), and transition meetings for the students to assist in the planning of their education. Additionally, schools have celebrations and activities throughout the year during which families participate, including graduation. Families are encouraged to communicate with school administrators and teachers throughout the year about their students' grades, goals and progress

TEAMING AND COLLABORATION

OOE partners within DCF, across state government, and with other stakeholders to provide high quality, individualized educational services. Highlighted partnerships include internal partners from CP&P, CSOC, and child care licensing. External partners include the NJ Department of Education (DOE), NJ Department of Health (DOH), school districts, and a variety of post-secondary settings including community colleges. The OOE also partners with the New Jersey Principals Association, and New Jersey Bar Association, which collaborate in providing professional development to faculty and administration.

PRACTICE MODELS

OOE schools make use of multiple program models in various sites throughout the network, as appropriate for the student population, including: use of Strengthening Families, Partnering with Teen Parents, and Safe Dates at the 6 Project TEACH programs; school and community based Structured Learning Experiences to facilitate student career education; the Ever Fi financial literacy program; Six Core Strategies to promote trauma informed classrooms; PLATO curriculum to support culinary arts training; and My Life, My Choice and Empowering Young Men to promote knowledge and awareness regarding human trafficking. The OOE schools exceed the professional development mandated for suicide awareness and trauma informed classrooms.

IMPLEMENTATION

The OOE schools are staffed with dedicated faculty that attend professional development that aligns with the needs of the students they serve. Program monitoring is managed by the Department of Education. State Facility Education and Title 1 program monitoring was successfully conducted at three programs in the summer of 2018, and resulted in minor corrective actions, which were successfully implemented by March of 2019. OOE is in the process of implementing a student information system that will assist with electronic records, attendance, scheduling and communication with parent and staff, and will allow for data collection and ease of reporting.

PART V: LICENSING



The Office of Licensing (OOL) is the licensing and regulatory authority of the Department of Children and Families. OOL is responsible for licensing, inspecting, monitoring and regulating New Jersey's child care centers, family child care homes, adoption agencies, group homes, youth residential facilities, partial care programs, youth substance abuse treatment programs, and residences for youth with intellectual and developmental disabilities. In addition, every out-of-home placement program utilized by CP&P or CSOC is first inspected and licensed by OOL to ensure that it meets rigorous standards for safety and quality.

Each year OOL licenses more than 1,300 child care, and more than 200 youth residential programs.

There are also more than 600 family child care certificates of registrations issued each year through OOL.

OOL is a critical component of DCF program oversight. It performs its work, in conjunction with the operational divisions, Institutional Abuse Investigation Unit (IAIU), and contracting. In addition, OOL maintains close working relationships with sister state agencies and local officials responsible for monitoring and regulating construction and environmental requirements to ensure that facilities housing DCF licensed programs comply with regulations and standards promulgated and enforced by those external entities. Because of the close alignment of both the services offered and the client population served, OOL also works closely with colleagues in the licensing arms of the Departments of Human Services (DHS) and Health (DOH).

Though charged by statute with regulatory and enforcement functions, DCF understands that the primary objective of everyone in the system, be they regulators or regulated providers, is to ensure the safety and well-being of children and provide critical supports to families. Whenever possible, OOL seeks to bolster programs and assist them to achieve compliance with regulatory requirements. As part of OOL's oversight, staff from child care and youth residential licensing inspect individual facilities and homes to ensure they adhere to and operate in accordance with regulations identified in the applicable State Manual of Requirements. Upon completion of each inspection, facilities receive a report that outlines areas of non-compliance that require corrective action. DCF's Office of Training and Professional Development provides formal training to staff via new worker training along with other trainings related to areas such as child safety, supervisory skills, and effective communication.

DCF licenses the following programs:

Child Care

Child care centers provide care for six or more children below 13 years of age that attend less than 24 hours a day and are required by State law to be licensed. Family child care homes (also known as family day care homes) provide care for five or fewer children below 13 years of age in the provider's private residence, and may choose to become voluntarily registered through [Child Care Resource and Referral Centers](#) under contract with the Department of Human Services. Child care licensing at DCF is staffed by 82 of full-time employees, including 55 child care field inspectors.

There are more than 4,000 licensed child care centers in New Jersey, and nearly 2,000 registered family child care homes. Collectively, these child care businesses provide daily care and supervision to more than 600,000 children, employ more than 90,000 staff, and provide an essential service to New Jersey's working families. In addition, OOL's child care licensing staff works closely with county-based Child Care Resource and Referral agencies to monitor and inspect family child care homes. They also work closely with the Division of Family Development at the NJ Department of Human Services to ensure the alignment of programmatic requirements for the Temporary Assistance for Needy Families (TANF) child care subsidy and state licensing regulations, ensuring that every licensed center and registered family child care home in the state is eligible to receive the subsidy. As part of DCF's commitment to transparency and ensuring that children remain safe, healthy and connected child care licensing reports are available online for public access.

Youth Residential Locations

Group homes, youth residential facilities, partial care programs, private and agency operated treatment homes, youth substance use treatment programs, adoption agencies, and residences for youth with intellectual and developmental disabilities that operate under contract with DCF, both in New Jersey and in other states (residential treatment centers) must be approved by OOL. Children's residential treatment centers provide 24-hour care for 13 or more children placed or financed by DCF. Children's group homes provide 24-hour care for 12 or fewer children placed or financed by DCF. Group homes include children's group homes, teaching family homes, supervised transitional living homes, treatment homes, alternative care homes and psychiatric community homes for children. Children's shelter facilities, juvenile-family-crisis shelters, and shelter homes provide temporary 24-hour care for non-adjudicated children including children who are dependent, neglected, abandoned or are runaways.

DCF's youth residential licensing is staffed by 29 full-time employees, including 22 field inspectors, who oversee licensing for some 625 youth residential programs. Staff work with the state Department of Community Affairs and code enforcement from local municipalities to ensure homes and facilities meet the safety standards for designated areas. These partnerships help to ensure that efficacy in communication and proper interpretation of codes for programs licensed by YRL.

