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PROGRESS OF THE NEW JERSEY
DEPARTMENT OF CHILDREN AND FAMILIES

MONITORING REPORT FOR
CHARLIE AND NADINE H. v. CORZINE
JANUARY 1–JUNE 30, 2007

Center for the Study of Social Policy
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I. INTRODUCTION

Purpose of this Report

In July, 2006 the Center for the Study of Social Policy (CSSP) was appointed by the Honorable Stanley R. Chesler of the United States District Court for the Third Circuit as Monitor of Charlie and Nadine H. v. Corzine. As Monitor, CSSP is to assess independently the State's compliance with the goals, principles and outcomes of the Modified Settlement Agreement (MSA) of the class action litigation aimed at improving the State's child welfare system.¹ CSSP released its Period I Monitoring Report in February 2007 describing progress New Jersey had made towards compliance with the MSA as of December 31, 2006.² This is the second Monitoring report under the MSA and covers the period of January through June 2007.

The MSA structures the State's commitments into two phases of work. Phase I (through December 2008) is primarily directed to building a strong infrastructure within the Department of Children and Families (DCF) to ensure that children are healthy and safe, achieve permanency and stability, and that resource and service delivery systems meet children's health, mental health, educational and developmental needs. This second Monitoring report reflects the State's continued work in and commitment to these foundational elements of a successful reform, and also describes the State's efforts towards implementing its new Case Practice Model (CPM), which will ultimately guide New Jersey's practice change and is intended to yield improved results for children and families.

Methodology

The primary source of information for this Period II Report is the Department of Children and Families (DCF). DCF provides the Monitor with extensive aggregate and back up data as well as access to staff at all levels to enable the Monitor to verify DCF data and report on actions taken and progress made. During this Monitoring period, the Monitor also visited seven Division of

¹ Charlie and Nadine H. et al. v. Corzine, Modified Settlement Agreement, United States District Court for the District of New Jersey, Civ. Action No. 99-3678 (SRC), July 18, 2006. To see the full Agreement, go to http://www.state.nj.us/dcf/home/Modified_Settlement_Agreement_7_17_06.pdf.

² *Progress of the New Jersey Department of Children and Families: Period I Monitoring Report for Charlie and Nadine H. v. Corzine – July 2006 through December 31, 2006*. Washington, DC: Center for the Study of Social Policy. February 26, 2007.

Youth and Family Services (DYFS) offices across the State: Warren, Ocean South, Atlantic West, Salem, Camden North, Essex North, and Somerset. The Monitor spoke with all levels of DYFS staff. The Monitor also spoke with various stakeholders of New Jersey's child welfare system, including foster and adoptive parents, relatives and birth parents, providers, advocacy organizations, attorneys and the Office of the Child Advocate.

Section II of the report provides overall conclusions and a summary of the State's progress in meeting the MSA through June 30, 2007.

Other sections of the report provide specific information on the requirements of the MSA as follows:

- Section III: Continuing to Build a High Quality Workforce and Management Infrastructure
- Section IV: Changing Practice to Support Children and Families
- Section V: Appropriate Placements and Services for Children
- Section VI: Meeting the Health and Mental Health Needs of Children

II. SUMMARY OF PROGRESS AND CHALLENGES AHEAD

Summary of Accomplishments

The past six months have been demanding for the relatively new Department of Children and Families (DCF) as it has moved to expand the range, scope and pace of its reform initiatives. Despite the complexity of the challenges and demands of widespread growth and change, DCF has built considerably upon its accomplishments from the previous monitoring period. As shown in summary fashion in Table 1 on pages 8 to 12 and discussed in more detail in this report, DCF fulfilled and often exceeded the expectations of the MSA in each area in which the MSA called for activity.

This monitoring period covers additional Phase I commitments in which DCF continued to focus on the development of leadership throughout the organization and on the fundamental building blocks which are the foundation of the overall reform effort. While keeping that focus, DCF has thoughtfully planned and begun to implement several major initiatives in this monitoring period which have promise to move the Department beyond building infrastructure and toward lasting systemic change and better outcomes for children and families.

Highlights of the Monitor's assessment of progress include:

The Department has continued to make progress in developing the infrastructure necessary to create lasting reform. Examples include:

- DCF achieved or exceeded the June 2007 caseload targets set for Permanency, Intake and Adoption staff. In site visits in different parts of the State, staff consistently confirm that their caseloads have improved markedly and that this reduction, in turn, has improved their ability to perform their jobs.
- DCF exceeded the benchmark for the ratio of supervisors to workers. Eighty-seven percent (87%) of offices are in compliance with the requirement of a five to one supervisory ratio. Having an adequate cadre of skilled supervisors is absolutely essential to the work ahead to improve direct practice with children and families.
- DCF continued to improve its ability to use data to monitor performance and expanded the data provided to the public on its website.
- Following a pilot deployment in Ocean County beginning in April 2007, DCF initiated Phase II of New Jersey SPIRIT in August—launching statewide a comprehensive automated child welfare information system. In preparation for the deployment, DCF trained over 5000 employees on how to use the system. Since deployment, DCF has been operating an extensive help desk and support system to identify and trouble-shoot problems and to alleviate the steep learning curve that is typically associated with the introduction of these complex data systems.

- The Institutional Abuse Investigations Unit (IAIU) achieved the June 2007 target for timely completion of investigations. By June 2007, IAIU was expected to complete 80 percent of its investigations within 60 days of referral. On June 30, 2007, the State reported that IAIU had 373 open investigations. Of those, 332 (89%) had been open less than 60 days. These open cases reflect investigations in-progress on referrals from May and June.
- The Department succeeded in reaching or exceeding all of the expectations in the MSA pertaining to training.
 - o The Pre-Service training curriculum was modified to incorporate principles from the Case Practice Model (CPM);
 - o Newly hired workers continue to be enrolled in Pre-Service training within two weeks of their start date;
 - o All newly promoted supervisors have taken Supervisory Training;
 - o All case carrying staff were trained in concurrent planning;
 - o 5,025 staff were trained on New Jersey SPIRIT; and
 - o All existing DYFS and IAIU staff were trained on Intake and Investigations, and new staff will now receive Intake training as part of the Pre-Service training curriculum

Simultaneously to focusing on fundamentals, the Department took important steps to fundamentally change the way it works with families in New Jersey. For example:

- DCF developed a thoughtful and ambitious Case Practice Model Implementation Plan to guide the Department's multi-year reform work.
- DCF developed a comprehensive plan to improve the health care delivery system for children in out-of-home placement. When fully implemented, this plan creates and resources Child Health Units in every DYFS office in order to coordinate care and provide information and supports to parents and Resource Parents so that children are healthy and able to thrive. The plan also expands access to medical and mental health providers to ensure that each child's developmental, health and mental health needs are appropriately assessed and met.

Finding appropriate placements for children, while still a major challenge, was a significant focus of the Department in the past six months and it achieved solid results.

- DCF exceeded its mandate to license 1030 non-kin Resource Family homes, licensing 1287 new non-kin families between July 2006 and June 2007.

- At the same time, more children than ever before are placed permanently with appropriate relatives, allowing them to maintain important family connections. The number of children placed through subsidized kinship legal guardianship grew by 26 percent from 2,002 in 2006 to 2,515 by June 2007.
- DCF directed significant resources to new programs to support adolescents, funding a youth permanency demonstration project and adding 112 transitional living beds for older youth.
- DCF contracted for additional in-state capacity to meet the treatment needs of severely troubled children and youth that have in the past necessitated out-of-state placement by the Division of Child Behavioral Health Services (DCBHS). When all of the programs are functioning, an additional 86 “specialty” treatment beds will be available in the State of New Jersey.

While there is a long way to go, there are promising data on some outcomes as the Department matures and meets or exceeds expectations in the MSA.

- The number of children supported in permanent families through adoption subsidies or kinship guardianship arrangements (13,244) as of August, 2007 exceeds the number of children in state custody in out-of-home placement (9,978).
- The Department finalized 634 adoptions as of June 30, 2007 and is on target to meet its 2007 goal of 1400 adoptions.
- There is a consistent net increase in the number of Resource Families licensed each month, fueled by new resources and departmental improvements in the recruitment and licensing processes. In the first half of 2007, the net gain of Resource Families (a total of 667 families) tripled compared to FY 2006.
- As of July 2007, 92 percent of children entering out-of-home care received pre-placement assessments conducted in non-emergency room settings.

Challenges Ahead

In structuring Phase I and II of the MSA, the parties deliberately attempted to recognize that system reform is a long-term process. Pressures for a “quick fix” come from all fronts, and are felt acutely by leadership, management, and the front lines of the workforce as well as by children and families. Despite the many accomplishments cited above, the state’s child welfare system does not consistently function well and the urgency of the reforms remains. At a number of site visits, the Monitor listened to staff’s understandable difficulty with the rapid pace of change. Different offices are at different places in terms of readiness for system change depending on how swiftly they have added staff, how new the staff are to the work, the strength of local leadership, and whether they have benefited from being one of the demonstration sites of

a new initiative. At the same time that some staff experience the changes as too much and too fast, some advocates and families wonder why problems remain and the reform is taking so long.

The Commissioner has made a conscious effort to expand and strengthen the leadership team in Trenton and at the Area and Local Office Manager level in this monitoring period, but this is still a work in progress. The leadership team is exceedingly strong in some areas, while there are other areas of weakness that continue to require attention as the Department's reform work continues and accelerates. There have been two major leadership changes during this period with the departure of the Director of the Child Welfare Training Academy (NJCWTA) and the Director of the Division of Child Behavioral Health Services (DCBHS). The Director of Administration has assumed responsibility for the management of the NJCWTA and an Acting Director has been appointed to DCBHS while the search for a permanent Director is completed.

A major challenge of the past year, which continues going forward, is completing the implementation and user acceptance of New Jersey SPIRIT. During the past six months, the daily demands to keep the project on track, respond to crises and ensure that the full deployment was as positive as possible for both workers in the field and the public occupied an enormous amount of leadership time and attention. The experience of most public child welfare systems implementing data systems like SPIRIT suggests that the months following deployment are typically as challenging as the months leading up to it. While it is true that staff have been trained and that the information system is functioning generally well in most areas of the State, realizing the intended benefits of SPIRIT will require consistent work over the next year or two. There are system bugs to be worked out, processes and reports to be modified, glitches to be unstuck, workers to be retrained and most importantly, consistent attention by managers at all levels on the need for proper data entry and on the use of the information for more effective case management and performance monitoring. Implementing a new data system is an enormous undertaking. Constant attention will be required over the next several months in order for SPIRIT's potential for management, data analysis and tracking to be fully realized.

As is clear from the Case Practice Model Implementation Plan discussed in detail in this report, implementing the new CPM is another formidable challenge, but a fundamentally necessary one in order to produce lasting change. In the Monitor's site visits, the inexperience of the workforce is readily apparent. Corroborated by the data on the number of new workers hired in the past year to 18 months, many offices are filled with workers who are either just completing training or have recently moved out of trainee status. The importance of their attachment to high quality Training Supervisors in their first few months was underscored by the workers who viewed the mentoring they received from those staff as essential for their successful transition to the job. As the Department moves forward to operationalize a practice model which demands new ways of working with families and with the community, training, support, coaching and mentoring will be necessary for not only the new and inexperienced workers but also for veteran workers. The demand for this kind of help is significant but it is hard to imagine the case practice transformations taking root and flourishing without such investments. Further, in implementing the Case Practice Model, the Department will need to consistently engage with and rely heavily on its partners in the community and across the State.

Another challenge the Department will face in the coming months is implementing its newly created Health Care Plan—moving quickly to deploy the resources of the Health Care Units to the field, ensuring that the provider capacity for comprehensive assessments and follow-up treatment and care is developed, resourced and connected, and putting in place the data systems to track successful implementation. The shortage of willing providers for dental care must be addressed through both changed relationships and commitments and will also likely require a change in Medicaid reimbursement.

A significant challenge for the Department in implementing both the Health Care Plan and the Case Practice Model is space constraints. At each site visit, the Monitor heard from every level of staff that more space is necessary to carry out the Department's new initiatives. More space is needed for nurses, for health care visits, for parent/child visits, for family team meetings and the like. Further, as the Department has expanded so quickly, many of the newer local offices are located in places that are inaccessible by public transportation and sometimes far from the children and families the Department serves. The challenges of space (both the lack of appropriate space and the poor conditions of some offices sites) need to be approached with both short-term and longer term solutions. This is an issue which DCF cannot solve on its own; it will require assistance from other parts of state government.

An additional challenge is the Department's work with older adolescents. The Department has made notable progress in directing attention and resources to older youth in out-of-home care. However, this is a population that has been long neglected by system efforts. The Department has amended policies and procedures, but will need to move beyond plans to action to ensure real change for youth.

DCF has a lot of hard work ahead to realize the vision of an integrated agency that meets the needs of children and families in less categorical ways. While beginning steps have occurred to link the work of the Division of Youth and Family Services (DYFS), the Division of Child Behavioral Health Services (DCBHS) and the Division of Prevention and Community Partnerships (DPCP), much more will be required to move beyond artificial boundaries and distinctions to better serve children and families. Further, in every site visit and despite the fact that the Department has moved aggressively in this last year to increase contracted resources for community-based services for families and children, staff report the difficulties they experience in gaining access to the services that families need in their communities. These include such basic services as substance abuse treatment, help to secure safe housing, in-home counseling and family preservation services, mental health services and family support. The Governor and the Legislature should be commended for providing DCF sufficient resources to begin the work to expand necessary community services and supports. Developing and sustaining an appropriate and complete service array across the State is likely however to require consistent and additional resource commitments over the next several years.

In summary, the Department's work in this monitoring period has been focused and productive. Many promising strategies have been introduced, which will need to be consistently translated into new practices and accessible services on the ground for the Department to succeed in its mission of fundamentally changing how it works with children and families in New Jersey.

Table 1:
Summary of State Progress on Modified Settlement Agreement Requirements
(January – June 2007)

Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No)³	Comments
New Case Practice Model			
II.A.3 Begin implementation of the case model practice.	Development of CPM--December 2006 Ongoing implementation	Yes	Case Practice Model Implementation Plan completed in August 2007. Implementation underway.
Training			
<u>Pre-Service Training</u>			
II.B.1.a Institute Pre-Service Training program to include training on intakes and investigations and the new case practice model	January 2007	Yes	Pre-Service training modified to reflect case practice model and First Responder curriculum on intake and investigation.
II.B.1.b 100% of all new case carrying workers shall be enrolled in Pre-Service Training	September 2006	Yes	412 workers completed Pre-Service training 01/07 – 06/30/07. 94% were enrolled within two weeks of starting date
II.B.1.c No case carrying worker shall assume a full caseload until completing Pre-Service training and until after she has passed competency exams	September 2006	Yes	New protocols for competency assessment developed.
<u>In-Service Training</u>			
II.B.2.a Develop and institute In-Service Training program for case carrying staff, supervisors and case aides	April 2007	Yes	By agreement of parties, training on New Jersey SPIRIT and concurrent planning meet In-Service training requirements for this monitoring period.
II.B.2.d Implement in-service training on concurrent planning for all existing staff	September 2006	Yes	3,251 staff trained in Concurrent Planning. 729 staff trained between 01/07 - 06/30/07.

³ “Yes” indicates that, in the Monitor’s judgment based on presently available information, DCF has substantially fulfilled its obligations regarding the requirement under the Modified Settlement Agreement for the January-June 2007 monitoring period; or is substantially on track to fulfill an obligation expected to have begun during this period and be complete in a subsequent monitoring period. “No” indicates that, in the Monitor’s judgment, DCF has not fulfilled its obligation regarding the requirement.

Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No) ³	Comments
II.B.2.e 100% of caseworkers, supervisors and case aides not previously trained on the new case practice model shall have received this training.	Beginning April 2007 Continued through December 2007	Yes	By agreement of parties, training on New Jersey SPIRIT and concurrent planning meet training requirements for this period. Case practice model training commences 1/08 and continues through 12/08.
<u>Investigations/Intake Training</u>			
II.B.3.a All new staff responsible for conducting intake or investigations shall receive specific, quality training on intake and investigations process, policies and investigations techniques and pass competency exams before assuming responsibility for cases.	September 2006	Yes	Incorporated in Pre-Service training.
II.B.3.b All staff responsible for intake or investigation not previously trained shall receive specific training on intake and investigations process, policies, and investigation techniques.	June 2007	Yes	769 DYFS and 64 IAIU staff trained 01/01/07 – 06/30/07.
<u>Supervisory Training</u>			
II.B.4.b 100% of all staff newly promoted to supervisory positions shall complete their 40 hours of supervisory training and shall have passed competency exams within 3 months of assuming their supervisory positions	December 2006	Yes	114 new supervisors trained 01/01/07 – 06/30/07.
II.B.4.c 100% of supervisors promoted to supervisor before December 2006 shall receive their 40 hours of the supervisory training and have passed competency exams.	June 2007	Yes	138 previously hired supervisors trained 01/01/07 – 06/30/07.
Services for Children and Families			
II.C.2 Seek approval from federal government for Medicaid structure to support the use of community and evidence-based, informed or support practices for children and families.	June 2007	Not applicable	DCF was able to meet this requirement without needing to seek approval from the federal government.
II.C.3 Permit the utilization of flexible funds for birth families involved with DYFS to better promote family preservation and reunification.	June 2007	Yes	\$1 million increase budgeted for FY08.
II.C.4 Develop and thereafter implement a plan for appropriate service delivery for gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth.	June 2007	Yes	GLBTQ plan developed; implementation is ongoing. Monitor views plan as preliminary and to be refined as case practice model is implemented.

Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No) ³	Comments
II.C.5 Promulgate and implement policies designed to ensure continuous services to youth between ages 18 and 21 similar to services previously available.	June 2007	Yes	Implementation is ongoing.
II.C.11 Add 18 transitional living program beds for youth between the ages of 16 and 21.	June 2008	Yes	DCF met this requirement early and far exceeded the number of beds, adding 112 transitional beds.
Finding Children Appropriate Placements			
II.D.3 Evaluate the needs of children in out-of-state congregate placements to determine and develop action steps with timetables to serve children with these needs in-state.	June 2007	Yes	Evaluation has been completed. Conferences to develop strategies for children's return have been scheduled through October 2007 for 119 children involved with DYFS and placed out of state.
II.D.8 DYFS will eliminate the inappropriate use of shelters as an out-of-home placement for children in its custody.	June 2007	Yes	Policy has been issued.
Caseloads			
II.E.9 79% of offices shall have average caseloads at the standard of 15 families or less and 10 children in out-of-home care or less for the permanency staff.	June 2007	Yes	84% of offices met this requirement.
II.E.10 58% of offices shall have average caseloads for the intake staff at an interim caseload standard of 15 families or less and 10 new referrals or less.	June 2007	Yes	82% of offices met this requirement.
II.E.11 85% of offices shall have sufficient supervisory staff to maintain a 5 worker to 1 supervisor ratio.	June 2007	Yes	87% of offices met this requirement.
Provision of Health (Medical and Mental Health)			
II.F.5 and II.F.6 Set health care baselines and targets. Methodology for tracking compliance decided.	January 2007	Yes	Baselines have been set for June 2007 and the staging of targets agreed upon. The methodology for measuring all health care indicators is still under negotiation.
II.F.7 90% of children entering out-of-home custody shall have pre-placement assessments in a setting other than an emergency room.	June 2007	Yes	Requirement met as of July 2007 (92% in non-emergency settings).

Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No) ³	Comments
II.F.8 Identify a statewide coordinated system of health care including a provision to develop a medical passport for children in out-of-home care.	June 2007	Yes	State has developed an ambitious plan which, among other things, expands the number of comprehensive medical exam providers and creates Child Health Units. Plan for Medical Passport developed.
Permanency Planning and Adoption			
II.G.12 Complete the adoption case transfer process across 100% of offices.	June 2007	Yes	
II.G.13 60% of offices for the adoption staff will have average caseloads consisting of 18 or fewer children.	June 2007	Yes	90% of offices have average caseloads at or below the standard.
II.G.14 Implementation of the adoption process tracking system.	June 2007	Yes	Tracking system is used in the 10 Concurrent Planning demonstration sites and is expected to be expanded statewide.
Resource Families			
II.H.9 Create an accurate and quality tracking and target setting system for ensuring there is a real time list of current and available Resource Families.	June 2007	Yes	Capacity developed in New Jersey SPIRIT
II.H.10 1,030 Non-kin Resource Family homes are licensed.	June 2007	Yes	1,287 non-kin family resource homes licensed.
II.H.15 Continue to further close by 25% the gap between current Resource Family support rates and the USDA's estimated cost of raising a child.	January 2007	Yes	New rates effective January 1, 2007.
Institutional Abuse Investigations Unit (IAIU)			
II.I.3 Completed 80% of IAIU investigations within 60 days.	June 2007	Yes	89% of investigations completed within 60 days.
II.I.4 All IAIU investigators provided with specific training on intake and investigations process, policies, and investigative techniques.	June 2007	Yes	64 IAIU workers trained 01/01/07 – 06/30/07.
Data			
II.J.5 Identify, ensure accuracy, and publish additional indicators.	February 2007	Yes	DCF continues to expand data published on website.
II.J.6 DCF agency performance reports produced with a set of measures approved by the Monitor.	February 2007	Yes	

Settlement Agreement Requirements	Due Date	Fulfilled (Yes/No) ³	Comments
II.J.7 New Jersey SPIRIT Release 2, Phase II	February 2007	Yes	State roll out beginning with Ocean County (pilot site) and full State deployment August 2007.
II.J.8 All case carrying workers trained on New Jersey SPIRIT.	May 2007	Yes	From April – August 2007, 5025 staff trained on New Jersey SPIRIT.

III. CONTINUING TO BUILD A HIGH QUALITY WORKFORCE AND MANAGEMENT INFRASTRUCTURE

A. Caseloads

New Jersey's child welfare system cannot be expected to be successful unless and until it has a sufficient, stable and well-trained workforce. During this monitoring period, the Department continued to make exceptional progress toward achieving this goal. For years, excessively high caseloads in DYFS were a visible problem and source of controversy. While there was unanimity that caseloads were too high, the accuracy of data tracking and the high turnover of staff made it difficult to assess and tackle the problem. A high priority for the Modified Settlement Agreement (MSA) is the accuracy and transparency of caseload data and steady and rapid progress toward reducing worker caseloads across the State. The Department continued to demonstrate progress in both of these areas in the past six months. As discussed below, the State has met or exceeded each of the staffing commitments of the MSA for this monitoring period. The support from the Governor and the Legislature for the additional funds needed to hire the large number of case workers and supervisors required to reduce caseloads has been critical to DCF's success in this area. Continued support will be needed in subsequent monitoring periods to comply with additional caseload reductions before the end of Phase I in December 2008.

The Monitor took several steps to verify independently the reported caseload information. First, the Monitor and Department staff reviewed previous draft reports and the methodology used to compute the caseloads as well as the process put in place for verifying and refining the caseload reporting. This included reviewing examples of communication between central office and local managers regarding the exception reporting. This review identified an average of 10 corrections per office that were needed to improve the accuracy of the caseload data. Types of corrections needed included:

- Updating the appropriate program and personnel systems with worker leave information, updated trainee status, name spelling corrections, worker program area (i.e., intake, adoptions, permanency) Each of these corrections affect the "available pool" of workers by which the caseload averages are calculated.
- Correcting case assignments.

In addition to assessing the Department's internal quality assurance on the accuracy of caseload data, the Monitor collected information from the seven site visits and telephone interviews with local office managers in ten randomly selected offices. All personnel interviewed confirmed the accuracy of the Department's reporting on caseload and the vast majority of staff highlighted the positive effects of recently reduced caseloads. This independent review confirmed the accuracy of the State's caseload reporting for June 2007. The principal accomplishments regarding caseloads include:

1. The State has continued to track and publicly report caseload information.

DCF can now accurately track and report on worker and supervisor caseloads. The tracking system allows the Department to provide accurate and increasingly more detailed caseload information quarterly on its website (www.state.nj.us/dcf). March 31, 2007 caseload data was posted on the website in May 2007 and June 30, 2007 caseload data was posted in September 2007. Additionally, caseloads for trainees in each unit are reported separately (MSA, Section II.E.2) and both levels of supervisory staff (SFSS1 and SFSS2) are separately counted and shown.

2. DCF exceeded the June 2007 caseload target for average caseloads of Permanency staff.

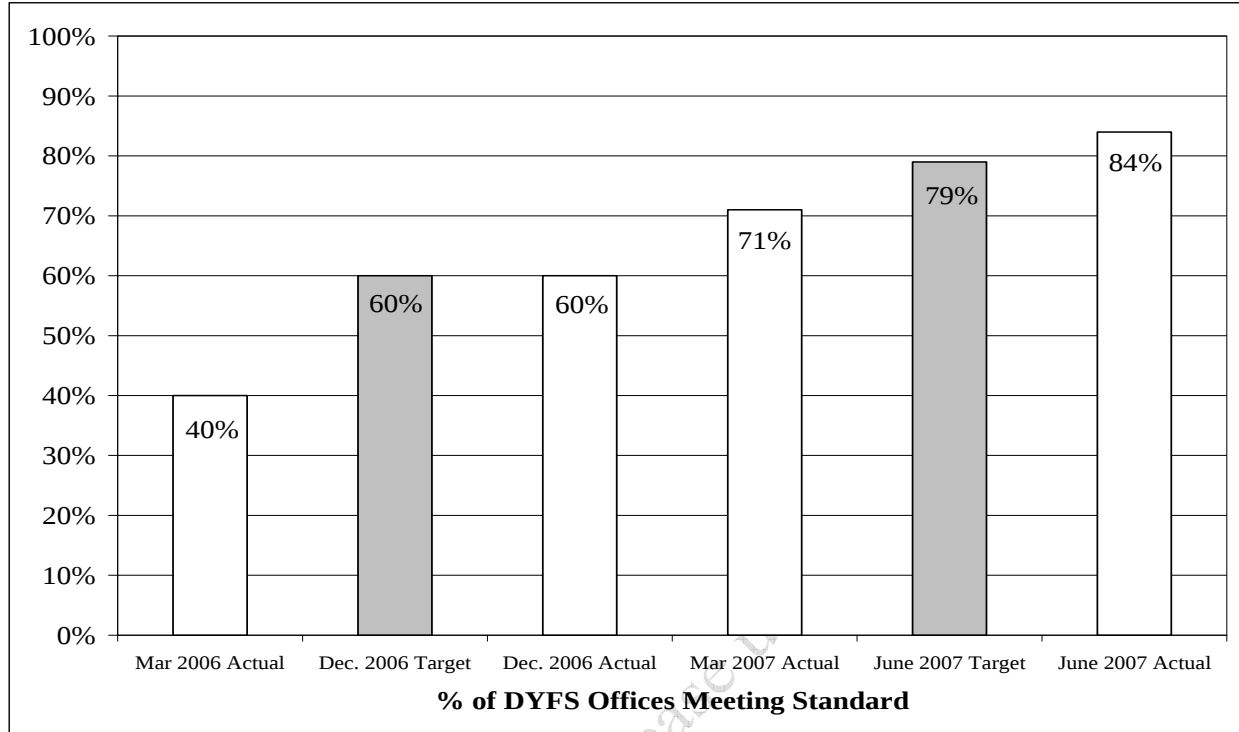
Permanency workers are assigned to provide case management of services to families whose children remain at home under the protective supervision of DYFS and those families whose children are removed from home due to safety concerns. To ensure staff has the time to devote to children and families with diverse needs and circumstances, the State agreed to achieve a caseload standard that has two intertwined components. One component is the number of families per worker and the other component is the number of children placed in out-of-home care per worker. This has been referred to as a “two prong” standard. Permanency workers are to serve no more than 15 families and 10 children in out-of-home care. If either of these standards is higher, the caseload is not compliant with the Modified Settlement Agreement standard (MSA, Section II.E).

During Phase I, caseload compliance is measured by average caseloads in an office. Ultimately, the Phase I goal is for 95 percent of all offices to have permanency workers that meet the two-pronged standard for average caseloads. This goal is to be achieved over a period of time with targets starting in 2006, and with the final target of 95 percent to be achieved by December 2008. As of June 2007, average caseloads in 79 percent of all local offices⁴ are to meet the caseload standard. (MSA, Section II.E.9.)

As displayed in Figure 2, the State exceeded this target with 84 percent of the offices having average caseloads for available Permanency workers of 15 families or fewer and 10 or fewer children in placement. The State also reported to the Monitor that less than one percent of all case workers had caseloads of more than 30 families in June 2007. This data was independently verified by the Monitor as previously described. Appendix A contains a table with supporting detail on caseloads for each local office.

⁴ On June 30, 2007, there were 46 local offices.

Figure 2:
NJ DCF DYFS Permanency Worker Caseloads* Compliance by Office



Source: New Jersey Department of Children and Families, Office of Policy and Planning

*Permanency caseload standard is 15 families and no more than 10 children in placement.

Note: DCF reports caseload data quarterly and the targets in the MSA were set at 6-month intervals (December and June).

3. DCF exceeded the June 2007 caseload target for average caseloads of Intake staff.

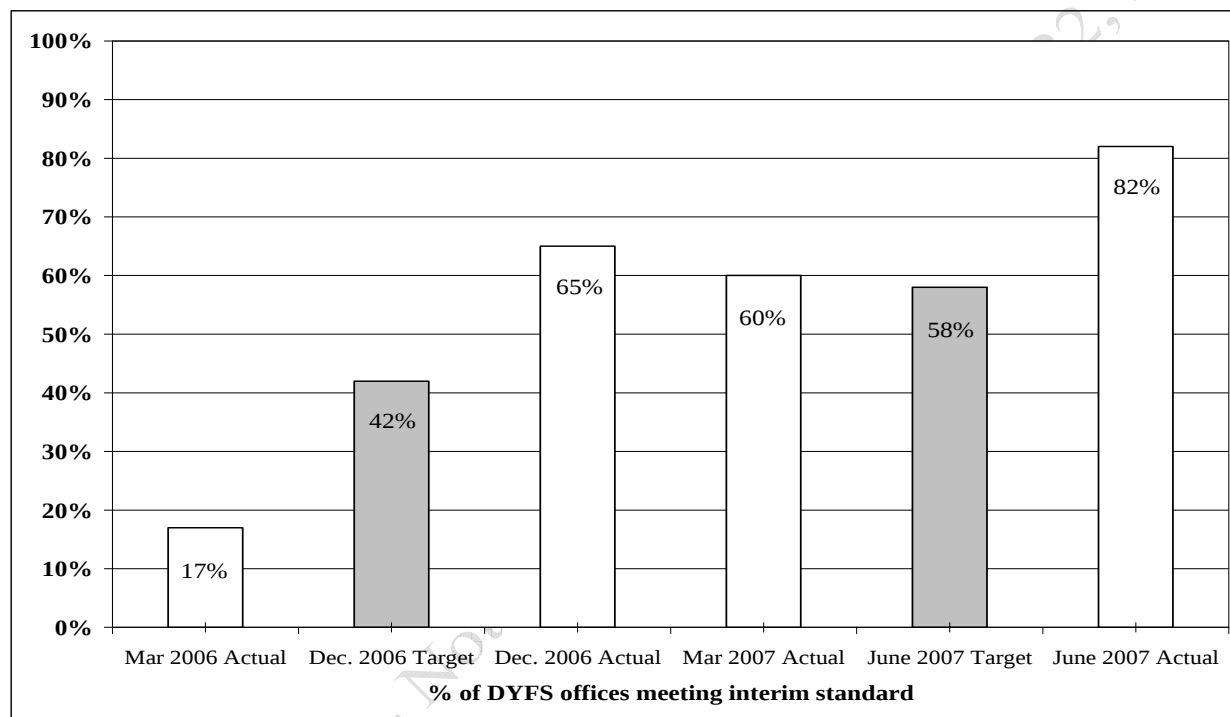
DYFS Intake staff is responsible for responding to community concerns regarding child safety and well-being. They take referrals from the State Central Registry and depending on the nature of the allegation, have 2 hours to 5 days to visit the home and begin their investigation and assessment under the MSA. They are to complete their investigation and assessment within 60 days. The caseload standard for Intake staff also has two components. One component is the number of families under investigation or assessment at any given time and the other component is the number of new referrals assigned to a worker each month. When fully implemented in Phase II, intake workers are to have caseloads of 12 families or less and 8 new referrals or less per month. (MSA, Section III.E). The interim standard in Phase I is caseloads of 15 families or less and 10 or fewer new referrals per month.

As with the Permanency caseloads, the Phase I standard for Intake staff is based on average caseloads in an office and by December 2008, the goal is for 74 percent of all offices to have average caseloads for intake workers that meet the two-pronged standard. As of June 2007, 58

percent of all local offices were to have average caseloads for Intake staff of 15 families or less and 10 or fewer new referrals per month. (MSA, Section II.E.10)

As displayed in Figure 3, the State has exceeded this second target with Intake staff since December 2006. As of June 2007, 82 percent of the offices had average caseloads for Intake staff at or below the standard. This data was independently verified by the Monitor as part of the previously described process. Appendix A contains a table with supporting detail for each office.

**Figure 3:
NJ DCF DYFS Intake Worker Caseloads***



Source: New Jersey Department of Children and Families, Office of Policy and Planning

*Interim Intake worker caseload standard is 15 families and 10 new referrals per month.

4. DCF exceeded the June 2007 caseload target for average caseloads of Adoption staff.

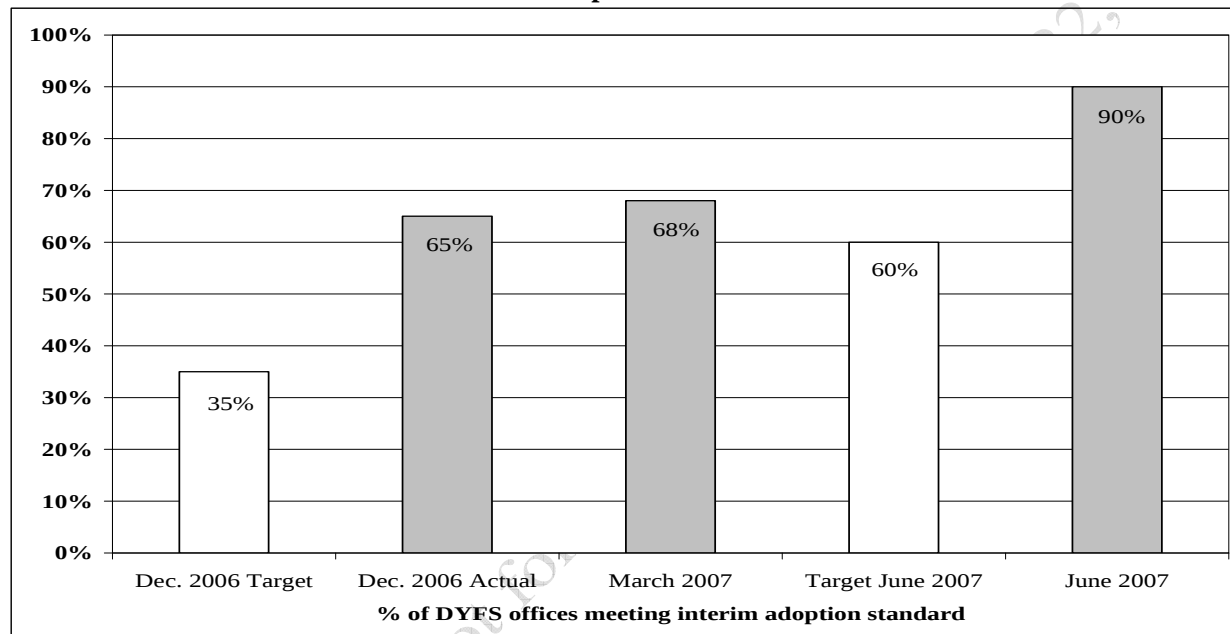
Adoption staff are responsible for moving children to permanency by developing adoptive resources and performing the work needed to finalize adoptions. The MSA requires the State to assign children with a goal of adoption to designated adoption workers (except in the small number of cases where there is a previously established relationship with a permanency caseworker or other acceptable reason) (MSA, Section II.G).