Mental Health Programs

Children's partial care services are community programs which provide structured clinical day treatment for seriously emotionally disturbed youth who are at risk of psychiatric hospitalization or in need of transitional services following hospitalization. There are currently 52 children's partial care programs licensed by DCF.

Adoption Agencies

Adoption agencies place children for adoption or provide other adoption services in New Jersey. There are currently 36 licensed adoption agencies in New Jersey, including DCF's Office of Adoption Operations. Adoption agencies are also required by State law to be licensed and must adhere to in the state Manual of Requirements for Adoption Agencies for all adoption agencies.⁵⁸

Resource Families

Resource family homes are private residences in which board, lodging, care and temporary out-of-home placement services are provided by a resource family on a 24-hour basis to a child under the auspices of the Child Protection and Permanency, CP&P, including a home approved by CP&P for the placement of a child for adoption.



**PART VI: INVESTIGATIONS
OF INSTITUTIONAL ABUSE**

Investigations of Institutional Abuse

DCF's Institutional Abuse Investigation Unit (IAIU) is a child protective service unit that investigates allegations of child abuse and neglect in out-of-home settings, such as foster homes, residential centers, schools, and detention centers. IAIU's structure is comprised of a Central Administrative Office and four Regional Offices. Additionally, IAIU's internal Continuous Quality Improvement Unit focuses on ensuring investigation quality by following up on concerns found on IAIU investigations in DCF regulated programs and leads quality improvement collaborations with system partners.

WHO IAIU SERVES

IAIU serves all children and youth who attend or reside in out-of-home settings, including those settings that are regulated by DCF (e.g., resource homes and congregate care facilities) and those that do not fall under DCF regulations, (e.g., public schools, bus companies and unregistered family childcare provider homes). On average the IAIU receives between 2,500 and 3,000 investigations in a year. However, in 2018, the IAIU received 3,100 reports of abuse and neglect statewide. The top three referrals by facility type includes 972 investigations at schools, 610 at child care centers and 562 at resource homes.

TEAMING AND COLLABORATION

The IAIU collaborates with our internal partners such as, the Children's System of Care (CSOC), the Division of Child Protection and Permanency (CP&P), the Office of Licensing (OOL) and the Office of Adolescent Services (OAS) to ensure that the needs of the children and youth involved in IAIU investigations receive appropriate support to help ensure they are safe, healthy and connected, wherever they reside. The IAIU also has representatives statewide that sit on the monthly Multi-Disciplinary Team (MDT) meetings for each of New Jersey's 21 counties, where collaboration occurs with law enforcement, regional diagnostic treatment centers, and child advocacy centers.

PRACTICE MODELS

The IAIU practice specifications are outlined in DCF policy. Reports of investigation allegations of child/abuse neglect in institutional settings are received by DCF's SCR hotline. In turn, reports requiring a field response are assigned via NJ SPIRIT from SCR to the respective regional office that covers the area in which the alleged incident occurred. Response times for child protection investigations in out-of-home settings mirror IAIU's sister office, CP&P, with Immediate and 24-hour time frames.

IMPLEMENTATION

The IAIU is staffed by approximately 100 full time employees, with approximately 55 field investigators. The majority of IAIU investigators have at least two years of CP&P casework experience, which is a current requirement to apply to be an IAIU investigator. Investigative staff respond to allegations of child abuse/neglect in their designated region. Upon completion of each investigation, a final report is issued within 60 days of the initial report. Each appropriate entity is notified of the findings of the investigation to enhance its ability to promote safety for the children in care and minimize the likelihood of future child maltreatment in the setting. IAIU's CQI Unit approves and monitors the development and implementation of all required corrective action plans (CAP) to ensure all concerns identified in a findings letter have been successfully corrected and resolved. DCF's Office of Training and Professional Development provides formal training to staff, via the new worker training as well as a business orientation and subsequent 3-day training on their role within IAIU and IAIU's policy and practices.



FUTURE STEPS

6

In 2019, DCF is finalizing a Strategic Plan to guide the work of the Department for the next two years. Rooted in the vision that every New Jersey resident will be *safe, healthy and connected*, this plan includes strategies to achieve or maintain service excellence throughout the department, focusing on areas such as improvement of permanency outcomes, increased support for resource parents, enhanced support for transition-aged youth, and promotion of empowerment for women and girls. These service excellence goals also will include coordination of strategies in place across the Department to satisfy federal mandates, advancing the goals of the Administration, and continuing progress toward an exit from federal monitoring.

The Department has identified five core approaches, which will be used in all aspects of the Department's work: *race equity, healing centered practice, protective factors framework, family voice, and collaborative safety*. These are not initiatives or programs, but instead are practices that will be embedded in all work. At the same time, DCF will launch four major efforts aimed at transforming the child and family serving system that DCF operates so that it more effectively supports family strengthening and the initial prevention of abuse.

The overarching transformational priorities include:

Prevention of maltreatment	Child maltreatment, sexual assault, and intimate partner violence have significant and life-long impacts on the health and life course of survivors. Large scale prevention of all of these forms of maltreatment will improve health and social outcomes for generations of individuals and families throughout the state
Dramatic increase in the use of kinship placement settings for children and youth in foster care	When children need to enter foster care in order remain safe, they experience trauma associated with the family separation. Children that have been separated from their family of origin but can live in foster care with someone they already know have far greater chances of experiencing stability, healing and thriving, ⁵⁹ and are ultimately less likely to re-enter foster care post-reunification. Increasing New Jersey's use of kin will benefit permanency and stability efforts for children and youth.
Promotion of staff health and wellness	Studies from jurisdictions across the United States have demonstrated that rates of secondary stress, including PTSD, range from 35 percent to 50% percent of child-welfare staff, ⁶⁰ and those working in other helping professions such as sexual assault and behavioral health care services are impacted as well. Staff who suffer on the job face great difficulties in carrying out the life-altering work of the department. A clear focus on staff health and wellness is necessary to humanely support them in all of the Department's child and family serving fields.
21st Century Children's System of Care	In the nearly 20 years since its formation, the Children's System of Care (CSOC) has built a suite of critical services for children and youth experiencing challenges with behavioral health and/or intellectual/developmental disability. In keeping with developments in the field and in response to feedback from constituents and other stakeholders, the next phase of CSOC's development will include: integration of health and behavioral health; building capacity to deliver evidence-based interventions and services and enhancing CSOC capacity to ensure equitable access to care.

DCF's strategic plan is posted on the DCF website, and the Department will continue to update stakeholders on progress at regular Regional Forums.

Specific efforts that DCF will pursue related to these strategies include:

Enhance primary prevention services

Continue to strengthen Kinship Navigator and Family Success Center networks, expand home visiting network, and make use of geospatial risk modeling to identify additional efforts that can be expanded or implemented in New Jersey to effectively prevent maltreatment of children.

Strengthen kinship practice

Undertake intensive redesign of policies and practices related to use of kinship foster families and Kinship Legal Guardianship as a permanency option.

Build culture of safety

Design and begin implementation of the use of safety science in review and learning from critical incidents

Promote workforce well-being

Launch Office of Staff Health and Wellness to design and implement workforce well-being strategies

Build 21st Century strategies for Children's System of Care

In collaboration with stakeholders, undergo a rapid cycle planning process to develop specific plans to achieve equitable access to care, integration of health care delivery, and use of evidence-based treatment and family support approaches by January 2020

Promote race equity

Launch DCF Race Equity Steering Committee to focus on reducing the use of short stays and promoting permanency in foster care; preventing maltreatment and family separation; and identifying decision points within the Children's System of Care that influence disparity

Expand Family Voice

Create constituent advisory councils, bring constituent advocates into the work of the Department, implement Father Engagement strategies in DCPD

Continue to enhance service delivery

Finalize audit of existing service array within the Service Delivery Framework, develop and implement data collection capacity for purchased services, and prioritize sequencing of further development of the service array to align with the framework

Maintain and enhance service excellence in child protection and permanency

Implement statewide effort to improve management of safety and risk throughout the life of the case; begin implementation of behavior-based case planning methods; continue partnership with Judiciary to promote timely permanency

Advance the safety of women in New Jersey

Design and launch implementation of efforts to prevent sexual violence and intimate partner violence in underserved communities, and promote girls' leadership opportunities

Strengthen supports to transition-aged youth

Continue to promote normalcy, update housing program models to better meet the complex needs of youth, increase use of technology to engage and support youth, and reimagine life skills services to develop skill-build opportunities in the context of relationships

DCF's 6,600 staff, and the thousands of staff employed within the DCF provider network are honored to play a role in supporting Governor Murphy's vision for a stronger, fairer state for New Jersey's children, youth, families and communities. Staff at DCF look forward to executing his priorities and the Department's strategic plan in the coming years, so that all of us, and all NJ residents are safe, healthy and connected.



APPENDICES

1. Acronyms
2. SEP metrics & discussion

2018 PERFORMANCE: PROCESS AND CASELOAD MEASURES

	SEP Measure (SEP Reference)	Target	Jan	Feb	Mar	Apr	May	Jun	Performance Monitor Conclusion	Target Met? Monitor Conclusion	Jul	Aug	Sep	Oct	Nov	Dec	Performance DCF Calculation of Actual Performance	Target Met? Monitor Conclusion		
Caseload	Supervisor/Worker Ratio (III.B.2)	95%	100%	100%	100%	100%	100%	100%	100%	Yes	100%	100%	100%	100%	100%	100%	100%	100%	Yes	
	IAIU Investigators Caseload (III.B.3)	95%	100%	100%	100%	100%	99%	100%	100%	Yes	100%	100%	100%	100%	100%	100%	100%	100%	100%	Yes
	Permanency Workers Caseload (Local Office) (III.B.4)	95%	100%	100%	100%	100%	100%	100%	100%	Yes	100%	100%	100%	100%	100%	100%	100%	100%	100%	Yes
	Permanency Workers Caseload (III.B.5)	95%	100%	100%	100%	100%	100%	100%	100%	Yes	100%	100%	100%	100%	100%	100%	100%	100%	100%	Yes
	Intake Workers Caseload (Local Office) (IV.E.24)	95%	100%	100%	100%	100%	100%	100%	100%	Yes	100%	100%	100%	100%	100%	100%	100%	100%	100%	Yes
	Intake Workers Caseload (IV.E.25)	90%	95%	96%	97%	94%	92%	96%	95%	Yes	97%	98%	97%	94%	93%	91%	95%	95%	95%	Yes
	Adoption Workers Caseload (Local Office) (IV.E.26)	95%	96%	100%	98%	98%	100%	98%	98%	Yes	98%	98%	98%	98%	98%	98%	98%	98%	98%	Yes
	Adoption Workers Caseload (IV.E.27)	95%	97%	97%	96%	98%	99%	98%	97%	Yes	99%	98%	96%	96%	97%	99%	98%	98%	98%	Yes
Process	IAIU Timeliness of Investigations (60 Days) (III.A.1.)	80%	84%	84%	87%	81%	86%	87%	87%	Yes	88%	85%	85%	88%	86%	82%	86%	86%	Yes	
	Timeliness of Current Plans (III.C.6)	95%	98%	95%	94%	97%	96%	98%	98%	Yes	96%	96%	95%	97%	96%	96%	96%	96%	Yes	
	Worker Contacts with Children- New/Changed Placement (III.F.9)	93%	93%	96%	94%	95%	96%	90%	90%	No	93%	93%	92%	94%	89%	94%	93%	93%	Yes	
	Worker Contacts with Children in Placement (III.F.10)	93%	97%	95%	96%	96%	96%	95%	95%	Yes	95%	95%	94%	94%	93%	94%	94%	94%	Yes	
	Timeliness of Investigations (60 Days) (IV.A.13)	85%	85%	86%	85%	85%	85%	83%	85%	Yes	83%	85%	84%	83%	81%	83%	83%	83%	Yes	