As with the Permanency caseloads, by June 2008, the goal is for 95 percent of offices to have average caseloads for Adoption staff of 18 or fewer children with a subset of 60 percent of the offices achieving average caseloads of 15 or fewer families (MSA, Section II.G.18). As of June

2007, 60 percent of local offices are to meet an interim standard of average caseloads for Adoption staff of 18 or fewer children (MSA, Section II.G.13).

As displayed in Figure 4, the State far exceeded the June 2007 target with 90 percent of the offices having average caseloads for Adoption staff at or below the interim standard. This information was verified by the Monitor using the previously described approach. Appendix A contains a table with supporting detail for each office.

Figure 4:
NJ DCF DYFS Adoption Worker Caseloads*



Source: New Jersey Department of Children and Families, Office of Policy and Planning

*Interim Adoption caseload standard is 18 or fewer children.

Note: Prior to December 2006, adoption staff and cases were included in permanency caseload data.

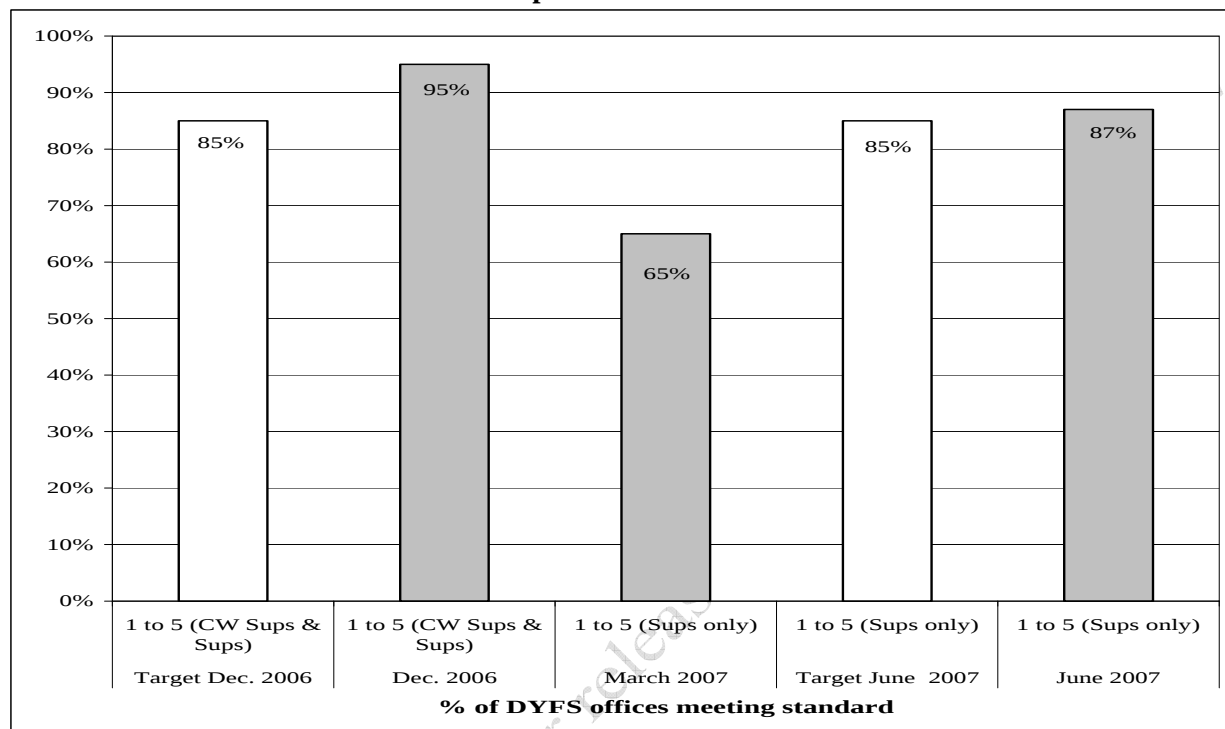
5. DCF exceeded the benchmark for ratio of supervisors to workers.

Supervision is a critical role in practice with children and families and the span of supervisor responsibility should be limited to allow more effective individual supervision of workers. Therefore the MSA established standards for supervisory ratios. By December 2008, 95 percent of all offices should be able to maintain a five worker to one supervisor ratio (MSA, Section II.E.17). Like the caseload standards, this standard was to be phased in starting in December 2006. As of June 2007, 85 percent of the offices were to have sufficient supervisory staff to maintain a five worker to one supervisor ratio. (MSA, Section II.E.11)

As displayed in Figure 5, the State exceeded the second target with 87 percent of the offices having 5 to 1 supervisory ratios. This ratio is calculated using only the SFSS2 staff.⁵

Appendix A contains a table with supporting detail for each office, including the number of supervisors in each level.

**Figure 5:
NJ DCF DYFS Supervisor to Caseload Staff Ratios**



Source: New Jersey Department of Children and Families, Office of Policy and Planning

⁵ The Department has two supervisor levels. One level, Supervising Family Service Specialist 2 (SFSS2), is a direct frontline supervisor position responsible for supervising a casework unit. The field refers to this position as “supervisor” or “unit supervisor.” The second level is Supervising Family Service Specialist 1 (SFSS1). In the field, this position is referred to as “Casework Supervisor.” In general, five unit supervisors typically report to a Casework Supervisor. Prior to the March 31, 2007 reporting, DCF had combined both casework supervisors and frontline supervisors in the generic category of “supervisors” in the reported supervisor ratios. The web site posting now reflects the effect of disaggregating the supervisors. For purposes of meeting the Modified Settlement Agreement Standards of Supervisory ratios, only the number of unit supervisors (SFSS2) will be used going forward.

6. *Local Office Insights and Comments about Caseloads*

In-person and telephone interviews with casework staff, supervisors and area and local office management confirm that caseload sizes have substantially improved since March 2006 and highlight caseload reduction as an area of significant progress. Even those offices that were not yet in compliance with all or some of the caseload standards have experienced notable reductions. When asked about the largest individual caseloads in June 2007, local office management indicated some Permanency and Intake workers might have had caseloads as high as 18 to 28 families. Some individual adoption caseloads were as high as 20 children in some offices. Local office personnel also cited individual caseloads as low as 13 families and adoption caseloads with no more than 9 or 14 children. Staff at many of the local offices visited commented on caseloads being more manageable, producing less stress and allowing more contact and better practice with children and families. Likewise, those workers who continue to have higher caseloads report that they don't have time "to do what we're supposed to do."

B. Training

As shown in Table 6, the State met each of its MSA obligations for training during this monitoring period. Given the large numbers of new staff added to the workforce, this has not been an easy accomplishment. The state's Director of the New Jersey Child Welfare Training Academy (NJCWTA) resigned during this period. Until a new permanent Director is selected, the NJCWTA is being managed by DCF's Director of Administration.

Highlights of the Department's work this monitoring period in training are:

- Modification of the Pre-Service training to incorporate principles from the Case Practice Model;
- All newly promoted supervisors have taken Supervisory Training;
- All staff were trained on concurrent planning;
- All case carrying staff, supervisors and others (5,025 staff) were trained on the State's new automated Child Welfare Information System, New Jersey SPIRIT; and
- Nearly all existing staff members were trained in Intake and Investigations; new staff members will henceforth receive Intake training as part of Pre-Service training.

Table 6:
DCF Child Welfare Training Academy MSA Compliance Data
January 1, 2007 – June 30, 2007

Training	Settlement Commitment Description	# of Staff Trained in 2006	# of Staff Trained in 1st 6 months 2007	Total # of Staff Trained (Cumulative)
Pre-Service	Ongoing: New caseworkers shall have 160 class hours, including intake and investigations training; be enrolled within two weeks of start date; complete training and pass competency exams before assuming a full caseload.	711	412	1,123
In-Service	Ongoing: Training on concurrent planning; may be part of 20 hours in-service training by December 2007.	2,522	729	3,251
Investigations & Intake: New Staff	Ongoing: New staff conducting intake or investigations shall have investigations training and pass competency exams before assuming cases.	0	650	650
Investigations & Intake: Prior Staff	Between September 2006 and June 2007, staff currently responsible for intake and investigations who has not received investigations training shall have that training.	150	DYFS 769 IAIU 64	DYFS 919 IAIU 64
Supervisory: New Supervisors	As of December 2006 and ongoing, newly promoted supervisors to complete 40 hours of supervisory training; pass competency exams within 3 months of assuming position.	0	114	114
Supervisory: Prior Supervisors	By June 2007, supervisors promoted before December 2006 who had not previously received supervisory training shall have 40 hours of that training and pass competency exams.	44	138	182
Adoption Worker	As of December 2006, adoption training shall be provided for adoption workers.	91	140	231
New Jersey SPIRIT	New Jersey SPIRIT training for all case carrying workers by May 2007; may be part of 20 hours in-service training.	0	5,025	5,025

Source: DCF data, verified by Monitor August 2007.

1. *Pre-Service Training*

- a. *DYFS revised its Pre-Service training to incorporate the new Case Practice Model and continues to provide a minimum of 160 hours of classroom training to newly hired staff.*

The New Jersey Child Welfare Training Academy (NJCWTA) revised its Pre-Service training curriculum in this monitoring period to reflect the newly developed CPM. (MSA, II B.1.a) The new Pre-Service curriculum, entitled Family and Community Engagement Training, contains concepts, strategies and skills building exercises on engaging families and communities. The Department will be working with consultants to review these initial modifications to ensure they are consistent with changes to its In-Service and other training curricula and New Jersey's new CPM is the organizing principle of all training offerings. The Monitor will be involved in this change process, and will evaluate revisions to the Pre-Service and the In-Service training curricula in upcoming monitoring periods.

The Pre- Service curriculum as revised consists of 162 hours of training, 27 classroom days and 21 field instruction days. Figure 7 below shows the 11 modules that comprise the revised curriculum.

Figure 7:
New Jersey Pre-Service Training Curriculum

	Orientation – Welcome to DCF
Module 1	Understanding Child Welfare in New Jersey
Module 2	Taking Care of Yourself
Module 3	Computer Applications
Module 4	Self-Aware Practitioner
Module 5	Focusing on Families: From Screening to Closing
Module 6	Engagement and Interpersonal Helping Skills
Module 7	Child Development and Identification of Child Abuse and Neglect
Module 8	Assessing Strengths and Needs of Families
Module 9	Facilitating Change
Module 10	Structured Decision Making (SDM)
Module 11	Simulation

Source: NJCWTA as of June 2007

- b. All new case-carrying workers are enrolled in Pre-Service training within two weeks of their start date (MSA, II.B.1.b).*

During the monitoring period, the Department hired 392 staff as Family Service Specialists. These 392 staff members as well as staff hired at the end of 2006⁶ were required to take Pre-Service training. A total of 412 staff was enrolled in Pre-Service training between January and June 2007. The Monitor reviewed training logs of Pre-Service training participation for the months of January 2007 to June 2007 and cross-referenced human resource records with rosters of participants in Pre-Service training sessions conducted in the same period. This review established that 94 percent of Department trainees are enrolled in Pre-Service training within two weeks of their start date as required by the MSA. The Monitor's discussions with staff at various local offices throughout the State reveal that the Pre-Service training is generally well received.

- c. DYFS revised and standardized its competency exams to better assess when new workers are ready to assume a full case load (MSA, II.B.1.c).*

The MSA requires the Department to have standardized exams to assess worker competency before assuming a full caseload. Trainees take competency exams associated with each module of the Pre-Service training. In the first Monitoring Report, the Monitor recommended the Department revise its protocol for certifying when a trainee can assume a full case load. The NJCWTA developed a comprehensive tool to make this assessment, and has begun implementing it during this monitoring period. The new tool allows Field Training Unit Supervisors and others to more effectively evaluate a trainee's strengths and weaknesses, and make suggestions for areas of improvement. The Department will continue to evaluate whether the new assessment tool meets its need to effectively evaluate the competence of a new trainee.⁷

2. In-Service Training

- a. The State has trained its staff on New Jersey SPIRIT as part of the requirement to begin an In Service training program (MSA, II.b.2.a).*

At the conclusion of the last monitoring period, the parties agreed to permit the Department's training of staff in New Jersey SPIRIT to satisfy the MSA requirement to institute In-Service training by April 2007. As discussed on page 29 of this Report, the Division began training on New Jersey SPIRIT in April 2007 in Ocean County and with web-based training throughout the State. By the end of August 2007 the State had trained 5,025 staff on its new information technology system, including all of its 2,026 workers and 500 supervisors.

⁶ 412 staff includes 20 staff hired at the end of 2006 who were required to take Pre-Service training within two weeks of their start so were trained in the current monitoring period.

⁷ The Monitor recommended that this instrument include a scaled grade rather than a pass/fail assessment in order to assist in evaluating staff development needs. The Department agreed re-evaluate this recommendation after gaining some initial experience with the assessment process.

- b. *DYFS has provided in-service training on concurrent planning for existing staff (MSA, II.B.2.d).*

The focus of concurrent planning is the development of permanency plans that incorporate reunification and long term planning in the event reunification is not possible. The Department has implemented In-Service training on concurrent planning through its contract with Rutgers University School of Social Work (Rutgers). In response to staff requests, the Department conducted the Concurrent Planning training in a variety of different locations and in local offices. As of June 30, 2007 the NJCWTA had recorded a total of 3,251 staff that Rutgers had trained. The Department reports all existing staff has now been trained on concurrent planning. The Monitor cross referenced a random sample of 37 staff transcripts with human resource data and found that all existing staff had taken Concurrent Planning training.

The Monitor attended the Department's Concurrent Planning training in Hunterdon, N.J. Staff were engaged and responded with enthusiasm to the training. Particularly useful to staff, as reported to the Monitor during site visits, was the consultant's use of case handlers' real cases (without names) as learning tools to construct permanency plans and tasks. Moving forward, the Department will need to ensure that the presentation and subject matter of the Concurrent Planning training conforms with more consistency and specificity to the new CPM.

3. *Intake and Investigations*

- a. *DYFS has trained nearly all existing staff members responsible for Intake and Investigations and has incorporated Intake into its Pre-Service training for new staff (MSA, II.B.3.a,b).*

As indicated in Table 6 above, the NJCWTA reports that it trained 1483 DYFS staff on Intake and Investigations, including 64 IAIU investigators between January and June 2007. Now that training of existing Intake staff is complete, all staff newly responsible for Intake and Investigations will be trained in these skills as part of their Pre-Service training. The Monitor cross referenced a random sample of 84 staff transcripts with human resource data and concluded that the State has complied with the MSA.

- b. *DYFS developed and implemented a competency examination for all workers performing Intake and Investigations, and has incorporated that material into its Pre-Service testing (MSA, II.B.3.a).*

Based on pilot testing of competency exams with Intake and Investigations staff, the NJCWTA developed a competency examination for staff that complete the 3-day Intake and Investigations course. The Monitor has taken and reviewed the exam. Starting in January 2007, the NJCWTA incorporated this exam into its testing of Modules 6, 9 and part of 8 of Pre-Service training, which cover Intake and Investigations. Supervisors

review the results of the competency exams and are notified if a trainee fails the exam after taking it a second time. The Department reports that there have been no second failures of competency exams.

4. *Supervisory Training*

Table 8:
Supervisory Training: Total Number of Supervisors
Trained January 1, 2006 – June 30, 2007

Category	# Trained	Percent of Staff Needing Training*
Supervisors Appointed Pre- 12/06		
- Trained in 2006 - Trained by 6/30/07 - Scheduled for Training	44 138 5 187	24% 74% 3% 100%**
Supervisors appointed 1/1/07 – 06/30/07	114	100%

Source: DCF, verified by Monitor

*Data excludes two supervisors on extended leave.

**Percentages add to greater than 100 due to rounding.

- a. 100 percent of newly promoted supervisors have taken NJCMTA's Supervisory Training; 93 percent had taken 40 class hours within 3 months of their promotion.(MSA, B.II.4.b,c).

Newly-appointed supervisors

DYFS reports that 141 new supervisors were appointed during the monitoring period, 114 of whom required supervisory training. The remaining 27 appointments had prior experience and training as supervisors. To verify this data, the Monitor cross referenced a random sample of 15 staff transcripts with human resource data and concluded that the State has met the MSA requirement. It will be important for the Department to schedule those supervisors who took their supervisory training in 2004-2005 for training on the new CPM as soon as possible.⁸

⁸ Based on the Monitor's random sample review of 15 staff, 4 staff took supervisory training in 2005 or earlier.

Supervisors appointed before December 2006

As indicated in Tables 6 and 8, the Department reports that 138 supervisors appointed prior to December 2006 have taken supervisory training during this monitoring period; 5 supervisors have not yet completed supervisory training but have been scheduled. The Monitor cross referenced a random sample of 21 staff transcripts with human resources data and concluded that the State has met the MSA requirement. It will be important for the Department to schedule those supervisors who took supervisory training in 2004-2005 for training on the new CPM.⁹ Further, the Monitor's independent review of class rosters for supervisory training against human resources reports of newly appointed supervisors indicates that NJCWTA is providing supervisory training within 3 months of the supervisor's promotion.