Timeliness of Investigations (90 Days) (IV.A.14)	95%	95%	95%	90%	95%	95%	94%	95%	Yes	94%	94%	95%	93%	94%	94%	94%	Yes
Initial Family Team Meetings (IV.B.16)	80%	86%	87%	87%	85%	90%	85%	85%	Yes	74%	82%	88%	82%	76%	95%	84%	Yes
Subsequent FTMs within 12 months (IV.B.17)	80%	77%	85%	88%	91%	86%	78%	78%	No	81%	84%	87%	92%	90%	84%	86%	Yes
Subsequent FTMs after 12 months (Reunification) (IV.B.18)	90%	100%	93%	94%	94%	95%	95%	96%	Yes	79%	94%	74%	96%	87%	95%	87%	Yes
Subsequent FTMs after 12 months (Other than Reunification) (IV.B.19)	90%	98%	96%	96%	91%	91%	96%	96%	Yes	94%	94%	94%	97%	91%	89%	93%	Yes
Initial Case Plans (IV.D.22)	95%	99%	95%	94%	95%	96%	95%	95%	Yes	97%	92%	94%	95%	95%	94%	94%	Yes
Worker Contacts with Family (Reunification) (IV.F.28)	90%	72%	70%	70%	73%	74%	70%	77%	No	79%	80%	78%	78%	74%	76%	78%	No
Parent-Child Visits (Weekly) (IV.F.29)	60%	78%	80%	79%	82%	81%	79%	79%	Yes	79%	79%	77%	79%	76%	77%	78%	Yes
Parent-Child Visits (Bi-weekly) (IV.F.30)	85%	94%	92%	94%	93%	91%	92%	92%	Yes	92%	92%	91%	92%	89%	91%	91%	Yes
Child Visits with Siblings (IV.F.31)	85%	71%	68%	69%	75%	72%	70%	75%	No	86%	86%	87%	87%	85%	88%	86%	Yes
Independent Living Assessments (IV.K.45)	90%	94%	93%	91%	92%	91%	91%	91%	Yes	90%	88%	88%	89%	89%	86%	88%	No

2018 PERFORMANCE: QUALITY, OUTCOME AND ANNUAL MEASURES

	SEP Measure (SEP Reference)	Target	2018		Target met? <i>Monitor Conclusion</i>
Quality	Educational Needs (III.G.11)	80%	83%		Yes
	Quality Investigations (IV.A.15)	85%	91% ⁶¹		Yes
	Quality of Teaming (IV.B.20)	75%	58%		No
	Quality of Case Plans (IV.D.23)	80%	51%		No
	Services to Support Transition (IV.J.44)	80%	62%		No
	Quality of Case Planning and Services (IV.K.46)	75%	70%		Yes
	Youth Housing (IV.K.47)	95%	88%	96%	Yes
	Youth Employment/Education (IV.K.48)	90%	80%	89%	Yes
Outcome	Abuse or Neglect of Children in Foster Care (III.H.12)	.49%	.27%		Yes
	Placing Siblings Together (2-3) (IV.G.32)	80%	77%		No
	Placing Siblings Together (4+) (IV.G.33)	80%	86%		Yes
	Placement Stability- First 12 months (IV.G.35)	84%	85%(2017)		Yes
	Placement Stability- 13-24 months (IV.G.36)	88%	95%(2016)		Yes
	Repeat Maltreatment (In-home) (IV.H.37)	7.2%	5.0%(2017)		Yes
	Maltreatment (Post-reunification) (IV.H.38)	6.9%	5.9%(2015)		Yes
	Re-Entry to Placement (IV.H.39)	9%	12.2%(2016)		No
	Permanency within 12 months (IV.I.40)	42%	41%(2017)		Yes
	Permanency within 24 months (IV.I.41)	66%	65%(2016)		No
	Permanency within 36 months (IV.I.42)	80%	81%(2015)		Yes
	Permanency within 48 months (IV.I.43)	86%	89%(2014)		Yes

Resources	Adequacy of DAG Staffing (III.D.7)	-	Total Staffing: 139 DAsG. DAsG assigned to DCF Practice Group: 135, with 9 on temporary leave and two temporary DAsG for leave coverage. Division of Law DAsG outside of DCF Practice Group assigned to perform DCF legal work: equivalent of 4.	Total Staffing: 137 DAsG. DAsG assigned to DCF Practice Group: 135, with 2 on temporary leave. Division of Law DAsG outside of DCF Practice Group assigned to perform DCF legal work: equivalent of 2.	Yes
	Adequacy of CHU Staffing (III.E.8)	-	172 Health Care Case Managers and 85 staff assistants.	163 Health Care Case Managers and 84 staff assistants.	Yes
	Needs Assessment (IV.C.21)	-	DCF, in partnership with Rutgers University School of Social Work, completed a multi-year needs assessment. In March 2018, DCF published the final report, <u>DCF Needs Assessment 2018 Report #3: Survey Findings and Synthesis</u> . In Summer 2018, DCF began developing an internal needs assessment process, which will include a review of existing county specific internal and external data sources, as well as information provided by the Human Services Advisory Councils. County-specific findings will be shared during Childstat presentations.		Yes
	Recruitment of Placements for 4+ Sibling Groups (IV.G.34)	-	DCF recruited 23 new SIBs homes. Total large capacity SIBs homes: 84. Homes that can accommodate 5+ children: 20. Homes that can accommodate 4 children: 64.	DCF recruited 19 new SIBs homes. Total large capacity SIBs homes: 73. Homes that can accommodate 5+ children: 18. Homes that can accommodate 4 children: 55.	Yes