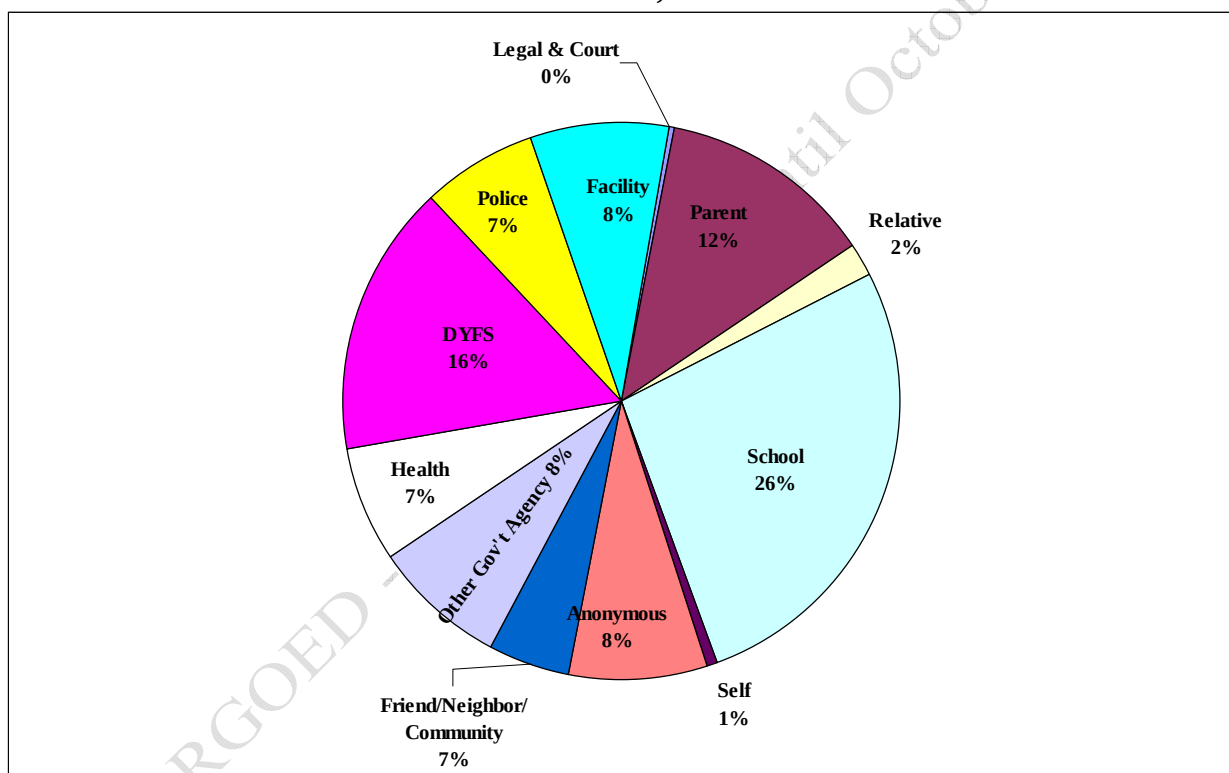
At the conclusion of the training, supervisors are expected to pass competency examinations. During the last monitoring period, the Monitor reviewed samples of portions of supervisory competency examinations of varying quality and was not able to satisfactorily assess how the results were evaluated and used. The Monitor has recommended and is in discussion with DCF about the development of a more structured and standardized assessment of supervisory skills and the use of a more clearly defined protocol for how the results of the exam are used to develop individual staff competency. The Monitor will reevaluate this expectation in the next six-month period.

⁹ Based on the Monitor's random sample review of 21 staff, 3 staff appear to have received supervisory training in January 2003.

C. Institutional Abuse Investigations Unit (“IAIU”)

The Institutional Abuse Investigations Unit (IAIU) is responsible for investigating allegations of abuse and neglect in any out-of-home care setting. This includes, but is not limited to foster care placement settings. It also includes correctional facilities, detention facilities, treatment facilities, schools (public or private), residential schools, shelters, hospitals, camps or day care centers that are licensed or should be licensed, Resource Family homes and registered family day care homes.¹⁰ In the first half of 2007, IAIU received 1730 referrals. Figure 9 displays the source of these referrals.

Figure 9:
IAIU Source of Referrals
January – June 2007
Total = 1,730



Source: DCF September 2007

¹⁰ DYFS (7-1-1992). IAIU Support Operations Manual, III E Institutional Abuse and Neglect, 302.

1. *The IAIU achieved the June 2007 target for timeliness of IAIU Investigations.*

The purpose of IAIU's investigative effort is to determine whether children in out-of-home care settings have been abused or neglected¹¹ and to ensure their safety by requiring corrective actions to eliminate the risk of future harm. By June 2007, IAIU was expected to complete 80 percent of its investigations within 60 days of referral. (MSA, III.I.3)

On June 30, 2007, the State reported that IAIU had 373 open investigations, 332 (89%) of which had been open less than 60 days. These open cases reflect investigations still in process based on May and June referrals. The remaining 11 percent had been open for more than 60 days. According to the State, a significant number of the cases that were open more than 60 days involve criminal investigations and the IAIU investigations were on hold until staff are given clearance from law enforcement or prosecution to proceed.

In addition to the month-end report supplied by the State, the Monitor reviewed randomly selected IAIU daily work-flow reports for ten days between July 1 and August 31, 2007. The trend shown in these reports indicates that IAIU was able to maintain the performance achieved on June 30, 2007 throughout July and August for all open reports. The proportion of cases open less than 60 days ranged from 83 percent to 88 percent. During the next period, the Monitor will review a selection of investigation records to further validate the State's performance.

2. *By June 30, 2007 all IAIU investigators had received appropriate training.*

All IAIU investigators are to have had specific training on the Intake and Investigations process, policies, and investigative techniques. (MSA, III.I.4.)

Sixty-four IAIU staff statewide received the "First Responder" investigative training between January and July 2007. DCF reports that this includes all IAIU supervisors.

D. Accountability through the Production and Use of Accurate Data

One of the principal accomplishments of the Department in its first year is its progress in producing timely and accurate data, making that data available to the field and to the public and increasingly using the data for planning, management and accountability. The importance of data for planning and accountability has been consistently identified as a high leadership priority. The Department has begun to move from one which could not rely on or be relied on for accurate data to one which has steadily improved its internal capacity and external communication through performance and outcome data. This has been the result of diligent work by the DCF Office of Planning and Policy and the entire DCF leadership team.

During this monitoring period, the MSA required further development of data capacity in two major ways:

¹¹ As defined by statute at N.J.S.A. 30:40C-12 or 9:6-8.21.

- The expansion of production and publication of accurate data on key indicators of system performance and
- The deployment of New Jersey SPIRIT, the State's Automated Child Welfare Information System (SACWIS).

Each of these is discussed separately below.

1. *DCF continues to expand and refine its data on performance indicators and its presentation of data to the public through its website.*

With the full deployment of New Jersey SPIRIT (discussed in more detail below), the State is poised to significantly expand the number and range of indicators on which it routinely collects and can report data. It is important to note that it will take time to achieve the expanded data reporting capacity of SPIRIT since producing accurate reports through a new data system require that staff learn to properly use the system to its full potential. Nevertheless, in this monitoring period and prior to full deployment of SPIRIT, DCF was able to continue to expand its data capacities and has made several modifications and additions that satisfy the MSA requirement to continue to expand performance reporting (MSA, II.J.5).

Important additions in DCF's Quarterly Data Update include:

- Demographic Data
 - o Children in DYFS Placement by Placement Type (with separate delineation of treatment home placements)
 - o Race/Ethnicity of Children Receiving DYFS Services (broken out by Placement and In-Home)
 - o Age and Gender of Children Receiving DYFS Services (broken out by Placement and In-Home)
 - o Age, Race/Ethnicity and Gender of Children Served by DCBHS (broken out by CMOs, and DCBHS placements)
- Caseload Data
 - o Staff with more than 30 Families
 - o Caseload Data by Local Office
- Recruiting Foster and Adoptive Families
 - o Data on Licensed Resource Homes (Kin and Non-Kin separately)
 - o Net Gain on Resource Families (Kin and Non-Kin)
- Health Care for Children in Placement
 - o Performance on Pre-Placement Assessments

Over the next year, it is the Monitor's expectation that the range of data elements that can be accurately collected and reported will substantially increase. Moreover, the monitoring requirements related to implementation of the CPM will require tracking of additional indicators and case processing functions that are not now captured. The Monitor will be working with DCF

staff to identify a timetable and plan for additional data measurement and reporting. Discussions between the Monitor, Plaintiffs and State will occur by December 2007 to reach agreement on a plan for additional data rollout beginning in 2008.

2. *Deployment of Phase II of New Jersey SPIRIT*

The MSA required the deployment of Release 2, Phase II of New Jersey SPIRIT by February 2007 (MSA, II.J.7). In the last monitoring report, the release date for SPIRIT was modified to April 2007 in order to avoid possible disruptions in end of fiscal quarter and programmatic reporting. The State then wisely decided to implement SPIRIT by first piloting the deployment in Ocean County and using the experience there to identify and fix problems that would cause major disruption if the system was initially implemented statewide. Postponement of full deployment to the summer of 2007 also enabled the Department to have sufficient time to provide initial training for each of its staff.

The decision to pilot test the release in Ocean County was a good one. The Monitor visited Ocean County during the pilot phase and heard from staff about the promises, irritations, and challenges of SPIRIT. During the pilot phase, many, many case processing and system problems were identified by users and fixed. In addition, the Department gained critical insight into the level of on-site and on-line support that would be needed for full deployment. During the pilot period, data were double entered into the new SPIRIT system and into the old legacy system so as to avoid the possibility of lost data.

New Jersey SPIRIT was deployed statewide on August 22, 2007. Department leadership approached the deployment with both careful planning and some understandable trepidation. In advance of the deployment, all staff was trained in how to log onto and use SPIRIT for case processing functions, thus meeting the MSA requirement to train all case carrying workers (MSA, II.J.8). In addition, DCF established a centralized help desk consisting of 13 employees and put 176 “production support staff” in the field throughout all 46 local offices and in central office units. The need for this kind of intensive on-site help is well documented in other States’ experiences with information system deployment. In the period between August 22 and September 5, the Department reports that the Helpdesk responded to 1905 different requests for assistance, reflecting the ongoing challenge of acclimating staff to a new system, making sure that all system problems are identified and resolved and the need for continuous implementation monitoring and training. However, implementation problems still remain and significant on-site help will continue to be needed in some areas of the State for the foreseeable future.

A second hurdle for the new system was the processing of its first set of monthly payments. This task was also approached with trepidation but it appears that the payment processing parts of SPIRIT are functioning. DCF implemented back up systems to process manual payments when needed to supplement automatic payments through SPIRIT. A hotline was established for providers and Resource Parents in the event that payments were improperly made. In the first run of payments, 85% were made automatically. In the second run at the beginning of October, less than 1% of payments required manual processing.

The deployment of New Jersey SPIRIT is a significant accomplishment. Diligent oversight and local office support will continue to be needed for the foreseeable future. Nevertheless, the implementation to date reflects the enormously hard work and attention of DCF managers and SPIRIT staff in the months leading up to and immediately upon deployment. The real test of the system's functionality will occur over the next six months to a year as workers get used to and are required to use the system and as managers learn to use SPIRIT and its data for tracking individual cases and for overall system and performance monitoring. The Monitor will more fully assess New Jersey SPIRIT implementation in the next six months.

IV. CHANGING PRACTICE TO SUPPORT CHILDREN AND FAMILIES

A. Implementing the New Case Practice Model

The Department faced significant challenges in communicating and disseminating the new Case Practice Model (CPM) to the field, but has responded to this challenge with a detailed, thoughtful and ambitious CPM Implementation Plan. The Plan incorporates broad and deep strategies that seek to use the CPM as a dynamic tool to frame and guide future work. The conceptualization of this Plan took time to develop, and the Monitor has consistently taken the position that rather than rush through a truncated version of a CPM training to meet the MSA timeframes, the State should approach the execution of the CPM Implementation Plan as a longer term and intensive process. The parties have agreed, therefore, to extend the deadline to complete staff training and mentoring on the CPM until the end of 2008 with intensive work beginning in October 2007 and continuing over the next 15 months.

In this monitoring period, the MSA (II.A.3-4) required the State to:

- *Begin to implement the CPM*
- *Identify the methodology to track successful implementation of the CPM;*

In reporting on the CPM for Phase I of the MSA, the Monitor is charged with focusing “*primarily on the quality of the Case Practice Model and the actions taken to implement it.*” (MSA, II.A.5).

After its finalization in December 2006, the work of planning for implementation of the CPM began. With the Monitor’s support, the Department took the necessary time to lay the foundation for a healthy and functioning department before it turned its attention to planning for implementation of the new CPM. These foundational steps included:

- Hiring large numbers of case-carrying staff to meet the needs of each office;
- Training staff, including Pre-Service, Investigatory, Supervisory, and New Jersey SPIRIT;
- Compliance with caseload standards to meet the MSA;
- Setting challenging adoption finalization targets;
- Reorganization of Resource Family licensing and recruitment units to meet aggressive new family recruitment targets.

Once these critical elements of a healthy system were underway, the Department began to focus on meeting its mandate to implement the CPM. Site visits reveal that some offices have begun to communicate and anticipate the change of practice envisioned in the CPM while others have not. In the Monitor’s site visits, many staff however expressed excitement about a new vision for the agency and the new role the agency will be expected to take in the community and in partnership with families and community stakeholders. Other staff had little to no knowledge of the Department’s CPM and its expectations for practice.

As described in detail in the Department's CPM Implementation Plan dated September 2007 (Appendix B), the first formal step towards implementation of the CPM began with a series of focus groups of staff, stakeholders and families. Key Department leadership, including Area Directors and Assistant Area Directors, then met in a two day retreat devoted to CPM implementation. Each division and level of DCF had an opportunity to express what it needed in order to successfully implement the new CPM, and leadership had the opportunity to hear, analyze and reflect upon those needs. The Monitor attended this retreat as an observer.

The Department's CPM Implementation Plan articulates a six prong approach to system change:

1. Leadership Development
2. Statewide Readiness Strategy
3. Immersion
4. Service Development
5. Continued Focus on the Fundamentals
6. Enhanced Planning Between DYFS and DCBHS

Each prong is important and necessary for the overall reform effort.

1. Leadership Development

Sound reform requires a cultural change that begins with leadership engagement and development. Executive leadership made a critical determination early on to involve Area Directors, Assistant Area Directors—and later office managers—in the decision-making and leadership of the reform effort. This is not easy to do given the size of New Jersey's child welfare system, and DCF should be commended in taking this step even before it could reap any direct benefits. In addition to regular meetings and better communication strategies generally, Central Office made critical data available to each director and manager for the first time and supported and encouraged directors and managers to make management decisions based on this data. The next step is a Leadership Summit to take place in October 2007 with key staff from DYFS, DCBHS, Prevention and Central Operations, DCF Executive Management and the Child Welfare Policy and Practice Group (CWPPG), a consultant group which was an important innovator and leader in Alabama and Utah's model child welfare reform efforts.

2. Statewide Readiness Strategy

By December 2007, the Department will have developed training curricula consistent with the CPM and will begin to intensively provide additional training to existing staff. Concurrently, DCF will again review and modify its Pre-Service curriculum to ensure consistency and to enhance necessary skill development. This work will be shared with the New Jersey Partnership for Child Welfare Program, a partnership of four regionally diverse schools of social work facilitated by Rutgers University School of Social Work. The chosen curricula will cover the principles of family engagement, while giving the staff practical tools for beginning to practice key principles.

Training staff on the CPM is a formidable task. DCF estimates that in 2008 at least 4000 case carrying staff will need to be trained for a minimum of 40 hours. Over 1,100 days of training—assuming a class size of 25—will need to be scheduled and delivered. To accomplish this task, the Department has developed a matrix relying on regional training teams that will include:

- the DCF Child Welfare Training Academy (NJCWTA);
- the University Training Consortium, facilitated by Rutgers University School of Social Work;
- a DYFS central office CPM technical assistance group;
- local providers, such as local CMOs who have experience and proven track records of family engagement and family centered practice; and
- consultant team members (CWPPG).

The regional teams will be deployed sequentially across the State as explained below and in depth in the Implementation Plan. The Department will utilize a train the trainer model so that, at the conclusion of the consultant's work with the State, the regional teams can seamlessly continue training the workforce as needed.

3. Immersion

At the same time the regional teams are training the statewide workforce, the Department will work more intensively with staff at carefully chosen sites to more fully develop new skills and practices. As discussed in detail in the Implementation Plan, beginning in January 2008, DCF will launch this intensive immersion process in four pilot counties. This process will provide intensive training, mentoring, and coaching for staff conducted by CWPPG and DCF technical assistance partners. It will also involve an examination of services available to families and, equally important, the development of an infrastructure to schedule and facilitate family team meetings. The Monitor heard from all levels of staff at all sites that a lack of appropriate space hindered their ability to provide families with proper, dignified team meetings and visits. This issue will have to be addressed in the immersion sites and hopefully will yield creative solutions including community-based options for these sites and for other parts of the State.

The intensive coaching and mentoring of staff envisioned by the Implementation Plan takes time to implement correctly and to seed the foundation for lasting change. The process of developing immersion sites is expected to take approximately seven months to complete. DCF has committed to an evaluation process to determine efficacy and the Monitor will be a partner in that process.

As the immersion sites develop, local office leadership will conduct training and focused coaching to ready the rest of the workforce. Advanced case practice training and advanced intensive coaching will be made available to staff across the state as local training capacity and technical assistance are developed by the second half of 2008. The Department will then stagger advanced training and coaching as needed.

4. Service Delivery and Budget Transparency

During site visits, the Monitor heard from staff about the need for more services that better align with the needs of children and families and with the vision of the CPM. Without a sufficient quantity and quality of services, a case practice model will fail; staff cannot successfully engage with families if they cannot offer them the services they need. Family teams cannot successfully assist families unless willing, trained and capable partners are members of the team.