SUSTAINABILITY & EXIT PLAN MEASURE DEFINITIONS

	SEP Measure (SEP Reference)	Measure Defined
Caseload	Supervisor/Worker Ratio (III.B.2)	95% of offices will have sufficient supervisory staff to maintain a 5 worker to 1 supervisor ratio.
	IAIU Investigators Caseload (III.B.3)	95% of IAIU investigators will have (a) no more than 12 open cases, and (b) no more than eight new case assignments per month.
	Permanency Workers Caseload (Local Office) (III.B.4)	95% of Local Offices will have average caseloads for Permanency workers of (a) no more than 15 families and (b) no more than 10 children in out-of-home care.
	Permanency Workers Caseload (III.B.5)	95% of Permanency workers will have (a) no more than 15 families, and (b) no more than 10 children in out-of-home placement.
	Intake Workers Caseload (Local Office) (IV.E.24)	95% of Local Offices will have average caseloads for intake workers of no more than 12 families and no more than 8 new case assignments per month.
	Intake Workers Caseload (IV.E.25)	90% of individual intake workers shall have no more than 12 open cases and no more than eight new case assignments per month. No intake workers with 12 or more open cases can be given more than 2 secondary assignments per month.
	Adoption Workers Caseload (Local Office) (IV.E.26)	95% of Local Offices will have average caseloads for adoption workers of no more than 15 children per worker.
	Adoption Workers Caseload (IV.E.27)	95% of individual adoption worker caseloads shall be no more than 15 children per worker.
Process	IAIU Timeliness of Investigations (60 Days) (III.A.1.)	80% of IAIU investigations will be completed within 60 days.
	Timeliness of Current Plans (III.C.6)	95% of case plans for children and families will be reviewed and modified no less frequently than every six months.
	Worker Contacts with Children- New/Changed Placement (III.F.9)	93% of children shall have at least twice-per-month face-to-face contact with their caseworker within the first two months of placement, with at least one contact in the placement.
	Worker Contacts with Children in Placement (III.F.10)	During the remainder of the placement, 93% of children shall have at least one caseworker visit per month in the placement.
	Timeliness of Investigations (60 Days) (IV.A.13)	85% of all investigations of alleged child abuse and neglect shall be completed within 60 days. Cases with documented acceptable extensions in accordance with policy are considered compliant.
	Timeliness of Investigations (90 Days) (IV.A.14)	95% of all investigations of alleged child abuse and neglect shall be completed within 90 days. Cases with documented acceptable extensions in accordance with policy are considered compliant.
	Initial Family Team Meetings (IV.B.16)	80% of children newly entered placement shall have a family team meeting before or within 45 days of placement.
	Subsequent FTMs within 12 months (IV.B.17)	80% of children will have three additional FTMs within the first 12 months of the child coming into placement.
	Subsequent FTMs after 12 months (Reunification) (IV.B.18)	After the first 12 months of a child being in care, 90% of those with a goal of reunification will have at least three FTMs each year.
	Subsequent FTMs after 12 months (Other than Reunification) (IV.B.19)	After the first 12 months of a child being in care, for those children with a goal other than reunification, 90% shall have at least two FTMs each year.
	Initial Case Plans (IV.D.22)	95% of initial case plans for children and families shall be completed within 30 days.
Worker Contacts with Family (Reunification) (IV.F.28)	90% of families will have at least twice-per-month, face-to-face contact with their caseworker when the permanency goal is reunification.	

	Parent-Child Visits (Weekly) (IV.F.29)	60% of children in custody with a reunification goal will have an in-person visit with their parent(s) at least weekly, excluding those situations where a court order prohibits or regulates visits or there is a supervisory approval of a decision to cancel a visit because it is physically or psychologically harmful to a child.
	Parent-Child Visits (Bi-weekly) (IV.F.30)	85% of children in custody will have an in-person visit with their parent(s) or legally responsible family member at least every other week, excluding those situations where a court order prohibits or regulates visits or there is supervisory approval of a decision to cancel a visit because it is physically or psychologically harmful to a child.
	Child Visits with Siblings (IV.F.31)	85% of children in custody who have siblings with whom they are not residing will visit those siblings at least monthly, excluding those situations where a court order prohibits or regulates visits or there is supervisory approval of a decision to cancel a visit because it is physically or psychologically harmful to a child.
	Independent Living Assessments (IV.K.45)	90% of youth age 14 to 18 have an independent living assessment.
Quality	Educational Needs (III.G.11)	80% of cases will be rated acceptable as measured by the QR in stability (school) and learning and development. The Monitor, in consultation with the parties, shall determine the standards for school stability and quality learning and development.
	Quality Investigations (IV.A.15)	85% of investigations shall meet the standards for quality investigations. The Monitor, in consultation with the parties, shall determine appropriate standards for quality investigations.
	Quality of Teaming (IV.B.20)	75% of cases involving out-of-home placements that were assessed as part of the QR process will show evidence of both acceptable team formation and acceptable functioning. The Monitor, in consultation with the parties, shall determine the standards for quality teaming.
	Quality of Case Plans (IV.D.23)	80% of case plans shall be rated as acceptable as measures by the QR process. The Monitor, in consultation with the parties, shall determine the standards for quality case planning.
	Services to Support Transition (IV.J.44)	80% of cases will be rated acceptable for supporting transitions as measures by the QR. The Monitor, in consultation with the parties, shall determine the standards for quality support for transitions.
	Quality of Case Planning and Services (IV.K.46)	75% of youth age 18-21 who have not achieved legal permanency shall receive acceptable quality case management and service planning.
	Youth Housing (IV.K.47)	95% of youth exiting care without achieving permanency shall have housing.
	Youth Employment/Education (IV.K.48)	90% of youth exiting care without achieving permanency shall be employed, enrolled in or have recently completed a training or an educational program or there is documented evidence of consistent efforts to help the youth secure employment or training.
Outcomes	Abuse or Neglect of Children in Foster Care (III.H.12)	No more than 0.49% of children will be victims of substantiated abuse or neglect by a resource parent or facility staff member.
	Placing Siblings Together (2-3) (IV.G.32)	At least 80% of sibling groups of 2 or 3 children entering custody will be placed together.
	Placing Siblings Together (4+) (IV.G.33)	All children will be placed with at least one other sibling 80% of the time.
	Placement Stability- First 12 months (IV.G.35)	At least 84% of children entering out-of-home placement for the first time in a calendar year will have no more than one placement change during the 12 months following the date of entry.
	Placement Stability- 13-24 months (IV.G.36)	At least 88% of these children will have no more than one placement change during the 13-24 months following their date of entry.
	Repeat Maltreatment (In-home) (IV.H.37)	No more than 7.2% of children who remain at home after a substantiation of abuse or neglect will have another substantiation within the next 12 months.