Over this past year, DCF has begun investing in service capacity and as discussed later in the report, has been using contracts with private providers as a means to expand local capacity for services to children and families. These include investments in three pilot sites implementing new differential response systems as well as resources for flexible funds to support family services, visitation support services, family success centers, substance abuse treatment, domestic violence treatment services and other service enhancements.¹² The State is also actively implementing a Strengthening Families child abuse prevention initiative which seeks to build services and supports around families through early care and education programs.

For the first time in the history of the Department, DCF is implementing a strategy of child and family-based budgeting of investments and services *by immersion site*. In order to create such a budget, the Department will first inventory, across all its divisions, the public and private investments it makes in each of the sites where the CPM immersion is underway. This is an innovative undertaking that will likely deliver critical information to the State to assist in developing more family centered service delivery models and for future resource planning and development.

5. Continued Focus on Fundamentals

In its CPM Implementation Plan, the Department stresses the importance of continuing to keep its attention on the fundamentals of the reform, while simultaneously rolling out major new initiatives such as the CPM. By a continued and simultaneous focus on the fundamentals, DCF will continue to devote attention and resources to actions including reducing caseloads, retaining qualified staff, improving recruitment and licensing of resource homes. Continued progress on fundamentals will require recognition, cooperation, and support from stakeholders to ensure that core elements of the reform remain center stage as the CPM implementation is underway.

6. Enhancing Planning and Coordination between DYFS and DCBHS

In 2006, the Division of Child Behavioral Health Services (DCBHS) held a series of focus groups with system partners, including Family Court judges, Mobile Response and Stabilization Services, Family Support Organizations, Youth Case Management (YCM), and Care Management Organizations (CMO) to discuss how to better serve families with the behavioral health system. A consistent message was that children's behavioral health needs must be better integrated into the daily work of the Department.

¹² The monitor intends to review the use of flexible funds in future monitoring reports.

In response, DCF will pilot reforms to unify case practice in DYFS and DCBHS in up to three counties in Spring 2008. The purpose of the pilots will be to test the elimination of dual case management within DCBHS, between YCMs and CMOs, and between DCBHS and DYFS by transitioning youth to the most appropriate entity. DYFS will be the lead on all cases that involve safety and permanency, but will continue to be supported by DCBHS.

Another component of the plan is DCBHS case management entities will deploy clinical staff into DYFS local offices to provide technical and other assistance to DYFS staff. DCBHS will also assign staff to DYFS Area Offices to become part of the team that works to return youth from out-of-home care. Taken together, these innovations are designed to improve the coordination of services within the Department and to better serve children with behavioral health needs. The Monitor will be looking closely at these improvements and the progress the Department anticipates as a result of them in the next monitoring period.

7. Implementation Plan Evaluation

The MSA requires the Department and the Monitor to track the implementation of the CPM going forward. Specifically, during Phase I the Monitor must evaluate and report “*primarily on the quality of the Case Practice Model and the actions taken to implement it.*” (MSA, II.A.5). The Monitor strongly supports the Department’s decision to track the implementation of the CPM through Quality Service Reviews (QSRs). The Department will also be collecting longitudinal outcome data such as the data developed for DCF by the Chapin Hall Center for Children. Quality Service Reviews will be phased in over time according to a schedule to be developed by DCF and the Monitor. The schedule will phase in QSRs throughout the State, beginning with the immersion sites. DCF offered suggestions for monitoring the State’s CPM implementation in its CPM Implementation Plan. The Monitor will take these suggestions into consideration in developing, with DCF and Plaintiffs, a comprehensive method of measuring whether the CPM has successfully taken hold in New Jersey.

B. Improving Results for Permanency and Adoption

Over the last several months, DCF has dramatically increased its efforts to move more children out of foster care, whether through safe reunification, placement with an adoptive family or placement in the permanent legal custody of an appropriate kinship family. The MSA requires DYFS to engage in several activities to promote permanency. Adoption units have been reconstituted and appropriate cases have been assigned to these units. Specific targets were set for each local office to ensure that DYFS meets the MSA requirement of 1400 adoption finalizations. Further, in an effort to change practice at the front end of the child welfare system, DYFS developed and implemented the Concurrent Planning “Enhanced Review” Model in ten demonstration sites. Concurrent planning is a concept employed by jurisdictions throughout the country in which workers assist children who come into out-of-home placement to reunify with their family of origin safely and quickly, while simultaneously pursuing alternative permanent placements for these children should reunification efforts fail. DCF describes concurrent planning as “a child-focused practice meant to minimize placement trauma and repetitive moves

for children entering care.”¹³ As DCF prepares to implement the CPM statewide, much planning and coordination will be necessary to help offices and workers understand that concurrent planning is a critical part of the CPM. Concurrent planning practice will “roll out” statewide with the implementation of the CPM.

It is also noteworthy that DCF has organized its policies and practices to heighten attention to identifying permanent homes for older adolescents in its care. Specifically, in accordance with the MSA, DCF targeted its efforts to find permanent homes for 100 youth in care who have been waiting the longest for a permanent family. DCF also launched a Youth Permanency Project to identify permanent, life-long connections for youth who are transitioning out of the foster care system.

1. Through adoption units, DCF continues to finalize adoptions at a steady pace.

As required by the MSA (Section II.G.12), DCF reports that all local offices have transferred appropriate cases to the adoption units. Reportedly, 95 percent of all adoption cases are now with adoption workers while 5 percent of cases remain in permanency units (due to an acceptable exception such as a previously established relationship with a caseworker). From January 2007 to June 30, 2007, DCF finalized 634 adoptions.¹⁴ The MSA requires 1400 adoptions to be finalized by December 2007. (Section II.G.17). Although DCF was less than halfway to this target, the State is operating at a steady pace to reach this goal. By comparison, in 2006 DCF had finalized 586 adoptions by June and ultimately finalized 1402 adoptions by December.¹⁵

Specific adoption finalization goals now have been set for each local office based on their current placement rates.¹⁶ Currently, eight Adoption Expeditors are working in counties with high numbers of legally free children (Essex, Union, and Ocean counties) to help those offices meet these targets. Two other counties (Middlesex and Bergen) have permission to hire Expeditors should they require assistance.

¹³ DCF, Concurrent Planning, Enhanced Review Model, update prepared 1/3/2007.

¹⁴ New Jersey Department of Children and Families, Quarterly Update, September 5, 2007.

¹⁵ The monitor previously reported 1,387 children had finalized adoptions. Because adoption data takes time to verify, a few more adoptions were finalized in 2006 but not reported before the monitoring report was issued. The final number of finalized adoptions in 2006 was 1402. The Monitor believes DCF can meet the MSA requirement of 1400 cases because, according to DCF, the second half of the year is strongest for finalizing adoptions as a result of activities during National Adoption Month in November.

¹⁶ The formula for adoption finalizations each office was: 90% of children already in adoptive placements + 80% of children in foster homes with an adoptive interest + 70% of children in kin homes with an adoptive interest. Additionally, 30% of children for who termination of parental rights process is underway will achieve the completion of litigation and finalization of adoption.

2. DCF launched 10 Concurrent Planning Enhanced Review demonstration sites and has begun to assess their progress through the use of the Adoption Process Tracking System.

The MSA requires DCF to improve concurrent permanency planning and adoption practice (Section II G.1 and 2). DCF began implementation of the concurrent planning process in ten demonstration sites this year. DYFS staff in these sites have received specific training on this new model and follow-up coaching focusing on developing appropriate case plans for families. In June 2007, a concurrent planning handbook for DYFS staff was completed. This handbook describes the concurrent planning process and provides checklists and other documents that help guide a worker's decision-making process. Additionally, the Deputy Attorney Generals who handle DYFS cases in these demonstration sites have received training and have begun to participate in the 10-month review hearings where a decision is made to provide more time for reunification with parent(s) or to recommend the termination of parental rights (TPR).

Currently, DCF is relying on the Adoption Process Tracking System to evaluate compliance with the concurrent planning model. The tracking system records 5 and 10 month reviews, the timeliness of case transfers to adoption workers, and the termination of parental rights. It is the responsibility of the Area Concurrent Planning Specialists to ensure that case information is entered promptly into the tracking system. As concurrent planning expands statewide, the measurements currently captured by the adoption process tracking system will be captured by NJ SPIRIT and/or Safe Measures.

In the first six months of implementing the concurrent planning process, the demonstration sites have experienced a not unexpected variety of successes and challenges. In most offices, staff were able to complete the majority (90% or higher) of 5 month reviews within the necessary time frame. However, offices varied more dramatically in their ability to successfully complete the 10-month reviews. Seven offices had timely 10 month reviews for 75 percent of their cases or higher, while two offices held timely reviews in less than 40 percent of their cases. The prompt transfer of cases (within 5 days) to an adoption worker also varied by office. Five offices achieved the timely transfer 100 percent of the time, while 4 offices had rates that ranged from 11 to 50 percent. Finally, a total of 45 cases were supposed to have TPR petitions filed within 45 calendar days, but this goal was only achieved in 14 cases (31%).

3. Services to support reunification have been expanded.

Recognizing the importance of providing services to parents whose children are in out-of-home care, DCF awarded \$6 million in contracted services for family engagement and therapeutic visitation across the State—\$575,000 of this award was dedicated to private agencies to work with the 10 demonstration sites to facilitate family engagement meetings. Additionally, as required by the MSA, the State amended its policies and procedures to allow for the use of flexible funds to support family preservation and reunification efforts, increasing the amount of expenditures on each parent annually and extending the time period for the use of these funds (Section II.C.3). The FY 2008 budget includes an additional \$1 million for flexible funds. Given the heightened effort to work with families, the Monitor recommends that DCF continue to track

and report on reunification rates as part of the concurrent planning process and on the use of flexible funds to support family reunification.

4. DCF has begun implementing permanency strategies for older youth in care.

- a. *DCF is making progress to identify permanency options for youth who are legally free for adoption and have been in care for long periods of time (“100 Longest Waiting Teens”).*

Specific attention has been paid over the last six months to finding permanent homes for youth in the foster care system who are legally free with adoption as their permanency goal. The total number of legally free youth awaiting adoption has declined from 2278 in January 2006 to 1939 in January 2007 and was 1740 in August 2007. Slightly more than 400 legally free children require DYFS to locate a permanent home for them—through the work of “Impact” Recruiters and select home adoption staff. In January 2007, five Adoption Impact Recruiters were hired and trained to find permanent connections for youth who have been identified as part of the “100 Longest Waiting Teens.” These workers, skilled in working with adolescents, are supervised by the Statewide Adoption Recruitment Specialist in the Office of Adoption Operations. Over the last six months, they have received specific training on working with adolescents who have been in care for extended periods of time and on strategies for recruiting appropriate families for these youth¹⁷.

According to DCF, the 100 youth who have been waiting the longest for permanent homes and are being targeted by the Adoption Impact teams are primarily African American (89 youth), with a little over half of them boys (59 boys and 41 girls). Most of the youth are between the ages of 14-16 (72 youth)¹⁸, and 70 percent of them live in highly structured group homes, treatment homes, or residential settings. The median length of stay for youth in out-of-home care is eight years (with the length of time ranging from 3 years to 16 years). These youth have many educational and mental health challenges related to being in care for so long and experiencing multiple placement moves.

Adoption Impact Recruiters have employed many strategies for finding potential permanent placements for these youth. Recruiters have “mined” the case files of youth in care and had conversations with the youth about individuals to whom they feel connected. Workers have tracked down family members or family friends to assess them as possible permanent caregivers. Some youth have chosen to participate in the Heart Gallery, a recruitment strategy where professional photographers take pictures of children in need of adoptive homes. 115 youth were featured in the Heart Gallery this year; 29 are teens who are part of the “100 Longest Waiting” group. Eight other children have had other media exposure including newspaper articles and television appearances on

¹⁷ This training was also offered to local office recruitment and adoption staff.

¹⁸ There are some latency age youth who are part of a sibling group that includes an adolescent.

Wednesday's Child. DCF is also in the process of developing a Speaker's Bureau of teens who can talk to other youth and potential adoptive parents about the need for homes for older youth in care.

DCF is adapting policy and practice to be flexible and responsive to meeting the needs of youth. For example, DCF recognizes that many foster parents might be willing to serve as a permanent resource for older youth. However, foster parents currently receive a foster care board rate until the child is 21, but if they were to adopt the child, the adoption subsidy only continues until the child is 18. As a result, DCF is working to identify and eliminate barriers to extending adoption subsidies to age 21 for youth who are adopted after the age of 14.

Table 10 summarizes the progress made by the Adoption Impact Teams in finding permanent homes for the "100 Longest Waiting Teens."

Table 10:
Progress on Permanency for "100 Longest Waiting Teens"

Permanency activity	Number of youth benefited
Finalized Adoption	1
Selected Home Adoption Placements	2
Foster Home Adoption Plan	7
Relative Adoption Placement	2
Relative Adoption Placements Pending	9
Kinship Legal Guardianship Plan	2
Adoption Home study in progress	2
Reconnecting with Birth Parents	2
Visiting (possible placement)	2
Other possible placement identified ¹⁹	10
Match Party Matches	5

Source: DCF, Longest Waiting Teens Report, Updated 9-6-07
Children are counted in one category only.

¹⁹ "Other possible placements" is a category that encompasses viable adults who are being assessed as a possible placement for a youth.

b. DCF is launching a Youth Permanency Demonstration Project.

DCF began a Youth Permanency Demonstration Project to address the problem of too many youth leaving the foster care system without permanent connections to caring adults. This project is “designed to combine independent living and youth development skills with extensive permanency planning.” Beginning July 1, 2007, DCF will work with three agencies to support permanency planning for approximately 60-75 youth. Youth referred to these agencies will be between the ages of 14 and 21. Some youth will be “legally free” and some “not-legally free” for adoption. The agencies’ success will be measured by the number of connections established for youth. Additional outcomes to be measured include: youth-adult connections still existing one year later, 80 percent of youth with some viable means of support (employment skills), and improvements in the youth’s sense of well being.

DCF will also begin working with youth who are at risk of aging out of the child welfare system without any permanent connection, and whose goal is neither adoption nor legal guardianship. DCF has begun using the Wendy’s Wonderful Kids model to assist with youth-specific recruitment to find permanency for these youth. This model has been used on a smaller scale in a few offices and will be expanding as services to adolescents expand. Both of these projects demonstrate the State’s commitment to finding permanent homes and/or adult connections for older youth in its custody. Further, these projects are part of a larger effort to improve practice with adolescents in DCF’s care.

V. APPROPRIATE PLACEMENTS AND SERVICES FOR CHILDREN

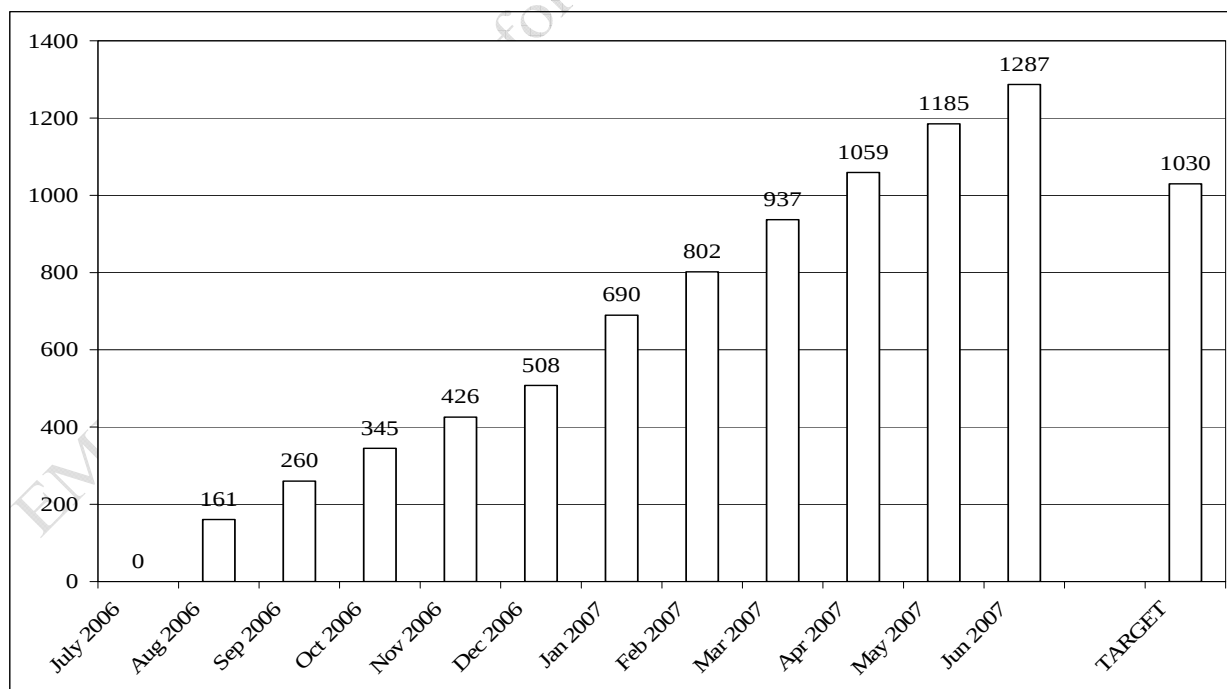
A. Resource Families

Recruitment and licensure of Resource Families has improved in the past year. Many changes have been made both structurally and substantively that have begun to bear fruit in this monitoring period. Impact Teams deployed statewide have been successful in reducing the backlog of waiting applications and the Department has licensed a record number of new homes. The Department licensed 1287 new non-kin Resource Family homes, significantly exceeding the MSA requirement to have licensed 1030 non-kin Resource Family homes by June 2007. Further, the Department now routinely achieves a net gain of Resource Homes each month, demonstrating the increasing success of recruitment and licensing efforts.

1. ***DCF recruited and licensed 1287 new non-kin Resource Families between July 2006 and June 2007 exceeding its mandate to license 1030 non-kin Resource Family homes in this period. (MSA, II.H.10.)***

The State licensed a total of 643 non-kin Resource Family homes from July 2006 through January 2007. This put the Department in very good stead to exceed its goal of licensing 1030 non-kin Resource Family homes by June 2007. Indeed, as early as April 2007, the goal of 1030 homes was met and by June 2007, a total of 1287 homes were recruited and licensed (see Figure 11).

**Figure 11: NJ DCF Resource Families
Number of New Non-Kin Families Licensed**



Source: New Jersey DCF, DYFS, verified by Monitor

The Department continues to collect and analyze data that distinguish the number of kinship and non-kinship homes licensed each month. Table 12 provides data for July 2006 through June 2007 on the total number of kin and non-kin homes newly licensed.

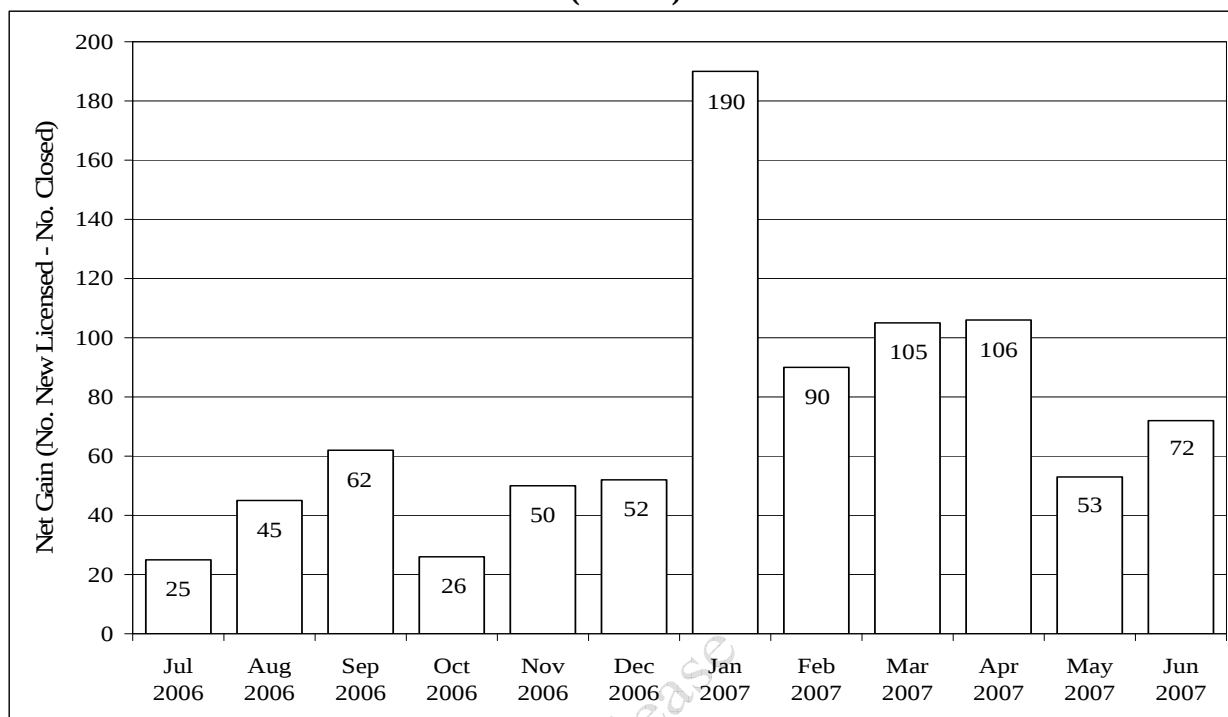
Table 12:
New Licensed Family Resource Homes
July 2006 – June 2007

	Kin	Non-Kin	Total
July 2006	18	60	78
August 2006	33	101	134
September 2006	35	99	134
October 2006	27	85	112
November 2006	21	81	102
December 2006	28	82	110
January 2007	59	182	241
February 2007	29	112	141
March 2007	61	135	196
April 2007	44	122	166
May 2007	37	126	163
June 2007	32	102	134
TOTALS	424	1287	1711

Source: New Jersey DCF, DYFS, verified by Monitor.

The Monitor reviewed a random sample of approximately 20 percent of licensing case files from January 2006 or before to verify data supporting that the Department reached its goal of licensing 1030 non-kinship Resource Families. The Resource Family Support and the Resource Family Licensing units of DCF are to be applauded for this tremendously successful effort. First, the Impact Teams established at the end of the last monitoring period moved into high gear beginning in January 2007. Working jointly with Resource Family Units first in Middlesex, Passaic and Atlantic counties, and then moving on to Union and Burlington counties, the teams vastly reduced the backlog of waiting applications and licensed a record number of homes so that there has been a consistent monthly net increase in the number of new homes. Figure 13 provides data on the net gain of licensed homes by month from July 2006 to June 2007.

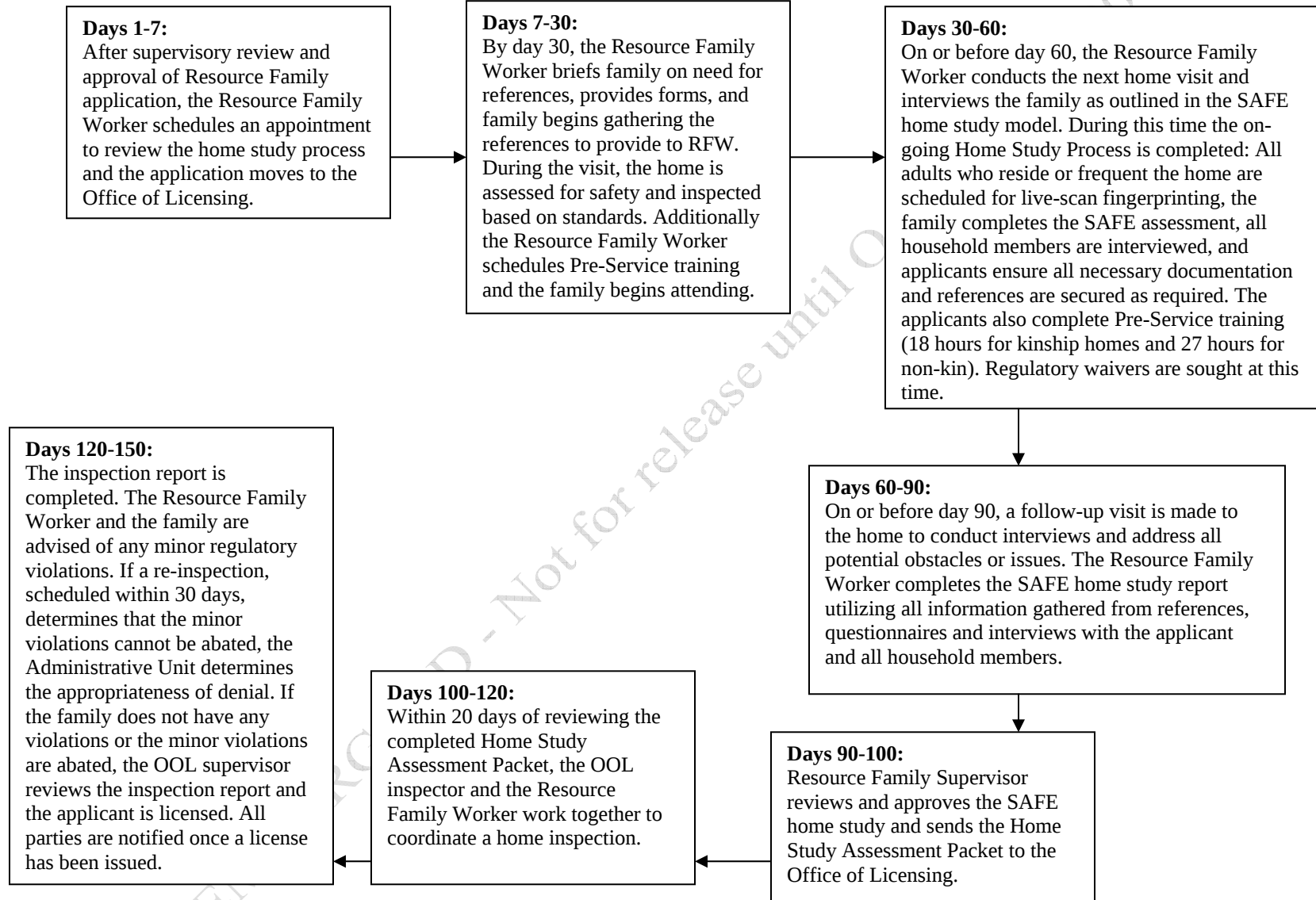
Figure 13:
NJ DCF Resource Families – Net Gain by Month
(n = 876)



Source: DCF, DYFS, verified by Monitor

The Impact Teams also established new protocols and began to standardize procedures to facilitate licensing within 150 days of a Resource Family's application. Figure 14 on the following page is a pictorial representation of the process a Resource Family application takes to become licensed within 150 days.

Figure 14: Resource Family 150 Day Flow Chart (Revised as of August 2007)



Resource Family Impact Teams developed a protocol for Resource Family Licensing staff to join Resource Family Workers in the inspection of homes. Monthly meetings between the two units are now an expectation. At the monthly meetings, outstanding licensing issues are discussed and are moved toward resolution. Resource Family Licensing staff are now routinely assigned to geographic areas and therefore have relationships with Resource Family Workers that did not exist with the prior organizational structure. These relationships have created an expectation of cooperation and a sense of mutual accountability for the work. The Monitor saw evidence of improved communication between Resource Family Licensing and Resource Family Workers in many, though not all, of the local DYFS offices visited.

The Impact Teams will continue to be deployed to the remaining Area Offices until the majority of Resource Family applications can be resolved in 150 days.

The Impact Teams also identified areas of training for both Licensing and Resource Family staff. The Department responded to this finding by assigning high level staff to develop cross-training curricula for the two units so that Licensing and Resource Family staff will better understand their corresponding roles. The training as currently constructed begins with training on New Jersey's new CPM and its role in work with Resource Families. Other components under consideration for intensive training are:

- Customer Service – A Brief Overview of Applicants Rights
- Job Responsibilities of Office of Licensing
- Job Responsibilities of Resource Family Worker
- Office Structure – How local offices and Licensing are structured and the general flow of work of each office
- Foster Parent Role – What is a SAFE home evaluation?
- What is an Office of Licensing Home Inspection?
- One day field experience – Licensing workers spend a day with Resource Family worker and Resource Family worker spends a day in Licensing.

The Department continues to rely on the Impact Teams to raise systemic and structural problems to leadership's attention. For example, during site visits, staff in several offices identified some structural licensing standards as a barrier for licensing families and kin in urban areas. The Department is now reviewing these barriers to determine how modifications can be made. The Monitor looks forward to more closely examining the results of the Impact Team's work in the next monitoring period.

The MSA requires the State to facilitate the process for potential Resource Families so that they can achieve licensure within 150 of their application (MSA, II.H.4). The Department is implementing the process and timeframes as outlined in Figure 16. However, the Department continues to evaluate, review and improve the process, and considers it a work in progress.

As evidence of its own self-evaluation, the State provided the Monitor with a breakdown of applications approved in January 2007, a month in which it received 311 applications. In

January, a total of 48 percent of applications were licensed within the 150-day period, and another 19 percent had issues resolved and were awaiting final licensing. The Monitor is satisfied that, given the complexity of the licensing process, the State is making significant progress towards its goal of a 150-day timeframe between application and licensure of Resource Families.

2. DCF created a tracking and target setting system for ensuring there is an accurate real time list of current and available Resource Family Homes (MSA, Section II.H.9).

In the previous monitoring period, DCF worked hard to produce an accurate baseline of available Resource Family Homes. The MSA requires the State to use this baseline information to create an accurate tracking system to determine in real time which Resource Family homes are available to staff seeking placement for a child. (MSA, II. H.9). The State has chosen to include this system as part of its New Jersey SPIRIT program, and has demonstrated to the Monitor its significant capabilities. When fully operational, a worker will have available online up-to-date and accurate information on the homes available as placement options: homes open, homes closed, family members in the homes, ages, active services available to the home, whether it is open to sibling groups, etc. The approval process for placements is clear and accessible. While this process does not supplant the need for quality case conferencing, it is a valuable tool that will greatly enhance the work of Resource Family staff, management, and leadership.

3. DCF further closed the gap by 25 percent between current Resource Family support rates and the USDA's estimated cost of raising a child.

The MSA requires the State to close the gap between current Resource Family support rates (foster care, kinship care, and adoption subsidy) and the United States Department of Agriculture's estimated cost of raising a child. (MSA, II. H.15). New rates sufficient to close the gap by 25 percent became effective January 1, 2007 (see Table 15).

**Table 15:
DYFS Approved Resource Family Rates, Effective January 1, 2007**

Age of Child	DYFS Rate 12/31/06 (STEP 0)	Revised USDA Rate CY 2005 (published April 2006)	Difference between USDA 2005 Rate and DYFS Rate 12/31/06	Percentage of increase required to close gap 25% by 1/1/07	Approved Increase to Monthly Rate	Approved DYFS Rate 1/1/07
0-5	\$497	\$667	\$170	33%	\$56	\$553
6-9	\$534	\$718	\$184	33%	\$61	\$595
10-12	\$557	\$741	\$184	33%	\$61	\$618
13-17	\$609	\$786	\$177	33%	\$58	\$667

Source: DCF, DYFS, January 1, 2007

B. Division of Child Behavioral Health Services (DCBHS)

DCF, through its Division of Child Behavioral Health Services (DCBHS) is responsible for finding appropriate community-based services and/or out-of-home placements for children and youth in New Jersey who experience significant emotional and behavioral challenges. Some of these youth are also involved with DYFS and the Division of Developmental Disabilities (DDD). Under the MSA, DCF, through DCBHS, is required to minimize the number of children in DYFS custody placed in out-of-state congregate care settings and work to bring these children placed out-of-state back to New Jersey as soon as they are ready to be “stepped down.”

DCBHS has experienced several leadership changes in this monitoring period. An interim director has been appointed with the expectation of selecting and appointing a permanent Director in the coming months. Despite the changes in Division leadership, the MSA requirements related to DCBHS’ work have been achieved for this reporting period.

1. *DCF took concrete actions to minimize the number of out-of-state placements and return children placed out-of-state to New Jersey.*

DCF continues to place children out-of-state. The majority of these children have significant mental health problems and are placed out-of-state following attempts to find an appropriate placement within the State. A few of the placements made out-of-state are in locations closer to the child’s community than alternative in-state placements. As of June 2007, there were 306 children placed out-of-state.²⁰ Table 16 depicts the number of new out-of-state placements made during this reporting period.

Table 16:
Out-of-State Authorizations
January – June 2007

Month	Number of authorizations for youth in DYFS custody (total number of authorizations)
January	8 (28)
February	8 (20)
March	6 (12)
April	3 (7)
May	2 (9)
June	9 (15)
TOTAL	36 (91)

Source: New Jersey Department of Children and Family Services, DCBHS

²⁰ New Jersey Department of Children and Families, Quarterly Update, September 5, 2007. The number of authorized placements has subsequently decreased in July and August 2007 (290 children and 287 children respectively).

For the most part, the number of authorizations is significantly lower than the three months tracked in the last monitoring report.²¹ Much work, including the development of additional appropriate in-state resources, remains in order to significantly minimize out-of-state placements.

Based on the State's analysis of the reasons youth were being placed out-of-state, DCF and DCBHS contracted with providers throughout New Jersey to add 86 "specialty beds." These beds will serve youth with complex behavioral and mental health issues. Several of the beds are specifically for teenage girls. Currently, 34 beds are operational and filled, 22 beds will be available by the end of October 2007, 15 are scheduled to be available in January 2008, and 15 are still under negotiation.

In addition to employing strategies to prevent out-of-state placement, DCBHS in partnership with DYFS has begun to examine each child placed out-of-state and implement an individualized plan for their return to New Jersey and their specific community. DCBHS and DYFS identified 119 children under the custody of DYFS for case planning conferences. These conferences will be held with DCF partners, including the Division of Developmental Disabilities (DDD), and will assess each child's current progress, feasibility of returning to the State, and appropriate programs and/or community services necessary to return the child to the State and/or step the child down to a lower level of placement. These conferences began in September 2007 and will continue through the early November 2007. In the first week, of 14 children reviewed, 7 have been identified as ready to leave their out-of-state placement and return to placement in New Jersey.

2. *DCF is able to find placements within 30 days for almost all of DYFS youth who are in juvenile detention awaiting placement.*

As described in the last monitoring report, DCF created a systematic process to identify and track youth in juvenile detention facilities who remain in these facilities solely because they are awaiting appropriate placement. Under the MSA, no youth in DYFS custody should wait longer than 30 days for placement (Section II.D.5). According to DCF, 18 youth in DYFS custody and in detention were awaiting placement from December 2006 to July 2007. Of these 18 youth awaiting placement post-disposition, 10 were male, 8 female.

Table 17 on the following page provides information on the length of time each of these youth waited for placement. All but two youth were placed within the 30-day time period.

²¹ In the last monitoring report the number of authorizations for out-of-state placements were as follows: 24 children in October 2006, 54 children in November 2006, and 39 children in December 2006.

Table 17:
Youth under DYFS custody in juvenile
detention post-disposition awaiting placement

Length of waiting time	Number of Youth
0-15 days	3
16-30 days	13
Over 30 days	2

Source: DCF, August 1, 2007 placement report

The two youth who were not placed in 30 days were both female—one waited 33 days, the other 37 days. Both of these teenage girls were characterized as assaultive, with severe emotional problems. DCBHS made significant efforts to find in-state placements, but after multiple rejections the girls were both placed out-of-state.

3. *DCF continues to find avenues to support new services for children and their families that are “evidence-based practices.”*

Under the MSA, the State was required to seek approval from the federal government for a Medicaid rate structure “to support the use of new services for children and families, including community-based and evidence-based informed, or support practices, such as Functional Family Therapy and Multi-Systemic Therapy” (Section II.C.2).