	Maltreatment (Post-reunification) (IV.H.38)	Of all children who enter foster care in a 12-month period for the first time who are discharged within 24 months to reunification or living with a relative(s), no more than 6.9% will be the victims of abuse or neglect within 12 months of their discharge.
	Re-Entry to Placement (IV.H.39)	Of all children who enter foster care in a 12 month period for the first time who are discharged within 12 months to reunification, living with relative(s), or guardianship, no more than 9% will re-enter foster care within 12 months of their discharge.
	Permanency within 12 months (IV.I.40)	Of all children who enter foster care in a 12-month period, at least 42% will be discharged to permanency (reunification, living with relatives, guardianship or adoption) within 12 months of entering foster care.
	Permanency within 24 months (IV.I.41)	Of all children who enter foster care in a 12-month period, at least 66% will be discharged to permanency (reunification, living with relatives, guardianship or adoption) within 24 months of entering foster care.
	Permanency within 36 months (IV.I.42)	Of all children who enter foster care in a 12-month period, at least 80% will be discharged to permanency (reunification, living with relatives, guardianship or adoption) within 36 months of entering foster care.
	Permanency within 48 months (IV.I.43)	Of all children who enter foster care in a 12-month period, at least 86% will be discharged to permanency (reunification, living with relatives, guardianship or adoption) within 48 months of entering foster care.
Resources	Adequacy of DAG Staffing (III.D.7)	The state will maintain adequate DAG staff positions and keep positions filled.
	Adequacy of CHU Staffing (III.E.8)	The state will continue to maintain its network of Child Health Units, adequately staffed by nurses in each local office.
	Needs Assessment (IV.C.21)	The state shall regularly evaluate the need for additional placements and services to meet the needs of children in custody and their families and to support intact families and prevent the need for out-of-home care. Such needs assessments shall be conducted on an annual, staggered basis that assures that every county is assessed at least once every three years. The state shall develop placements and services consistent with the findings of these needs assessments.
	Recruitment of Placements for 4+ Sibling Groups (IV.G.34)	DCF will continue to recruit for resource homes capable of serving groups of 4 or more.

2018 SUSTAINABILITY AND EXIT PLAN PERFORMANCE

Discussion of areas needing improvement

SERVICES FOR CP&P INVOLVED OLDER YOUTH

Measure 47: 95% of youth exiting care without achieving permanency shall have housing.				
Monitoring Period	Jan. – June 2017	July – Dec. 2017	Jan. – June 2018	July – Dec. 2018
DCF Performance	100%	92%	88%	96%
# youth below target	0	5	6	2

Measure 48: 90% of youth exiting care without permanency shall be employed, enrolled in or have recently completed a training or an education program or there is documented evidence of consistent efforts to help the youth secure employment or training.				
Monitoring Period	Jan. – June 2017	July – Dec. 2017	Jan. – June 2018	July – Dec. 2018
DCF Performance	94%	95%	80%	89%
# youth below target	4	3	8	6

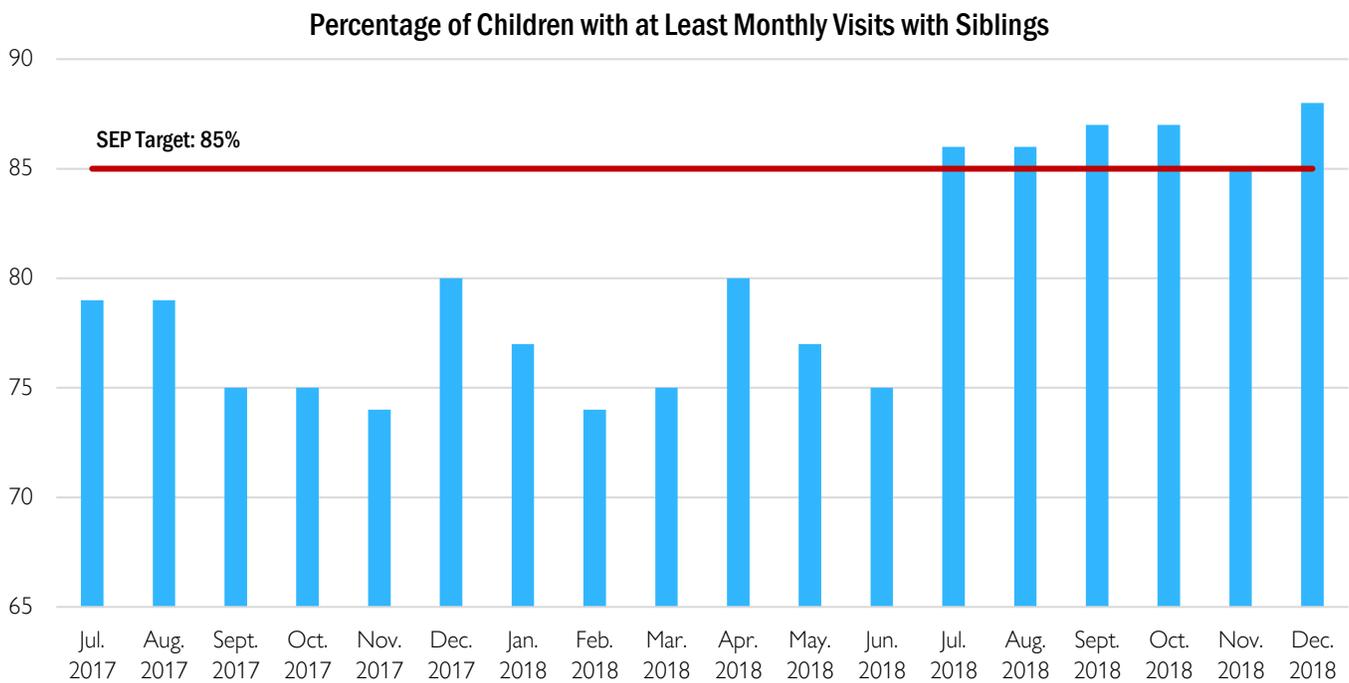
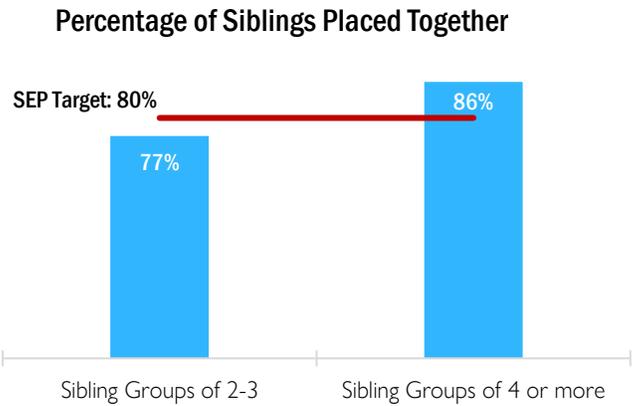
Since the inception of the Sustainability and Exit Plan (SEP) and through 2018, the Department of Children and Families' (DCF's) performance for Measures 47 and 47 has been determined through a bi-annual case record review completed jointly by DCF's Office of Quality, DCF's Office of Adolescent Services and the Center for the Study of Social Policy. The review of youth who exited care without permanency between January and June 2018 took place in October 2018. Most recently, the review of youth who exited care without permanency between July and December 2018 took place in March 2019.

During 2018, DCF's performance on measures related to practice with adolescents fluctuated. Because these measures involve a very small number of youth, such fluctuations in performance can be expected. After a decline in performance for Measures 47 and 48 during the first half of 2018, the Office of Adolescent Services committed to review each case that was out of compliance to better understand the needs of the youth and to determine strategies to improve performance. Observations and strategies for improvement were reviewed with leadership during a statewide management meeting and with front-line staff during Adolescent Practice Forums in Spring 2019. During the second half of 2018, performance for both Measures 47 and 48 improved.

Performance on additional measures related to older youth also varied. Completion of independent living assessments for youth ages 14 to 18 exceeded the SEP target during the first half of the year but fell slightly below the SEP target in the latter half of the year. The quality of case planning and services for youth who have not achieved permanency fell below the target. DCF will monitor performance on all related measures to ensure improvements, and strategies identified in the discussion of Case Practice at the end of this section, are also expected to impact assessment, engagement and case outcomes for youth in care.

SIBLING CONNECTIONS

DCF recognizes the importance of familial connections for all children and, in particular, those children experiencing an out-of-home placement. One such familial connection is that between siblings. DCF works to ensure that sibling groups entering placement remain intact and, when separated, that siblings have visits with one another. In CY2018, 77% of sibling groups of two or three were placed together and 86% of children from a sibling group of four or more were placed with at least one other sibling. While DCF exceeded the target for placement of sibling groups of four or more children together, placement of sibling groups of two or three fell below the target. DCF is reviewing sibling groups that did not remain intact during 2018 to identify reasons for separation and strategize for improvement.



When out-of-home placement results in separated sibling groups, it is critical for DCF to arrange sibling visits. After multiple monitoring periods falling just below the target, DCF reached the SEP target for the first time during the second half of 2018. Between January and June 2018, performance ranged from 75% – 80%. Between July and December 2018, performance ranged from 85% – 88%. Improved performance can likely be attributed to an elevated focus by CP&P leadership on practice and documentation in this area, as well as improved measurement of sibling visits taking place in service provider settings.

INVESTIGATION TIMELINESS

Measure 1: 80% of IAIU investigations will be completed within 60 days.												
Monitoring Period	MP22						MP23					
Month (2018)	Jan.	Feb.	March	April.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
DCF Performance	84%	84%	87%	81%	86%	87%	88%	85%	85%	88%	86%	82%

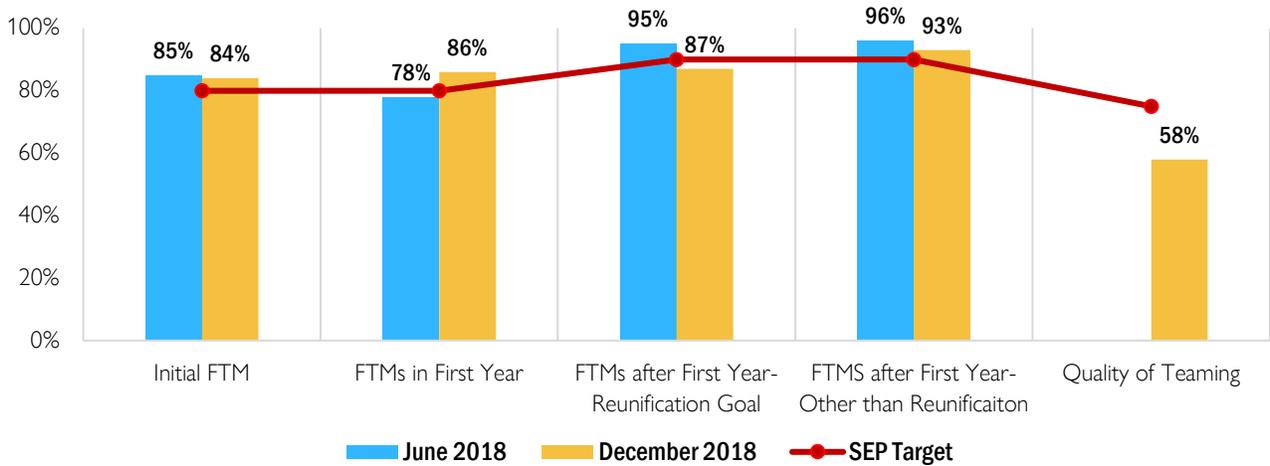
Measure 13: 85% of all investigations of alleged child abuse and neglect shall be completed within 60 days.												
Monitoring Period	MP22						MP23					
Month (2018)	Jan.	Feb.	March	April.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
DCF Performance	85%	86%	85%	85%	85%	83%	83%	85%	84%	83%	81%	83%