The State examined different avenues for funding this evidence-based practice. Based on the analysis, DCF decided that these services could best be supported by the Intensive In-Community service line within the existing New Jersey Medicaid State Plan. Approval was sought from the Division of Medical Assistance and Health Services (DMAHS) and DMAHS determined this expenditure was appropriate and that approval from the federal government was not required. Thus, the MSA requirement is not helpful or necessary to the State in accomplishing the ultimate requirement of supporting these new services for children and families.

The State intends to issue an RFP for Evidence-Based Services by December 2007. The RFP will identify targeted populations and a menu of evidence-based practices approved by DCBHS. The goal is to select four evidence-based practice sites in FY 2008 and then expand services based on lessons learned.

4. *DCF has amended its policies to prevent the inappropriate use of shelters for children coming into out-of-home care.*

The MSA requires the State to eliminate the inappropriate use of shelters as an option for youth who need to be placed out of their homes. The only appropriate use of shelters will be: “(i) as an alternative to detention, or (ii) a short-term placement of an adolescent in crisis which shall not extend beyond 45 days; or (iii) a basic center for homeless youth.” (Section II.D.8) Further, beginning in July 2007, shelters shall not be used as a placement option for children under the age of 13 (MSA, II.D.7). DCF developed the policy to support these new placement restrictions.

C. Services and Supports for Youth

Unfortunately, in jurisdictions throughout the country, the specific needs of adolescents in foster care are too often neglected. Over the last several years, child welfare agencies and foundations have brought heightened attention to adolescents’ need for permanency and well-being, especially for youth growing up in and transitioning out of the foster care system. This report has highlighted some of New Jersey’s permanency activities for older youth in Section IV.B. Additional activities DCF has taken to support youth are described below.

During this monitoring period, the State was required to report on changes to its policies and practices for youth aged 18 to 21 and for youth who identify as gay, lesbian, bisexual, transgender, questioning or intersex (GLBTQI). DCF spent much of this year assessing its data about youth in care, understanding where they are placed, and the current state of practice supporting them. The State has taken some preliminary steps to focus on the specific needs of this population, and the Monitor hopes that in the upcoming months, additional progress will be made in providing for the permanence and well being of adolescents.

DCF is focusing on expanding the number of youth aged 18 to 21 who receive services if they have not achieved permanency by age 18, and the range of supports available and provided to older youth. As of June 2007, DCF reported the following:

- 1250 youth ages 18-21 were receiving in home services;
- 471 youth ages 18-21 were receiving out-of-home services;
- 323 youth were enrolled in Chaffee Medicaid; and
- 418 youth received tuition assistance, room, board and books through the New Jersey Scholars program (an 86% increase over the previous year at a cost of \$2.5 million).

1. *DCF significantly revised existing policies in order to continue to provide supportive services to youth aged 18 to 21.*

Upon reviewing the policies regarding the provision of support to older youth, DCF leadership discovered that there was an operating presumption in policy and practice of closing the DYFS case when youth turned 18. The information system presumptively closed a youth’s case on his/her 18th birthday unless there was a *proactive* request by the worker and youth to keep the case open. DCF worked with the Office of Information services to amend the SIS computer

system to correct the presumption of case closure. Further, DCF changed its written policies to create a presumption in *favor* of keeping the youth's case open. Now, according to DYFS policy, a youth's case is closed only upon written request of the youth or no later than his/her 21st birthday. Further, Resource Homes will continue to receive a daily board rate for youth aged 18 to 21 who have left their homes, but return for college breaks or unexpected or prolonged illness. DCF will need to continue to work with case workers and Judges to help them understand this change in policy and practice. These actions by DCF meet the MSA requirement (Section II.C.5). The Monitor will continue to investigate the State's efforts to implement these policy changes.

2. DCF added 112 transitional living beds.

In April 2007, DCF far exceeded the MSA June 2008 requirement to establish 18 beds available to youth transitioning out of the foster care system. (Section II.C. 11). DCF established 112 transitional living beds, and dedicated a handful of these beds to youth who identify as gay, lesbian, bisexual, transgender, and intersexual (GLBTI).²² According to DCF, "the investment by DCF of \$2.7 million to support these transitional housing services will be leveraged to gain additional federal and state dollars, primarily in capital acquisition and rehabilitation funds, through New Jersey's Department of Community Affairs, who partnered with DCF on the request for proposal (RFP) process."²³

3. DCF created a preliminary GLBTQI Plan.

DCF's GLBTQI Plan represents its "first statement of how it intends to meet the needs of this most vulnerable population."²⁴ According to DCF, the plan was designed with consultation from three different workgroups looking at issues faced by GLBTQI youth. This plan is to be part of the general enhancement of services to adolescents and is an initial document that will grow as the CPM is implemented. Most of the plan will be implemented by June 2008 (meeting the MSA requirement Section II.C.4).

Highlights of the GLBTQI Plan include:

- Examining screening procedures for youth and reviewing in-service training;
- Providing additional training in "adolescent development, including adolescent sexual development, integrating the issues associated with GLBTQI youth"²⁵;
- Recruiting appropriate Resource Families, counseling and health services that can be sensitive to needs of GLBTQI youth; and
- Analyzing policies and practices to assess the impact on GLBTQI youth.

²² These are 4 beds at Anchor House according to the New Jersey Department of Children and Families Plan for Service Delivery for Youth who Identify as Gay, Lesbian, Bisexual, Transgender, Questioning, or Intersexual, State Fiscal Year 2007. (New Jersey DCF, GLBTQI plan).

²³ New Jersey Department of Children and Families, Transitional Living Beds report, 2007.

²⁴ New Jersey DCF, GLBTQI plan.

²⁵ Ibid.

4. *DCF directed significant resources to new programs to support adolescents.*

As stated previously, DCF has committed many new dollars to supporting services specifically to address the needs of adolescents under their care and supervision. Tables 18 and 19 below describe how these resources are distributed.

Table 18: Youth Transitional and Supported Housing Grants

Name	No. of Beds	Award	Counties Served
Anchor House	4	\$88,740	Mercer County
Cape Counseling	4	\$137,440	Cape May
Catholic Charities, Diocese of Newark	8	\$435,000	Hudson County
Catholic Charities, Diocese of Trenton	8	\$129,299	Monmouth County
Collier Services	5	\$283,274	Monmouth County
Corinthian Homes	18	\$248,900	Essex County
Covenant House	15	\$212,314	Essex County
Garden State Home of New Brunswick	5	\$273,943	Middlesex County
Middlesex Interfaith Partners with the Homeless (MIPH)	6	\$209,666	Middlesex County
NJ Community Development Corporation	9	\$198,000	Passaic County
Robin's Nest, Inc	10	\$150,000	Gloucester County
Tri-City People Corporation	6	\$97,145	Essex County
Union Association Children's Home	4	\$80,000	Burlington County
Volunteers of America	10	\$200,000	Hudson/Essex Counties
Total:	112	\$2,743,721	9 different counties

Source: DCF, 2007

Table 19: Youth Permanency Demonstration Project*

Provider	Award	Counties Served
Robin's Nest	\$83,333	Atlantic/Burlington/Camden/Cape May/Cumberland/Gloucester/Salem Counties
Family Services	\$83,333	Burlington/Camden/Mercer Counties
Children's Aid and Family Services	\$83,333	Bergen/Essex/Passaic Counties
Total:	\$249,999	11 different counties

Source: DCF/DYFS

*See description of Youth Permanency Demonstration Project on page 46 of this Monitoring report.

VI. MEETING THE HEALTH AND MENTAL HEALTH NEEDS OF CHILDREN

A. Building a new system for the provision of health care to children in out-of-home placements

Redesigning the delivery of quality health care services to children and youth in out-of-home placement is a key obligation under the MSA (Section II.F.8). Like other MSA reform efforts, the improvement of health care service delivery requires a thoughtful and staged process. Numerous studies in the past several years, including two reports by the Office of the Child Advocate have highlighted the need for reform of the health care delivery system for children in out-of-home placement. As reported in the first monitoring report, the State fulfilled its requirement to gather and analyze health care data regarding the frequency of pre-placement assessments, Comprehensive Health Evaluations for Children (CHECs), and the provision of dental care. Based on this information, the State was required to establish baselines and targets for the delivery of health care services to children in out-of-home placement and to develop a comprehensive health care plan for these children and youth. Over the next year, DCF will be aggressively implementing this new plan and modifying it as necessary to ensure quality health care services are appropriately developed and delivered to all children and youth in an accessible and timely manner. Both DCF and the Monitor will be evaluating the effectiveness of this new model.

DCF undertook a deliberative process to build a new comprehensive health care model. DCF contacted many external partners to obtain feedback and information—including the Regional Diagnostic and Treatment Centers (RDTC), existing Comprehensive Health Evaluation for Children (CHEC) providers, the Office of the Child Advocate (OCA), and the Monitor. The Plan that emerged is both comprehensive and ambitious.

As the result of deliberate work over several months to analyze data, track progress, and develop creative solutions, nearly all children entering out-of-home care received pre-placement assessments, with the majority receiving these assessments in a non-emergency room setting. DCF met the MSA requirement (Section II.F.7) in July 2007 by having 90 percent of these exams occur in a setting other than an emergency room. Additionally, DCF reached agreement with the Monitor on health care targets to be measured over the next several years.

1. DCF designed a comprehensive, coordinated health care plan for children in out-of-home placement.

On May 22, 2007, DCF released their vision for providing comprehensive coordinated health care to children and youth who are placed out of their homes.²⁶ Specifically, this plan outlines a health care model which “emphasizes:

- Care should be provided in a manner sensitive to the child.
- Continuity of care is critical and will be managed by child health units providing health care case coordination in each of the DYFS local offices.
- Children’s access to care requires expansion of existing providers statewide and flexibility in the service delivery model which will be addressed through contracting via a public Request for Qualifications Process (RFQ) in June 2007.
- Health care planning must be integrated into permanency planning for children in out-of-home care.
- Success requires real partnership between state agencies, with and among providers, and with the child and family team.”²⁷

Noteworthy changes provided for in the new “coordinated” health care plan include:

- Modification of the manner in which comprehensive medical examinations can be delivered;
- Building of children’s medical health units and significantly expanding the number of nurses in local DYFS offices;
- Redefining the referral protocols to Regional Diagnostic and Treatment Centers (RDTC); and
- Refining the definition of pre-placement assessments.

a. Rethinking Comprehensive Medical Examinations

Under the MSA, the State is required to provide all children entering out-of-home care with comprehensive medical care. Services the State has committed to providing include pre-placement assessments, a comprehensive medical examination within the first 60 days of placement, yearly medical exams in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines, semi-annual dental exams, mental health assessments for children with suspected mental health needs, and any follow-up care needed by a child (MSA, II.F.2). Previously the State relied on the Comprehensive Health Evaluation for Children (CHEC) model as the intended vehicle to comprehensively assess the health care needs of all children and youth entering out-of-home placement. CHEC examinations require a three part examination—medical, neuro-developmental, and mental health assessments—and in most instances took place on a single day for four to six hours. These services, which were to be completed within the

²⁶ New Jersey Department of Children and Families, Coordinated Health Care Plan for Children in Out-of-Home Placement, May 22, 2007. http://www.nj.gov/dcf/DCFHealthCarePlan_5.22.07.pdf

²⁷ Ibid, Executive Summary, p.2.

first 60 days of placement, were provided once a year primarily by a limited number of medical facilities who contracted with DCF.

After careful analysis, DCF determined there were many challenges to the CHEC approach. Many regions of the State had no facilities available to provide CHEC examinations and as a result children were either exempt from this examination or traveled a great distance to be seen by a CHEC provider. Further, case workers experienced great frustration because these exams were difficult to schedule due to the limited number of CHEC examination slots available and CHEC providers were frustrated by the high rates of cancellations or “no shows” of children. Because the existing structure prevented efficient coordination of CHEC schedules, children experienced long waits to be seen by CHEC providers and CHEC providers were not providing services at their full capacity. A final concern was that the CHEC model was developed with essentially no provisions for follow-up care or for linking children and their families with a “medical home.”

A CHEC audit in 2005, lead by the Office of the Child Advocate, similarly found that CHEC examinations were not occurring on a timely basis, children were attending CHEC appointments with individuals that had little or no knowledge of their health history or current needs, and follow-up care was insufficient.²⁸ On October 3, 2007, the current Child Advocate released another CHEC audit that re-examined this service and found similar challenges.²⁹ Specifically, the report found that the CHEC program provided an invaluable service, but only to a select number of children. Less than one-third of children entering care received a CHEC evaluation, and those that received these evaluations did not receive them within the 30 day recommended time period. Few children received the identified follow-up care and vital medical information was not always shared with caregivers and other medical providers.³⁰

Obviously, thoughtful health care reform is necessary and crucial for children entering out-of-home care. In developing its reform plan, DCF set to accomplish two goals; to ensure: 1) that more children in the State of New Jersey who are placed out of their homes receive timely comprehensive medical examinations upon coming into out-of-home care and 2) that providers of these exams have the ability to serve as an ongoing medical home for the children they see. This model is promoted by the American Academy of Pediatrics. The comprehensive medical examinations the State has proposed for implementation differ from the current CHEC model. These health examinations require a comprehensive physical examination as well as an initial mental health screening. Should a child be found to have a mental health need, a full mental health evaluation will then be conducted.

²⁸ Office of the Child Advocate, Needs and Assets Assessment of the Comprehensive Health Evaluation for Children (CHEC) Program, December 19, 2005.

²⁹ Office of the Child Advocate, Health Matters: A Study of the Comprehensive Health Evaluation for Children (CHEC) Program, October 3, 2007.

³⁰ Ibid.

DCF leadership met with some federally qualified health centers (FQHCs) and other qualified providers in areas of New Jersey where children were not receiving CHEC exams due to a lack of a CHEC provider to determine their interest and availability to become “medical homes” for children in out-of-home placement and what, if any, impediments they might face in meeting the comprehensive medical examination requirements. Based on these conversations, it was determined that some FQHCs and other providers had the capacity to serve these children, but that the comprehensive medical exam may require them to partner with additional providers for particular parts of the exam (such as mental health assessments). Thus, the Request for Proposal that DCF published in June 2007 provided for this flexibility. A bidders’ conference was held on July 25, 2007 and additional questions emailed to DCF were answered publicly on the DCF website. DCF is now reviewing provider responses to the health care RFP. When new contracts are in place, all children in DYFS custody in New Jersey will receive a comprehensive medical examination from a FQHC, CHEC, or other qualified medical provider.

Under the MSA requirement, DCF is required to provide comprehensive medical exams within the first 60 days of a child entering out-of-home placement. DCF is working with staff and providers to meet the more rigorous American Academy of Pediatrics standard of comprehensive exams being conducted within 30 days of placement. The Monitor supports this goal, but in keeping with the MSA requirement, will measure the completion of comprehensive medical exams within 60 days of placement. Over the next few months, the Monitor will be working with DCF and other partners in the State to design an effective means of measuring the timeliness and quality of health care services provided to children in out-of-home placement.

b. Building Child Health Units

After examining different States’ models of coordinating health care service delivery for children in foster care, DCF leadership decided that the responsibility for coordinating the health care of children in out-of-home placement must lie with DCF. Therefore, each local DYFS office will have a Child Health Unit (CHU) consisting of at least a nurse and a scheduler. Eventually, each office will have one nurse for every 50 children in out-of-home placement, with appropriate administrative supports. These units will be responsible for medical case management—compiling medical records and documentation and providing key information and documentation to appropriate service providers. Schedulers will be responsible for coordinating all comprehensive medical exam appointments for the local office and assuring the maximum use of these health care facilities by filling cancellations with other eligible children. Nurses will provide medical consultation to workers and pre-placement assessments as necessary.³¹

³¹ A flow chart delineating the responsibilities of the Child Health Unit is included in DCF’s Coordinated Health Plan. New Jersey Department of Children and Families, Coordinated Health Care Plan for Children in Out-of-Home Placement, p. 16.

DCF identified the University of Medicine and Dentistry of New Jersey(UMDMJ)'s Francois-Xavier Bagnoud Center (FXB) to provide appropriate nursing support to local DYFS offices throughout the State. With a Memorandum of Understanding beginning July 1, 2007, DCF is working with FXB on a phased roll-out of the CHU throughout fiscal year 2008. The first phase begins December 2007 in Sussex, Hunterdon, Bergen, and Passaic counties (there will be one unit in each area except for Bergen which will begin with two CHUs). DCF intends to evaluate the roll-out with FXB on a regular basis to adjust the roles and responsibilities of the CHU.

Table 20 below identifies the care coordination functions of the proposed CHUs.

Table 20:
Health Care Coordination Functions of Child Health Unit

- Performing Pre-placement assessments
- Initial full health examinations scheduled
- Children received CHEC or initial full health examination
- Children received annual EPSDT examination
- Children ages 3 and older receive semi-annual dental exams
- Children receive appropriate follow-up care
- Creation of Health Care Plan for children in out-of-home placement
- Participation in Case Review conferences
- Participation in Family Team Meetings (or equivalent)
- Participation in the Case plan implementation in the pilot local offices and ongoing as new local offices come on-line

Source: DCF, The Child Health Program, Francois-Xavier Bagnoud Center, University of Medicine and Dentistry of New Jersey, Fiscal Year 2008.

Local office workers are enthusiastic about the creation of Child Health Units and the expanded services of nurses and schedulers. Site visits revealed that space will be a constraint in the planned roll-out but the pressure to make these units available and operational in every office as soon as possible is significant. Integrating this comprehensive health model into the developing CPM will be another challenge which the Monitor will continue to follow over the next several months. Several of the targets DCF will be tracking will also be incorporated into monitoring of the CPM and of the delivery of quality health care to children in out-of-home placement. Over the next several months, as the CHUs are established, DCF must balance a rapid roll-out plan with ensuring quality medical care for children in their custody.

c. Clarifying the use of Regional Diagnostic Treatment Centers (RDTCs)

Currently, DCF works with four Regional Diagnostic and Treatment Centers (RDTCs) and one satellite office to assist in the evaluation of severe cases of child abuse and neglect. This is a specialized service that requires highly trained physicians (who are a limited resource in New Jersey). DCF spent several months meeting with the staff at the RDTCs to discuss their current capacity to meet the needs of children who have experienced severe abuse and neglect. According to DCF, many children who require this service are not able to be seen by RDTCs. DCF believes that the reason for this gap in service is due to inappropriate referrals of children to RDTCs and, similar to the CHEC exams, high cancellation and “no show” rate for appointments. As a result of these discussions, DCF and the RDTCs agreed that new protocols were necessary to prioritize and target their services to youth most in need of their services. On May 3, 2007, DCF issued new referral protocols to address these concerns. DCF will assess the effectiveness of the dual strategies of clarifying the protocol for referrals to RDTCs and using schedulers at the local office Child Health Units to coordinate filling spots for cancelled appointments and reducing no show rates. The combination of these strategies will be assessed to determine if the RDTCs as currently resourced are capable of fully meeting the needs of children requiring this service, or if the capacity of RDTCs will ultimately need to increase.

d. Refining the definition of pre-placement assessments

Over the last year, DCF has worked with local offices to assess their ability to provide pre-placement assessments in a non-emergency room setting for all children entering out-of-home care. Under the MSA, all children entering out of home care are required to have this assessment and beginning in June 2007, 90 percent of children entering out-of-home placements must have pre-placement assessments in a setting that is not an emergency room (Section II.F.7). DCF is to be commended for achieving nearly 100 percent of pre-placement exams, with 92 percent of all children in out-of-home care in July 2007 receiving their pre-placement health assessments in a non-emergency room setting (see Table 21).

Table 21:
Completion of Pre-Placement Health Assessments (PPA)
and Use of Emergency Rooms for Assessments
January – July 2007

Month	No. of children Entering care	No. PPA Completed	Percent PPA Completed	Percent completed in Non-ER Setting
Jan-07	420	420	100%	66%
Feb-07	380	379	100%	59%
Mar-07	419	418	100%	63%
Apr-07	301	301	100%	58%
May-07	442	442	100%	70%
June-07	328	328	100%	78%
July-07	377	377	100%	92%
TOTAL	2667	2665	100%	

Source: DCF, Healthcare Pre-placement Assessment Update, August 2007 and September 5, 2007
 NJ Department of Children and Families Quarterly Data Update

DCF worked with local offices to identify barriers to receiving pre-placement assessments outside of an emergency room and tailored strategies to achieve this goal. For example, in both Camden and Essex counties, new after-hours pre-placement assessment resources were created. Additionally, nurses in local offices had their job responsibilities reorganized to prioritize providing pre-placement assessments. Some local offices staggered the hours nurses worked so that pre-placement assessments could be provided outside of traditional office hours. Further, DYFS caseworkers were encouraged by leadership to prioritize pre-placement assessments when they recognized the need to remove a child. Workers were urged to contact a child's current primary care provider to determine if a pre-placement assessment could be conducted; if that was not possible, the local office nurse, or medical provider partner were to be contacted for an appointment.³² Finally, DYFS still requires a pre-placement assessment to be conducted before a child is placed out of his/her home, but has added the caveat that under exceptional circumstances a child may receive a pre-placement assessment within 24 hours of placement if it is determined that it is in the child's best interest (For example, a child is removed late at night and has no noticeable and immediate health concerns. The worker would be responsible for ensuring that child be seen the next day, rather than take the child to an emergency room and wait that night.)³³

³² See New Jersey Department of Children and Families, Coordinated Health Care Plan for Children in Out-of-Home Placement, p. 8. for pre-placement assessment flow chart.

³³ Exceptional circumstances are detailed in the policy guidelines.

As a result of these strategies, DCF reports that it was able to decrease the use of emergency rooms, particularly during evening hours. DCF increased the percentage of pre-placement assessments completed during the day and reduced the number completed in the evenings. Pre-placement assessment data will continue to be monitored moving forward, especially in light of the proposed coordinated health care delivery system.

e. Creating a Medical Passport for all children in out-of-home placement

Under the MSA, all children entering out-of-home placement are to have a Medical Passport created for them. This passport will gather all relevant medical information in a single place and be made available to parents, children (if old enough), and any other caregivers. The CHU nurses will be responsible for ensuring that the passports are created, given to children, families, and providers, and updated regularly. The information for the passport will be entered into New Jersey SPIRIT by the nurses, and then exported to a “passport” form. Items included in the passport are: medication of child, immunizations, hospitalizations, chronic health issues, practitioners and contact information, key mental health and developmental milestones, last EPSDT, dental information, and any special transportation needs. These passports will be tested in Hunterdon and Sussex counties first, adjusted as needed, and then rolled out to other CHUs.

DCF decided to launch this Passport Plan now rather than wait for the Medicaid project, eMedic, to be finalized. The Medicaid project will pull together all existing medical information from electronic records from Medicaid and Health databases.³⁴ When Medicaid has created eMedic, DCF will revisit the current Medical passports for compatibility and/or merger with the Medicaid documents.

2. DCF set health care baseline and targets to be measured over the next several years.

The DCF Child Health Unit staff conducted two studies of DYFS and Medicaid data to assess current status of health care delivery and inform the setting of health care baselines and targets. The studies were of a small, but significant sample size. Based on this information and after discussion with the Monitor, the following health care baselines and targets were agreed upon in August and September 2007 (MSA, II.F.5-6).

³⁴ Medicaid is in the process of developing this integrated medical information database. DCF is involved in the planning and will use that database to populate the Medical Passport system once it becomes available. (Target date is Fall 2008).

**Table 22: Health Care Baseline and Targets
(June 2007 – December 2011)**

	Baseline as of 6/30/07	June 2008	Dec. 2008	June 2009	Dec. 2009	June 2010	Dec. 2010	June 2011	Dec. 2011
Indicator 1: Pre-Placement Exam Completed; 90% of which shall be in a non- emergency room setting.	90%	95%	95%	98%	98%	98%	98%	98%	98%
Indicator 2: Comprehensive medical exams completed in 60 days of child entry into care	75%	75%	80%	85%	95%	98%	98%	98%	98%
Indicator 3: Annual medical examinations in compliance with EPSDT guidelines for children in care for one year or more	75%	75%	80%	90%	95%	98%	98%	98%	98%
Indicator 4: Children ages 3 and older in care 6 months or more receive semi- annual dental examinations.*	Annual 60%	Annual 60%	Annual 65%	Semi- annual 70%	Semi- annual 75%	Semi- annual 80%	Semi- annual 85%	Semi- annual 90%	Semi- annual 98%
	Semi- Annual 33%		Semi- Annual 50%	Annual 90%	Annual 95%	Annual 95%	Annual 98%	Annual 98%	Annual 98%
Indicator 5: Mental health assessments for children with a suspected mental health need.	TBD	75%	80%	85%	95%	98%	98%	98%	98%
Indicator 6: Children receive timely accessible and appropriate follow-up care and treatment to meet health care and mental health needs.	TBD	60%	65%	70%	75%	80%	85%	90%	98%

*Due to need to ramp up dental service capacity, this standard is phased in, beginning with requirements for annual dental examinations.

The Monitor has proposed that DCF add two additional health care targets:

- Children are current with immunizations; and
- Children's caregivers receive up-to-date health passport upon placement or following completion of the 72-hour Family Team Meeting.

DCF and the Monitor have agreed to review these indicators by December 2007, determine how and when data can be collected to measure them and make a decision about their inclusion in the health care targets to be monitored.

3. DCF is pursuing other health-related strategies

Psychiatrist

Many children and youth who come into contact with DCF have significant behavioral and mental health challenges. DCF recognized the need to have the help of a child/adolescent psychiatrist as they implement the new health care plan, begin reforming the children's behavioral health system, and develop prevention services for children and families. Further, DCF staff require clinical consultation on the use of psychotropic medications and understanding psychiatric diagnoses of children in their care. Thus, DCF has entered into a Memorandum of Understanding to obtain the assistance of a qualified psychiatrist to help meet these needs. While not required by the Modified Settlement Agreement, using the expertise of a psychiatrist at a senior leadership level should help DCF with its reform efforts.

Dental Care Provider Capacity

New Jersey still faces significant challenges in building capacity for dental care for children in its custody. The lack of dentists willing to accept Medicaid patients is one of the resounding themes identified by the seven sites visited by the Monitor in the spring 2007. Workers described spending significant time transporting children across the State in order to receive dental care. In upcoming months, DCF leadership will meet with dentists across the State to discuss the gap of services and will work with the Child Health Units to identify additional providers. Adequate and timely dental care is an area that requires new state partnerships with the dental community. The State must also consider raising Medicaid reimbursement rates so that more dentists are willing to see children and youth involved with DYFS.

APPENDIX A

Caseload and Supervisory Level Detail for Local Offices

Table A-1: Permanency Caseloads by Local Office June 2007					
Local Office	Perm Children in Care	Perm Families	Perm Avg Children in Care	Perm Avg Families	Perm (Jun 07)
Atlantic East	90	186	6	12	Yes
Atlantic West	63	188	5	16	No
Bergen Central	77	220	5	15	Yes
Bergen South	144	409	5	15	Yes
Burlington East	160	378	6	14	Yes
Burlington West	113	309	4	12	Yes
Camden Central	146	329	4	9	Yes
Camden East	160	511	5	16	No
Camden North	137	369	3	9	Yes
Camden South	128	433	4	14	Yes
Cape May	88	207	6	14	Yes
Cumberland East	70	100	8	11	Yes
Cumberland West	115	243	5	12	Yes
Essex Central	268	489	7	13	Yes
Essex North	108	399	4	13	Yes
Essex South	94	308	3	11	Yes
Newark Center City	283	589	7	15	Yes
Newark Northeast	275	432	6	10	Yes
Newark South	262	487	7	14	Yes
Newark West/Adoption					
Gloucester East	63	215	4	13	Yes
Gloucester West	52	170	4	13	Yes
Hudson Central	109	331	5	16	No
Hudson North	91	335	6	21	No
Hudson South	99	237	7	16	No
Hudson West	80	194	5	11	Yes
Hunterdon	16	43	3	9	Yes
Mercer North	191	353	6	11	Yes
Mercer South	118	331	3	10	Yes
Middlesex Central	53	148	4	11	Yes
Middlesex Coastal	168	541	3	9	Yes
Middlesex West	155	381	4	11	Yes
Monmouth North	216	366	7	11	Yes

Table A-1:
Permanency Caseloads by Local Office (continued)
June 2007

Local Office	Perm Children in Care	Perm Families	Perm Avg Children in Care	Perm Avg Families	Perm (Jun 07)
Monmouth South	177	289	6	10	Yes
Morris	111	345	4	12	Yes
Ocean North	235	458	7	13	Yes
Ocean South	136	331	4	10	Yes
Passaic Central	188	312	5	9	Yes
Passaic North	117	299	6	14	Yes
Salem	68	199	3	10	Yes
Somerset	92	242	6	16	No
Sussex	57	162	5	15	Yes
Union Central	113	307	4	11	Yes
Union East	113	305	4	10	Yes
Union West	165	290	6	10	Yes
Warren	61	175	6	18	No
<i>Totals</i>	<i>5,825</i>	<i>13,945</i>	<i>5</i>	<i>12</i>	<i>84%</i>

**Table A-2:
Intake Caseloads by Local Office
June 2007**

Office	Intake Assignments	Intake Families	Intake Avg Assignments	Intake Avg Families	Intake (Jun 07)
Atlantic East	96	171	6	11	Yes
Atlantic West	77	155	8	16	No
Bergen Central	91	163	6	11	Yes
Bergen South	137	195	7	10	Yes
Burlington East	94	181	7	13	Yes
Burlington West	103	142	8	11	Yes
Camden Central	78	89	5	6	Yes
Camden East	109	216	6	12	Yes
Camden North	54	103	5	9	Yes
Camden South	116	171	6	10	Yes
Cape May	66	146	7	15	Yes
Cumberland East	57	71	6	8	Yes
Cumberland West	79	207	6	15	Yes
Essex Central	109	116	7	7	Yes
Essex North	69	73	6	6	Yes
Essex South	71	102	5	7	Yes
Newark Center City	58	201	3	12	Yes
Newark Northeast	100	176	6	10	Yes
Newark South	51	106	6	13	Yes
Newark West/Adoption					
Gloucester East	79	135	7	12	Yes
Gloucester West	90	138	6	9	Yes
Hudson Central	52	188	5	19	No
Hudson North	75	176	6	14	Yes
Hudson South	76	248	8	25	No
Hudson West	63	145	5	12	Yes
Hunterdon	32	71	5	10	Yes
Mercer North	90	139	7	11	Yes
Mercer South	97	116	7	9	Yes
Middlesex Central	77	153	7	14	Yes
Middlesex Coastal	91	148	5	8	Yes
Middlesex West	101	118	4	5	Yes
Monmouth North	131	278	7	15	Yes
Monmouth South	110	276	7	18	No
Morris	154	307	6	11	Yes
Ocean North	156	233	7	11	Yes
Ocean South	118	233	6	12	Yes

Table A-2:
Intake Caseloads by Local Office (continued)
June 2007

Office	Intake Assignments	Intake Families	Intake Avg Assignments	Intake Avg Families	Intake (Jun 07)
Passaic Central	159	352	8	19	No
Passaic North	155	246	9	14	Yes
Salem	56	95	5	9	Yes
Somerset	105	375	8	29	No
Sussex	59	114	8	16	No
Union Central	70	170	6	14	Yes
Union East	75	141	5	9	Yes
Union West	76	114	5	8	Yes
Warren	82	220	6	16	No
<i>Totals</i>	<i>4044</i>	<i>7713</i>	<i>6</i>	<i>12</i>	<i>82%</i>

**Table A-3:
Adoption Caseloads by Local Office
June 2007**

Office	Adoption Children	Adoption Avg Children	Adoption (Jun 07)
Atlantic East	71	14	Yes
Atlantic West	23	12	Yes
Bergen Central	64	13	Yes
Bergen South	130	19	No
Burlington East	67	17	Yes
Burlington West	70	18	Yes
Camden Central	81	14	Yes
Camden East	57	14	Yes
Camden North	71	14	Yes
Camden South	71	24	No
Cape May	48	24	No
Cumberland East	93	16	Yes
Cumberland West			
Essex Central	135	17	Yes
Essex North	86	17	Yes
Essex South	53	11	Yes
Newark Center City			
Newark Northeast			
Newark South			
Newark West/Adoption	568	18	Yes
Gloucester East	31	16	Yes
Gloucester West	34	17	Yes
Hudson Central	70	12	Yes
Hudson North	59	15	Yes
Hudson South	42	14	Yes
Hudson West	46	12	Yes
Hunterdon	22	11	Yes
Mercer North	93	16	Yes
Mercer South	67	13	Yes
Middlesex Central	51	13	Yes
Middlesex Coastal	106	18	Yes
Middlesex West	40	13	Yes
Monmouth North	83	17	Yes
Monmouth South	50	10	Yes
Morris	71	14	Yes
Ocean North	117	17	Yes
Ocean South	88	15	Yes

Table A-3:
Adoption Caseloads by Local Office (continued)
2007

Office	Adoption Children	Adoption Avg Children	Adoption (Jun 07)
Passaic Central	78	16	Yes
Passaic North	59	20	No
Salem	115	16	Yes
Somerset	42	14	Yes
Sussex	42	14	Yes
Union Central	65	13	Yes
Union East	128	13	Yes
Union West	128	16	Yes
Warren	46	15	Yes
Totals	3,461	15	90%

Table A-4: June 2007				
Local Office	Total Number of Workers	Total Number of Supervisors	Ratio 5 to 1	Supervisory Ratio (June 07)
Atlantic East	44	9	5	Yes
Atlantic West	27	6	4	Yes
Bergen Central	44	10	4	Yes
Bergen South	60	12	5	Yes
Burlington East	52	11	5	Yes
Burlington West	54	9	6	No
Camden Central	63	14	4	Yes
Camden East	62	11	6	No
Camden North	59	14	4	Yes
Camden South	62	13	5	Yes
Cape May	39	8	5	Yes
Cumberland East	27	6	4	Yes
Cumberland West	49	9	5	Yes
Essex Central	73	14	5	Yes
Essex North	53	11	5	Yes
Essex South	50	11	5	Yes
Newark Center City	67	13	5	Yes
Newark Northeast	75	18	4	Yes
Newark South	64	15	4	Yes
Newark Adoption	40	9	4	Yes
Gloucester East	35	8	4	Yes
Gloucester West	36	7	5	Yes
Hudson Central	51	11	5	Yes
Hudson North	41	9	5	Yes
Hudson South	39	11	4	Yes
Hudson West	34	8	4	Yes
Hunterdon	16	4	4	Yes
Mercer North	54	13	4	Yes
Mercer South	57	11	5	Yes
Middlesex Central	34	7	5	Yes
Middlesex Coastal	88	17	5	Yes
Middlesex West	71	12	6	No
Monmouth North	67	13	5	Yes
Monmouth South	55	11	5	Yes
Morris	75	15	5	Yes
Ocean North	72	13	6	No
Ocean South	72	13	6	No
Passaic Central	62	13	5	Yes

Table A-4 : June 2007 (continued)				
Local Office	Total Number of Workers	Total Number of Supervisors	Ratio 5 to 1	Supervisory Ratio (June 07)
Passaic North	59	11	5	Yes
Salem	47	9	5	Yes
Somerset	43	10	4	Yes
Sussex	25	6	4	Yes
Union Central	52	12	4	Yes
Union East	67	12	6	No
Union West	59	12	5	Yes
Warren	36	9	4	Yes
TOTAL	2411	500	87%	



APPENDIX B

**New Jersey
Department of Children and Families**

Implementing the Case Practice Model

September 2007

EMBARGOED - Not for release until October 22, 2007