Measure 14: 95% of all investigations of alleged child abuse and neglect shall be completed within 90 days.												
Monitoring Period	MP22						MP23					
Month (2018)	Jan.	Feb.	March	April.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
DCF Performance	95%	95%	90%	95%	95%	94%	94%	94%	95%	93%	94%	94%

Measures 1, 13, and 14 of the SEP provide standards for timeliness of investigations completed by IAIU and CP&P investigators. While IAIU's performance exceeded the SEP targets for timeliness, completion of investigations by CP&P within 60 and 90 days fell below the SEP standards during multiple months. While this appears to be an insubstantial decline in performance, CP&P will closely monitor the timeliness of investigations to identify the cause of the decline and ensure the trend does not continue.

CASE PRACTICE AND ITS IMPACT ON OUTCOMES

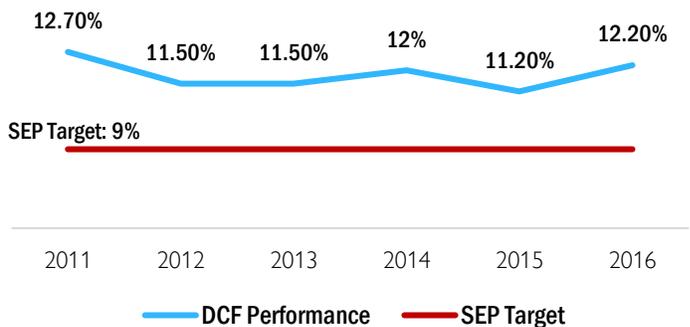
Percentage of Cases with Required Number of FTMs and Quality Teaming



Throughout 2018, DCF achieved, or nearly achieved, all performance standards related to frequency of Family Team Meetings. The quality of teaming, however, remains to be achieved. In 2018, 58% of cases scored at or above the SEP target for quality of teaming. Similarly, while CP&P generally performs at or near the target for completing case plans, the quality of case plans continued to fall below the SEP target. In 2018, 57% of cases scored at or above the SEP target for quality of case planning. DCF’s expectations of its workforce go beyond conducting the required number of events at the required time intervals. DCF is committed to engaging in quality case practice in its work with children and families.

A review of some outcomes metrics shows the longer-term effects of case practice that falls below performance standards. While most children who discharge from DCF custody to a permanent placement remain home, New Jersey continues to have a high rate of re-entry into out-of-home placement. Observed performance has remained steady and above the SEP target of 9%. In New Jersey, for 2018, the re-entry rate was 12.2%. To the contrary, post-reunification child abuse and neglect was well below the target of 6.9%, leading DCF to believe that re-entry is happening for reasons other than maltreatment. For 2018, the post-reunification repeat maltreatment rate was 5.9%.

Percentage of Children Re-Entering Out-of-Home Placement



In the short-term, CP&P, through Case Practice Liaisons and Area Quality Coordinators, will continue to make efforts to improve the quality of case practice related to teaming, case planning and assessment. DCF will continue to analyze data, findings, practice and policies related to re-entry to identify factors that contribute to re-entry and those that prevent it. In the longer-term, DCF plans to implement statewide improvement efforts as part of its federal Child and Family Services Review Program Improvement Plan, which are intended to achieve improvements in practice areas such as assessment and engagement of families, and outcomes such as decrease in time to permanency and reduction in rates of re-entry. Specific efforts will include the including incorporation of evidence-informed behavior-based case-planning practice into the DCF Case Practice Model, and increased attention to concurrent planning.

ENDNOTES

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- ⁵² An allegation shall be "Substantiated" if the preponderance of the evidence indicates that a child is an "abused or neglected child" as defined in N.J.S.A. 9:6-8.21 and either the investigation indicates the existence of any of the circumstances in N.J.A.C. 10:129-7.4 (i.e., the "absolutes") or substantiation is warranted based on consideration of the aggravating and mitigating factors listed in N.J.A.C. 10:129-7.5.
- ⁵³ An allegation shall be "Established" if the preponderance of the evidence indicates that a child is an "abused or neglected child" as defined in N.J.S.A. 9:6-8.21, but where the act or acts committed or omitted do not warrant a finding of "Substantiated."

⁵⁴ An allegation shall be "Not Established" if there is not a preponderance of the evidence that a child is an abused or neglected child as defined in N.J.S.A. 9:6-8.21, but evidence indicates that the child was harmed or was placed at risk of harm.

⁵⁵ An allegation shall be "Unfounded" if there is not a preponderance of the evidence indicating that a child is an abused or neglected child as defined in N.J.S.A. 9:6-8.21, and the evidence indicates that a child was not harmed or placed at risk of harm.

⁵⁶ <https://njchilddata.rutgers.edu/portal/>

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⁶¹ DCF and the Center for the Study of Social Policy conduct an Investigative Case Record Review approximately every two years. The last review took place in March 2018. The next review is expected to take place in 2020.

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